IMPROVING PALLIATIVE CARE IN AGED CARE SETTINGS: IMPLEMENTATION OF NEEDS ROUNDING IN THE CENTRAL COAST

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Aged Care, Palliative Care, Needs rounding

EXECUTIVE SUMMARY:

Specialist Palliative Care Needs Rounding (SPCNR) is an evidence-based, collaborative model implemented within Central Coast Local Health District to strengthen early identification of palliative care needs, advance care planning, and care coordination in Residential Aged Care Homes (RACHs). The model commenced in February 2026 and has expanded to six RACHs by June 2026. SPCNR builds capability through structured multidisciplinary discussions, education, and evidence-informed tools that support person-centred end-of-life care in place. Early outcomes demonstrate improved clinical collaboration, increased staff confidence, and strengthened advance-care-planning which can contribute to hospital avoidance. This aligns with NSW Health priorities for integrated, value-based care.

INTRODUCTION:

Specialist Palliative Care Needs Rounding (SPCNR) is a multidisciplinary model supporting early identification of palliative care needs and advance care planning for residents of Residential Aged Care Homes (RACHs). The model was implemented in the Central Coast Local Health District (CCLHD) and aligns with the CCLHD Caring for Our Community Plan 2021–2031. The project was funded by the Comprehensive Palliative Care in Aged Care (CPCiAC) initiative.

HIGHLIGHTS:

- Six RACHs implemented SPCNR within five months
- Early identification and ACP supported for high-risk residents
- Workforce capability strengthened through structured and case-based education
- Nurse Practitioner engagement enabled continuity of clinical actions
- Flexible implementation overcame GP and provider participation barriers

METHODOLOGY/PROCESS:

Model Implementation

Specialist Palliative Care Needs Rounds (SPCNR) were implemented through regular, structured multidisciplinary case discussions between Residential Aged Care Homes (RACHs) and the CCLHD Specialist Palliative Care Service. Implementation was supported by a Comprehensive Palliative Care in Aged Care (CPCiAC) funded Clinical Nurse Consultant role, which provided coordination, education, and clinical leadership across participating sites.

Implementation Supports

Key implementation supports included the development of:

- a care staff discussion tool to support early identification of residents with increasing palliative care needs during handover
- a palliative needs trigger code system
- a structured Needs Rounds checklist informed by current literature

- case-based education embedded within each Needs Round
- structured key learning presentations distributed monthly, based on themes identified during Needs Rounds (e.g. communication with multidisciplinary teams, residents, and carers)

These supports were designed to enable inclusive, whole-of-facility practice change across all levels of care. Each RACH was provided with an implementation and engagement period prior to the initial Needs Round, with the first session used to tailor processes to local staff engagement, health literacy, and workflow.

Adaptive Engagement Strategies

- During infectious disease outbreaks, SPCNRs were offered via Microsoft Teams to minimise service disruption.

RESULTS/OUTCOMES:

As of July 2026, 26 SPCNRs had been conducted, engaging 194 RACH staff and discussing 193 residents, with 22 referrals recommended to specialist palliative care. Education was embedded within each round, most frequently relating to pharmaceutical management, communication with families, phases of end-of-life care, and advance care planning. Resident discussions were primarily triggered by irreversible physical or cognitive deterioration and complex symptom concerns. Hospital avoidance outcomes are not yet available and will be reviewed over a 12-month period. 48 Needs Rounds are planned for completion by October 2026.The first Key Learning was circulated titled: The Palliative Approach, End-of-Life and Actively Dying Phases of Resident Care.

Successes

- Needs Rounds strengthened multidisciplinary collaboration and capability across participating RACHs.
- Feedback indicated increased staff confidence in identifying residents with escalating palliative care needs and initiating advance care planning. Practice changes included organisation of resident case conferences and increased use of person-centred, palliative-appropriate terminology in discussions with GPs and care teams, demonstrating culture change and translation of learning into practice.
- Given wide variation in existing communication and education practices across RACHs, the flexible, transferable, and scalable design of the SPCNR model and resources enabled adaptation to local contexts.

Challenges

- General Practitioner attendance was limited. This was mitigated through RACF-led GP follow-up discussions, alignment of Needs Rounds with Nurse Practitioner availability, and flexible engagement with willing providers.
- Implementation of SPCNR during this initial research phase was complex due to each aged care provider having their own approval processes for research governance at their facilities.

CONCLUSION:

The implementation of SPCNR within CCLHD demonstrates the feasibility and early impact of the model. SPCNR strengthened early identification of palliative care needs, advance care planning, and workforce capability through structured case discussions, education, and adaptable implementation strategies. Despite challenges related to GP engagement and provider participation, flexible, locally responsive approaches have enabled sustained delivery and early practice change. Ongoing evaluation, including hospital avoidance and staff satisfaction outcomes, will further inform the effectiveness and scalability of SPCNR as a mechanism to support integrated, person-centred palliative care in aged care settings.