BMC Palliative Care

RESEARCH

Open Access

Evaluation of palliative care needs rounds in residential aged care homes in South Australia: a qualitative study

Sara Javanparast[1,2*] and Jennifer Tieman[1]

Abstract

Background Palliative care needs rounds have been introduced to improve palliative and end-of-life care in residential aged care homes. As part of the Australian Government initiative 'Comprehensive Palliative Care in Aged Care Measure', needs rounds have been trialled in seven metropolitan and fifteen regional/rural aged care homes in South Australia. This qualitative study examined stakeholders' perspectives about potential values and factors that facilitate or hinder the implementation and sustainability of needs rounds.

Methods A qualitative approach was employed by using individual interviews and focus groups. Semi-structured interviews ($n=13$) were conducted with executives, project team members and staff from both sites. Additionally, four focus groups were facilitated in regional/rural sites ($n=10$) to further unpack specific elements of needs rounds' model that were tailored based on their needs. The interview and focus group data were recorded and transcribed verbatim. The transcripts were transferred into the qualitative data management software NVivo (version 14) for coding and analysis. Guided by a coding framework, thematic analysis was undertaken.

Results Participants found palliative care needs rounds valuable in providing a structured approach to improving palliative care planning and enhancing workforce knowledge and confidence in identifying and managing care towards the end of life. Access to telehealth facilitated needs rounds participation, especially in regional/rural areas. Comparing the nurse practitioner with the medical consultant led needs rounds revealed that there is no 'one size fits all' approach with advantages and disadvantages for each model. Successful implementation of such a model depends on the context within which needs rounds are implemented such as organisational needs, capacity and infrastructure, geography, and resources. Organisational commitment to palliative care, preparedness for change, strong leadership and financial support, and access to online platforms were noted as key factors enabling successful implementation of needs rounds.

Conclusions Palliative care needs rounds can contribute to improving organisational culture and workforce knowledge in palliative and end-of-life care. Policy commitment and financial support to adopt and tailor palliative care needs rounds that meet local needs are highly recommended.

Keywords Palliative care, Needs rounds, Residential aged care homes, Australia

*Correspondence:
Sara Javanparast
sara.javanparast@flinders.edu.au
Full list of author information is available at the end of the article

Background

The share of population over 60 years of age is increasing worldwide and is predicted to almost double from 12% in 2015 to 22% in 2050 [1]. As with many other developed countries, Australia's population is also ageing. Between 2000 and 2020, the proportion of the Australian population aged 65 years and over increased from 12.4% to 16.3%, and by 2066, this percentage is projected to be approximately 23% [2]. This has led to an increasing number of older people living and dying in residential aged care homes. Over a time period of 10 years (2011–2021), the number of Australian people who used aged care homes permanently increased from 165,000 to 184,000, an increase of almost 11% [3]. This increase was greater (15%) among those aged 85 years and older [3] who are more likely to have multiple health conditions, moving towards end-of-life stage, and utilise healthcare services. For example, a study of transfer to the hospital emergency department during 2009–2013 revealed a fourfold greater percentage of older people in the aged care group than in those living in the community [4]. These figures highlight an urgent need to focus on residential aged care homes as a priority setting for designing and delivering palliative and end-of-life care models to prevent avoidable hospital transfers and improve quality of life and death for this population group.

In Australia, improving palliative and end-of-life care in aged care has been emphasised in national and jurisdictional policies and strategic plans. The final report of the Australian Royal Commission into Aged Care Quality and Safety highlighted the need for improved palliative care in aged care homes, including better distribution and training of the workforce, access to specialist palliative care staff, improved integration between aged and health care systems as well as primary and specialist palliative care services, and stronger engagement with residents and families [5].

Aged care system in Australia provides a range of government subsidised care and support services for older Australians at home or in residential aged care homes [3]. This includes care provided by nursing staff who are employed by the residential aged care homes, as well as services provided by general practitioners, medical consultants, pharmacists and allied health professionals who regularly visit the aged care home. Standards, tools and guidelines have been developed to monitor the quality of care services in aged care including palliative care [6].

Initiatives have been developed and trialled to improve palliative care in aged care, for example; palliative and end-of-life care training for the aged care workforce, outreach specialist care, and advance care planning [7]. End of Life Directions for Aged Care (ELDAC) project supported by the Australian government, provides online training toolkits and information to support palliative care [8]. However, palliative care training is not routinely provided to all care staff and depends on the resources available and access to specialist palliative care workforce. Palliative care needs rounds model (hereafter referred to as needs rounds) is an evidence-based approach that has been tested in Australia. The original model of needs rounds, as implemented in the Australian Capital Territory (ACT), involved monthly hour-long triage meetings led by a palliative care nurse practitioner or specialist palliative care nurse to identify residents at greater risk of dying and to plan and monitor palliative care for them [9]. Checklists have been developed to guide aged care staff in identifying residents at risk and prioritising areas for discussion and action. Evaluation of this model revealed a reduction in hospitalisation rates and length of hospital stays among residents, an increase in staff capability and confidence in planning and managing palliative and end-of-life issues, and improvement in the quality of death and dying [10, 11]. The Australian needs rounds model has been adopted in other countries, such as the UK, where researchers codesigned and implemented a scalable model that could meet their specific contextual needs [12].

Palliative care needs rounds in South Australian aged care homes

The Comprehensive Palliative Care in Aged Care Measure is an initiative by the Australian Government (2019–2024) aiming to improve palliative care for older people living in aged care homes. Cost-sharing between federal and state governments encouraged buy-in and commitment, with each jurisdiction customising their trial of palliative care models. The South Australian government undertook scoping activities to inform, identify and prioritise models of palliative care [13, 14]. Needs rounds were identified as one key element of a pilot project called 'Hospice in Residential Aged Care'. The project was implemented at two South Australian sites: 1) a not-for-profit aged care provider (seven facilities in metropolitan areas with a total of 744 aged care beds); and 2) publicly funded facilities in regional/rural South Australia (fifteen facilities with a total of 573 aged care beds).

Between 2021 and 2022, monthly needs round meetings—a new intervention for all project sites—were held face-to-face or online. The composition and facilitation of these needs rounds differed between the two sites. In metropolitan sites, needs rounds were led by a palliative care nurse practitioner and attended by a specialist palliative care nurse and other senior nurses and clinical leaders. In regional/rural sites, needs rounds were led by a palliative medical consultant and attended by senior nursing staff, general practitioners and pharmacists. Both

sites used similar referral checklists to identify residents at high risk and those in need of palliative care.

The evaluation of needs rounds in participating sites was commissioned by the South Australian Department for Health and Wellbeing and aimed to:

- examine the perspectives of aged care staff about benefits of needs rounds and their potential contribution to better residents' outcomes;
- explore factors that enable or hinder the successful implementation of needs rounds;
- compare needs rounds implementation and facilitation processes in metropolitan versus regional/rural sites; and
- examine issues around the sustainability and transferability of needs rounds.

Methods

We employed a qualitative methodology for a deeper understanding of participants' perspectives, needs rounds' processes and perceived outcomes. Qualitative data were collected through individual interviews and focus group discussions with stakeholders. Semi-structured interviews were conducted with executives, project team members and nursing staff from both sites ($n=13$). In regional/rural sites, four focus groups were facilitated by the research team and attended by those who were involved in needs rounds including site managers, senior nurses, general practitioners and pharmacists ($n=10$) to further unpack specific elements of the needs rounds' model that were tailored based on their needs.

The interviews and focus groups were conducted (face-to-face or online) between September and November 2022. An interview guide was developed by the research team and discussed in meetings that were held monthly with the South Australian Department for Health and Wellbeing and the project sites. With assistance from the project teams, an invitation along with a participant information sheet and consent form were sent to those who were involved in needs rounds in each aged care home. Participants contacted the researcher (first author) if they were willing to participate. Focus groups were organised at a time convenient to all participants.

The interview and focus group data were recorded and transcribed verbatim. The transcripts were transferred into the qualitative data management software NVivo (version 14) for coding and analysis. Guided by a coding framework, thematic analysis was used. We used a hybrid approach using deductive and inductive analysis processes [15]. It involved codes developed deductively from the research questions and the literature and the generation of additional themes from the interview and focus group data during the inductive analysis. The coding framework and emerging themes were regularly discussed and revised by the research team to reach consensus. Ethics approval was sought and granted by the Flinders University Human Research Ethics Committee (project number 5252).

Results

Sections below present the implementation process of needs rounds and participants' views about tools they used to identify residents, facilitation of needs rounds, documentation of action plans and follow ups. It also presents perceived values of needs rounds and factors that enabled or hindered the successful implementation of needs rounds model.

Implementation of needs rounds

The implementation of needs rounds involved premeeting activities to identify residents in need, facilitation and discussions during the meeting, as well as documentation and care monitoring afterward (Fig. 1).

Identification of residents at high risk

A referral checklist, previously developed by Forbat et al. [16], was used by senior nurses prior to the meetings. Most participants felt that the checklist was valuable in helping them identify those who could benefit from further discussion about palliative care support. It also prompted a discussion between members of the care team about residents at higher risk.

> *We've got a referral form which we complete, which has got information about diagnosis and medical conditions, and what the concerns are and why we've referred, which is helpful. (nurse, regional site)*
>
> *I've received this notification and checklist this morning about the meeting coming up in relation to the next round. So, I've touched base with other staff, and we've workshopped through our residents to see if there's anybody there that's deteriorating and might look like they're heading towards a palliative phase. We go through our list of residents and just make sure that there's anyone there that we might want to capture and discuss to be able to provide better care to them. (nurse manager, regional site)*

An area for further improvement that was noted by some participants was related to better communication and information sharing prior to needs rounds particularly with visiting professionals including general practitioners and pharmacists who are not familiar with the residents.

> *The idea was that a list of patients would be sent out to everyone. I never got a list of patients whom we*

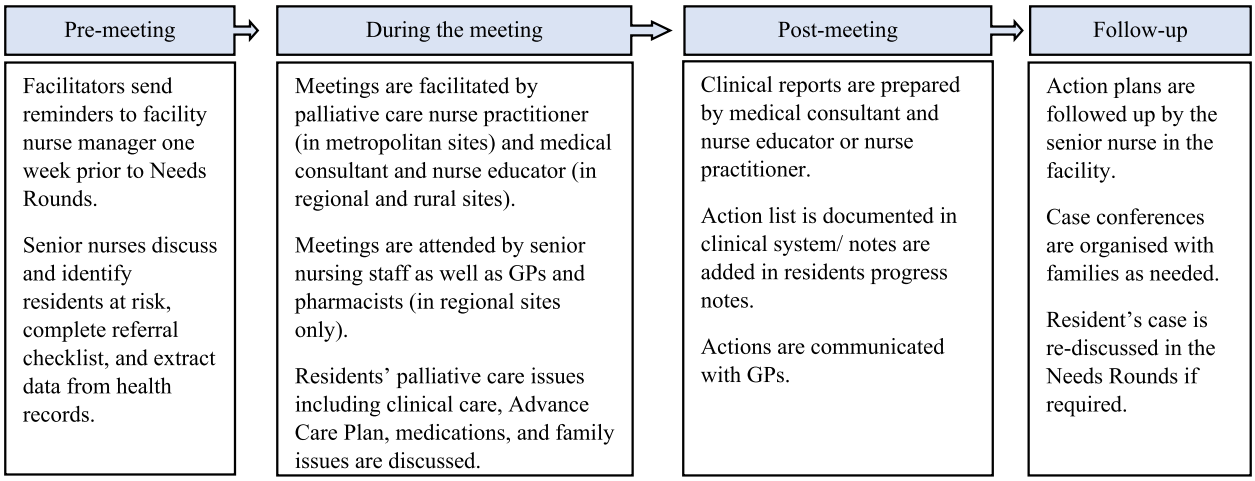

Fig. 1 Needs Rounds implementation and follow-up processes

were going to speak about. So, it was very hard from a pharmacy point of view to follow who we were talking about without actually having a chart in front of me to see what was prescribed. (pharmacist, regional site)

There was also inconsistency across sites in the understanding of palliative versus end-of-life stages. While some participants talked about selecting residents who were *'heading towards a palliative phase'* and *'deteriorating in the last month'*, other sites took a broader approach, including residents with longer-term projection towards the end of life.

When I look at palliation, I probably look at the last few weeks of life… It is around the care when they're actually passing that we're looking at and maintaining their comfort and dignity and all those aspects of palliative care. (nurse, metropolitan site)

Facilitation of needs rounds

The two sites undertook different approaches to needs rounds facilitation. This provided an opportunity to collect stakeholders' perspectives in relation to nurse practitioner-led model used in metropolitan sites versus the medically led model in regional/rural sites.

Participants commented on the pros and cons of each model. Staff at regional/rural sites found a great benefit from having a palliative care medical consultant on board who provided specialised medical *'knowledge'*, *'confidence'* and '*credential*'.

It would provide a great deal of reassurance to the general practitioners that they have had an opinion from a specialist palliative care consultant. I think it is very valuable. (nurse, regional site)

From a pharmacist perspective, general practitioners were more likely to take on board the medication recommendations when they came from the medical consultant rather than a pharmacist.

As a pharmacist, when I put through the suggestions, some of the suggestions are not being actioned…some doctors just stick to their approaches once they pick up certain things and they do not review certain medications. However, with input from the specialist consultant, you get them to think about what can be done better. (pharmacist, regional site)

One executive member of the regional team also noted:

I think the key success of our program is that we have invested in the medical field. Doctors listen to doctors.

However, a few participants raised concerns about the clinical and medical dominance of needs rounds when led by medical practitioners.

There is a strong focus on medications. We're not really triaging what needs to happen for the whole package; we're looking at more of the clinical aspects of that person's care… Needs rounds here are very much more formal, I guess. (nurse, regional site)

On the other hand, nurse practitioner-led needs rounds were found to be useful for addressing power hierarchies and enhancing interactions and contributions from nursing staff.

The great advantage of the nurse-led model is that we are engaging directly with the senior nursing staff in the facilities, and I guess it is a very safe environment for them to talk about their concerns about

residents who may be approaching end of life… when doctors are involved, nursing staff may not feel as confident in raising questions and exploring ideas for fear of looking stupid. (nurse, metropolitan site)

Access to experienced palliative care nurses prior to the project and pre-existing relationships with general practitioners at metropolitan sites were seen as factors that, despite the absence of a medical consultant, resulted in general practitioners being more receptive to recommendations from needs rounds.

I think overwhelmingly, it has been positive that we have the nurse practitioners here who have developed truly good relationships with most of the general practitioners and that they are usually very receptive to our suggestions. (nurse, metropolitan facility)

The key point raised in comparing the two models was related to sustainability and transferability issues. The nurse practitioner model was felt to be more sustainable. The affordability of engaging with palliative care medical consultants and their access particularly in rural and regional areas to lead needs rounds beyond the life of the pilot project was a concern.

Whether the respective governments, either Commonwealth or state, will continue to fund it [palliative care medical consultant] and expand it I guess remains to be seen. It looks like an expensive model, but I think that this program has proven to be quite cost-effective using palliative care consultant. (project team member, regional site)

Furthermore, the monetary incentive provided to general practitioners to attend the needs rounds was seen as a major enabler and that the ending of financial incentive will negatively impact the project roll out and sustainability in the future.

I worry about the sustainability of it. We are getting general practitioners along from some sites, and that is fantastic, and that is partly because there is a financial incentive for them to do that, and partly because they have an interest. However, beyond the scope of the project, I do not know how much buy-in we will get from them in that way. (nurse, regional site)

A few participants raised issues around equity and access to palliative care physicians in regional/rural areas as a broader system barrier requiring political and policy commitment, consideration, and investment.

I don't really know whether you continue with the specialist palliative medicine input, which is very valuable, but it would need to be available for all of our facilities in regional and remote areas. There is such inequity in access to palliative care medical practitioners in regional South Australia. (nurse, regional facility)

Documentation and information sharing

Discussions and action plans from needs rounds were recorded using action sheets that were completed by senior nurses and clinical reports that were prepared by the medical consultant for sharing with general practitioners. Some participants felt the need for further improvement in the documentation of needs rounds notes and action plans into the existing digital clinical systems that in turn facilitates access to information for other staff in the facility. While clinical systems in some aged care homes allowed the broader staff to access notes and recommendations, other sites had no structure in place to document and share needs rounds information with staff.

It does concern me that after the needs rounds [our general practitioner] visit the patient, that's it. He doesn't really document anything in [the clinical system]. I guess from an accreditation perspective, if they came along and wondered why someone's medications changed, we don't have the evidence other than a few times I've received a report from [medical consultant], and I've uploaded it to their notes… I think occasionally [general practitioner] might quickly document something, but it's not consistent. (nurse unit manager, regional facility)

Perceived values of needs rounds

A majority of interview and focus group participants found the model feasible and valuable in providing a more structured approach to identifying residents at higher risk and discussing palliative care issues. Furthermore, it was viewed as an opportunity to enhance palliative care capability and skills among staff. None of the participants had prior experience with needs rounds and felt that needs rounds are '*very positive*', '*respectful*', '*truly beneficial*', and '*professionally run*'.

Comments from participants provided insight into how needs rounds can contribute to the organisational palliative care culture and capacity, the knowledge of aged care staff and the care quality of residents and their families.

The educational value of needs rounds was frequently noted. The interview and focus group participants provided strong views about the positive impact of needs rounds on improving knowledge and confidence in palliative care, which in turn would assist in providing better care for residents. A nurse described her positive learning experience as follows:

To actually be able to sit and discuss in a discussion setup around particular residents, and then their individual issues, to me is much more helpful than a learning course you go to for a day. (nurse, metropolitan site)

General practitioners provided many examples of when advice from medical consultants assisted them in the clinical management of complex cases.

The [consultant] has been good in terms of suggestions and doses and alternatives for medications that we normally wouldn't use much. She once suggested an alternative medication, which I've only ever used once before, and didn't know it existed until then in a palliative setting. It's been really helpful. (general practitioner, regional site)

Similarly, a pharmacist commented on his positive experience with learning:

It was good to get the [medical consultant] to talk about deprescribing of medications. They'll be still taking a whole heap of oral medications, and I think it's time to stop this. (pharmacist, regional site)

Despite all positive learning experiences expressed by people who were directly involved in needs rounds discussions, passing on this learning to the broader team within the aged care home seemed to occur more on an ad hoc basis.

Many participants perceived needs rounds as an opportunity to enhance multidisciplinary care for residents with complex needs and as a way to assist staff to provide appropriate and consistent palliative care advice for the benefit of residents and their families.

So, this gives me consistency of palliative care advice to residential aged care clients in a really effective manner. And it supports the staff supporting the clients. So to me, I can't see anything other than positives out of this whole needs rounds process. (general practitioner, regional facility)

Perceived facilitators and challenges to implementing needs rounds

Needs rounds was a new initiative in both metropolitan and regional/rural sites. Organisational commitment to palliative care, preparedness for change, leadership and financial support, and access to online platforms were noted as key factors in the successful implementation of needs rounds. Both metropolitan and rural sites leveraged their existing infrastructure, capacities, and resources to facilitate needs rounds planning and engagement. Prior to the commencement of the project, metropolitan sites had already made palliative care a priority, so there was a more seamless establishment of needs rounds which built on existing expertise and relationships.

We were already committed to palliative care. We were already resourced for palliative care. We already had done a lot of work to raise the profile and to build the expertise of our staff for palliative care…higher level of baseline (executive, metropolitan facilities)

Similarly, regional/rural sites utilised funding and resources from various internal and external sources to engage with stakeholders and to adjust models of care to meet their local needs. One example was additional funding that was allocated to increase general practitioners' and pharmacies' participation through the provision of monetary incentives.

Participants noted that telehealth and access to online platforms facilitated meeting attendance. This approach was particularly effective during the COVID-19 lockdowns at both sites. Online platforms were particularly important at regional/rural sites where distance was a major barrier for external professionals to attend the meetings.

I think because of COVID-19, it [online meeting] probably helped make this process go. I think it's made the most of technology and that's actually working really well for this specific meeting. I just don't think that they would get the oversight from a palliative care specialist if it was based face to face. (general practitioner, regional site)

It [online platform] gives us access to people no matter their situation, so people can be at home or wherever, that opens up a better or varied option of when they can tap into the meeting, rather than having to physically come here, which is a three-and-a-half-hour drive. Without it, I don't think it would have happened every month, it's not practical. (nurse manager, regional site)

Staff shortages and turnover and a busy working environment in the aged care setting were major structural issues hindering the implementation of needs rounds. Additionally, during the COVID-19 outbreak in aged care homes, a large amount of time was absorbed by senior staff.

One of the key challenges was the timing of COVID-19, as you can expect. It did delay some timelines and some of the actions. It was obviously significant because we had sites closed down…also the priorities of our operational staff through COVID-19 are just getting enough staff to give people the basic care they need around medications, food, and hydration.

Therefore, people's priorities can potentially shift. (executive, metropolitan site)

Engagement with general practitioners and pharmacists at regional/rural sites was found to be beneficial but extremely challenging. Time pressure was perceived as a major barrier for those who were externally contracted and not embedded in the aged care homes. Pre-existing and good relationships with general practitioners, contribution from palliative care medical consultants, and offering monetary incentives were noted as factors enabling general practitioners and pharmacists' engagement. Nevertheless, the level of general practitioners engagement varied across sites.

Both general practitioners and the pharmacists..., a lot of the services they provide to aged care, they're providing it as a private business. They're not in salary time whereas everybody else that attended needs rounds was within salary time...So yeah, it is the time constraints for a lot of general practitioners. (medical consultant, regional facility)

Discussion

This qualitative study confirms the contribution that needs rounds make to improved palliative care planning and enhanced workforce capability and skills. Previous studies have demonstrated that needs rounds contribute to improved knowledge and confidence in providing palliative care, residents' care planning and management and reducing hospital admission [17, 18]. Despite differences in organisational contexts, governance, and resources at the two participating sites, both have been able to build internal capacity and leadership, which would assist them institutionalising needs rounds within their care model.

Given the increasing trend in people living and dying in aged care homes, continued support to institutionalise and tailor needs rounds can provide an opportunity to address many challenges reported in relation to palliative care in aged care. However, a key finding from this study is that there is no 'one size fits all' approach to needs rounds. The characteristics of such a model depend on the context within which the needs rounds are implemented such as organisational needs, capacity and infrastructure, geography, and access to financial and human resources [12, 18, 19]. Palliative care needs rounds should be also tailored according to the organisations' prioritisation and capabilities. Although the gap in access to specialist palliative care was addressed by the employment of a palliative care medical consultant at regional/rural sites; the metropolitan sites benefited from existing access to specialised palliative care nurses, organisational capacities, and interprofessional relationships.

Supporting needs rounds implementation requires clearer processes for resident identification, documentation of action plans, and knowledge transfer. Despite the development of guidelines, checklists, and procedures for needs rounds [16], a designated role within the facility to communicate needs rounds discussions and action plans with other staff is recommended. The role can also assist in training staff to prepare information for needs rounds, using checklists, and following up on actions. Furthermore, a consistent and linked electronic system that is accessible to all staff would be an effective way to document action plans and to share information with other staff who are involved in residents' care.

The training and educational aspects of palliative care needs rounds through case-by-case and on the job training for general practitioners, pharmacists, and nurses was highlighted in this study. Given the barriers to access and expanding formal training opportunities in palliative care for example time constraints to attend training and poor access to tailored content and mode of delivery to meet the needs of different organisations and health professional groups [20–22], case-based discussions in needs rounds can provide a great opportunity to gain and sustain new knowledge and skills in a real world setting.

Our study confirmed the findings from other studies [23, 24] that access to online platforms is critical to increase participation in needs rounds. The provision of appropriate digital infrastructure, especially in regional/rural areas, will increase access and participation in needs rounds. Easy access and continuation of needs rounds during the COVID-19 pandemic confirms needs rounds as an effective strategy to maintain and improve palliative care services and interprofessional communication in residential aged care homes should another pandemic arises.

Finally, this study reaffirms the need for continued policy commitment and engagement with the aged care sector to identify needs for equitable access to specialist palliative care expertise across metro and regional areas if needs rounds are to be transferable across sites. For the medically led needs rounds' model, greater investment and policy support are needed to ensure active participation of medical practitioners in needs rounds. Further research to prove the cost-effectiveness of engaging GPs and medical consultants in needs rounds will assist to inform future policies.

Our study had strengths and limitations. Comparing needs rounds implementation in two different contexts (not-for-profit metropolitan versus public regional sites) provided an opportunity to explore context-specific factors which inform how the model can be tailored to meet organisational needs. The limitation of this study is the lack of engagement with residents

and families and aged care staff not directly involved in needs rounds. Likewise, the impact of the needs rounds on the residents' health outcomes was not measured.

Conclusion

Palliative care needs rounds are an evidence-based model of care that is proven to be effective in improving quality palliative care in aged care and reducing unnecessary transfers to hospitals. Our study evaluating the implementation of needs rounds in South Australian aged care homes confirmed the potential contribution of needs rounds to improving organisational culture and workforce knowledge in palliative and end-of-life care. Policy commitment and financial support to scale up palliative care needs rounds that are tailored to meet local contexts and needs are highly recommended.

Acknowledgements
We acknowledge the funding from South Australian Department for Health and Wellbeing for this evaluation work. We would like to acknowledge our interviews and focus groups participants for their time to share their knowledge and perspectives about palliative care needs rounds in aged care homes. We would also like to acknowledge support from project teams at metropolitan and regional sites in this evaluation work.

Authors' contributions
SJ and JT both made substantial contributions to the conception and design of the work; SJ conducted individual interviews. SJ and JT facilitated focus groups. SJ led data analysis. Both authors contributed to the draft of manuscript and revisions and approved the final version of the manuscript.

Funding
The study was commissioned by the South Australian Department for Health and Wellbeing.

Data availability
The interview and focus groups data from this study are not publicly available due to confidentiality but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
We confirm that the collection of interviews and focus groups data, data analysis and storage were performed in accordance with relevant guidelines and regulations. Ethics approval for individual interviews and focus groups was granted from the Flinders University Human Research Ethics Committee (project ID 5252). Study information sent to participants and informed consent was obtained from all participants. Participants signed and sent us a written consent prior to the interview or focus group.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Author details
[1]Research Centre for Palliative Care, Death and Dying, College of Nursing and Health, Sciences, Flinders University, Adelaide, Australia. [2]Allied Health and Human Performance Unit, University of South Australia, Adelaide, Australia.

Received: 11 November 2024 Accepted: 17 February 2025
Published online: 13 March 2025

References

1. WHO. World report on ageing and health. 2015. Available from: https://iris.who.int/handle/10665/186463. Accessed 21 Feb 2024.
2. AIHW, Older Australians, Australian Institute of Health and Welfare. Canberra; 2021.
3. AIHW. People using aged care. Australian Institute of Health and Welfare 2022. Available from: https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care.
4. Dwyer R, et al. Patterns of emergency ambulance use, 2009–13: a comparison of older people living in Residential Aged Care Facilities and the Community. Age Ageing. 2018;47(4):615–9.
5. Royal Comission into Aged Care Quality and Safety, Royal Comission into Aged Care Quality and Safety Final Report: Care, Dignity and Respect. Canberra: Commonwealth of Australia; 2021.
6. Australian Government, Strengthened Quality Standards framework analysis, Australian Commission on Qualiy and Safety. Canberra; 2023.
7. Candy B, et al. Hospice care delivered at home, in nursing homes and in dedicated hospice facilities: a systematic review of quantitative and qualitative evidence. Int J Nurs Stud. 2011;48(1):121–33.
8. ELDAC. Quality Improvement. 2023, End of Life Directions for Aged Care. Available from: https://www.eldac.com.au/tabid/5033/Default.aspx.
9. Forbat L, et al. Palliative care Needs Rounds: Implementation guide. Calvary Hospital: University of Stirling; 2020.
10. 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. Palliat Med. 2020;34(5):571–9.
11. Chapman M, et al. Avoiding costly hospitalisation at end of life: findings from a specialist palliative care pilot in residential care for older adults. BMJ Support Palliat Care. 2018;8(1):102–9.
12. Macgregor A, et al. Supporting care home residents in the last year of life through "Needs Rounds": Development of a pre-implementation programme theory through a rapid collaborative online approach. Front Health Serv. 2022;2:1019602.
13. Health SA. Stakeholder Mapping and Analysis: The Comprehensive Palliative Care in Aged Care Project Agreement. South Australian Department of Health: Adelaide; 2020.
14. Health SA. Literature Review: The Comprehensive Palliative Care in Aged Care Project Agreement. South Australian Department of Health: Adelaide; 2020.
15. Proudfoot K. Inductive/deductive hybrid thematic analysis in mixed methods research. J Mixed Methods Res. 2023;17:308–26.
16. Forbat L, et al. Improving specialist palliative care in residential care for older people: a checklist to guide practice. BMJ Support Palliat Care. 2018;8(3):347–53.
17. Rainsford S, et al. 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. 2020;28(5):308–17.
18. Koerner J, et al. Context and mechanisms that enable implementation of specialist palliative care Needs Rounds in care homes: results from a qualitative interview study. BMC Palliat Care. 2021;20(1):118.
19. Moore DC, et al. Strategies for the implementation of palliative care education and organizational interventions in long-term care facilities: A scoping review. Palliat Med. 2020;34(5):558–70.
20. Cairns W, Yates PM. Education and training in palliative care. Med J Aust. 2003;179(6):S26.
21. Iida K, et al. Palliative and end-of-life educational interventions for staff working in long-term care facilities: An integrative review of the literature. Int J Older People Nurs. 2021;16(1): e12347.
22. Froggatt K. Palliative Care Implementation in Long-Term Care Facilities: European Association for Palliative Care White Paper. J Am Med Dir Assoc. 2020;21(8):1051–7.
23. Rainsford S, Hall Dykgraaf S, Phillips C. Effectiveness of telehealth palliative care Needs Rounds in rural residential aged care during the COVID-19 pandemic: A hybrid effectiveness-implementation study. Aust J Rural Health. 2022;30(1):108–14.

24. Samara J, et al. Telehealth Palliative Care Needs Rounds During a Pandemic. The Journal of Nurse Practitioners. 2021;17:335–8.

Publisher's Note

Sara Javanparast SJ is a Senior Research Fellow at the Research Centre for Palliative Care, Death and Dying.

Jennifer Tieman JT is the Director of the Research Centre for Palliative Care, Death and Dying. Both authors are located at Flinders University of South Australia.