Palliative care for older people in nursing homes

Healthcare does not follow a linear track of prevention, health gain, health maintenance and palliative care. Instead, aspects of each occur to differing degrees at various stages of life. While the palliative care component increases as we near the end of our life span, we also engage in a range of preventive measures in later life (and in nursing homes). In this context, an influenza vaccination, falls prevention programmes, and cardiovascular prevention. Finding the right equipoise between the various components is a complex task, and the emergent interest in end of life care for older people provides an opportunity for reflection on the global care needs of this population. This is a significant issue, as although at any one time less than 5% of older people are resident in nursing homes, 6% of older people will spend some time in a nursing home before they die. Those in nursing homes are the most frail group of older people, and nursing homes are an increasingly common place for older people to die. Are there synergies for improving during-life and end of life care in nursing homes, and what skill sets do we need to develop to ensure person-centred care throughout the stay in nursing home?

The promotion of better standards of care in nursing homes has been a growing theme in the international literature, a is the been the catalyst for major initiatives such as the Minimum Data Set (a standardized needs assessment) in the USA and other countries. At the heart of solving the challenge of high quality nursing home care is the provision of adequate numbers of adequately trained staff, with adequate support structures. The recent interest in palliative care for older people in Ireland serves as a prompt to see where this initiative might fit into, and support, the wider care spectrum of needs of older people. Navigating the juncture when really sick becomes dying is particularly challenging, and is a core part of gerontologically-attuned health care, whether general practice, medicine or gerontological nursing. Is it possible that improving during life care will improve end of life palliative care? All members of professional groups provide care for older people in nursing homes, the two largest professional groups are nurses and family doctors. At least three sets of training skills are relevant to these professions in nursing home care: gerontology, dementia care and palliative care. Gerontological nursing promotes both during-life and end of life care for older people in nursing homes: the specialist knowledge, skills and attitudes facilitate the understanding and ability to deal with the complex issues of ageing, disability, rehabilitation, communication and palliation. Although this type of training or care staff in nursing homes can greatly improve quality of life for older patients, it is under-represented currently in nearly all settings of care for older people.

Official recognition has been tardy and has failed to adequately recognize the specialist skills needed for the complex care of older people. A document released by An Bord Altranais in 2009 on nursing older people failed to mention gerontological nursing or specialist nursing of older people, an omission highlighted by a similar document in the UK released two months previously which specified that nursing older people was a specialism. Similarly, a review of end of life care in Irish nursing homes catalogued various technical and professional capacities, but not whether the nursing staff had any training in gerontological nursing. Even the Health Information and Quality Authority (HIQA) standards for nursing homes (excellent in geriatric medicine) do not specify gerontological training for directors of nursing. For dementia care, specialist skills have been revolutionized by the pioneering work of Kitwood. In recognising that the experience of dementia is unique to the individual and dependent on the interaction of many factors a person-centred approach can be developed when considering care (including palliative elements) in this group. Dementia follows a disease trajectory that is progressive, individual and heterogeneous, and patients with dementia account for an increasing proportion of demand for palliative care, both in nursing homes and in the community.

Finally, the need for specific palliative care skills has become an emergent priority. A formal focus on palliative care in nursing homes has been relatively recent and referral to hospice care for patients with dementia is very low. The majority of nursing home care staff in Ireland has not received any formal qualifications in palliative care. Less than one third of all facilities reported that their nurses held a post-registration qualification in palliative care or that their care/support staff had attended short courses in end-of-life care; it is of some relevance that we do not know the corresponding figures for general practice or dementia care training. Since 1994 there have been several reports on the reform of policy for palliative care services but many of the recommendations from these earlier reports have not been implemented and the focus remains on palliative care for cancer patients with little emphasis on older people, especially older people in long stay settings. The value of educational interventions in palliative care can be considerable. A WHO Palliative Care Demonstration Project proposed that training in palliative care for all healthcare professionals increased access to specialist care in palliative care for long term, non-cancer, chronic conditions and saved approximately eight million euro on acute hospital services and resources.

Strategically, the Irish health services, and in particular nurses and general practitioners need to consider the best approach to developing a synthesis of gerontological, palliative and dementia expertise in the nursing home and community setting which will enhance care of this patient group in conjunction with specialist nurses, physicians, psychiatrists and allied health professions. A gerontologically attuned approach to care is central as ageing and disability affect virtually all nursing home residents, while dementia and death are common but not...
universal. A synthesis of these skill sets is essential as expertise in one particular area is not sufficient in isolation. We do not yet know the right combination, and a recent study on end of life care of those with advanced dementia in nursing homes omitted to factor in the skill bases of the attending nurses and doctors. Further studies need to factor in the three skill sets in order for us to appraise how we care for people with age-related disease and disability, and in particular dementia at the end of their lives. It would be prudent to address the gap in the education of our nurses and doctors in relation to gerontological, dementia and palliative skills so that these specialist skills can be developed from an early stage in training. If a drive for better palliative care for older people also improves gerontological and dementia care, could it be that: “In my end is my beginning”?

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References