Review of literature to identify barriers and enablers to the provision of palliative care in residential aged care and to the implementation of a sustainable model of palliative and end-of-life care

A collaboration between Ballarat Hospice Care, Grampians Region Palliative Care Consortium and its members, Grampians Regional Palliative Care Team (Grampians Health) and Central Highlands Rural Health.

BALLARAT HOSPICE CARE INC.
Home Based Palliative Care

Project partners: This literature review is an outcome of the 2023/24 Comprehensive Palliative Care in Aged Care Project, a collaboration between Ballarat Hospice Care, Grampians Region Palliative Care Consortium and its members, Grampians Regional Palliative Care Team (Grampians Health) and Central Highlands Rural Health.

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Contents

Abstract

Background

As Australia's population ages and the number of people using aged care services increases, the demand for palliative care in aged care is also increasing. Almost one-third of people using residential aged care will die in the year that they enter care. Death is the most common reason for ceasing residential aged care. As the Royal Commission into Aged Care Quality and Safety Final Report (2021) states, not all people in aged care receive the evidence-informed end of life care (EoLC) that they need. This can result in

- avoidable hospitalisations towards or at the end of life
- suboptimal symptom management for residents
- difficult bereavement for family and carers
- and/or a significant burden for staff providing the care.

To change this, palliative care must be strengthened to become a core component of aged care service delivery.

Objective

This realist review is conducted with the objective of:

1. Gaining an understanding of factors hindering and enabling the provision of comprehensive, high quality palliative care in residential aged care.
2. Gaining an understanding of factors enabling and hindering the implementation of a comprehensive model of palliative care in residential aged care and its sustainability.

Methods

A literature search was carried out through three different methods:

(1) A key word search using Google Scholar, Research Gate, PubMed
(2) Snowballing upon the bibliographic references discovered through the research team's literature review
(3) Database searching by the research team.

A structured selection and decision-making process was followed to assess all search results for inclusion/exclusion. Data from the literature chosen for inclusion was extracted into a spreadsheet. This information was then critically appraised under four main categories: barriers and enablers, to the provision of palliative care in residential aged care, and to the sustainable implementation of a palliative care intervention in residential aged care. A thematic analysis of the extracted data using qualitative data analysis software (MAXQDA), was then conducted by the authors. Based on the results achieved through this analytical process, a narrative account of barriers and enablers was developed.

Results

34 full-text publications were identified as relevant and assessed for meeting the eligibility and inclusion criteria. Ten key concepts concerning barriers, as well as seven key concepts regarding enablers (each comprising various sub-concepts), were uncovered in relation to the delivery of comprehensive palliative care within residential aged care settings:

- Barriers: Wider system barriers (outside the project scope), a lack of support from other healthcare professionals, time pressure, a lack of formal palliative care education and training, communication barriers, a lack of an appropriate model of care, a lack of or inadequate advance care planning in general and for patients with cognitive impairment in particular, patient and family/carer inherent barriers, the emotional burden on and

lack of grief and bereavement support for staff, and a lack of appropraite space for end of life care.

- Enablers: Wider system enablers (outside the project scope), organisational enablers, education and training to improve staff knowledge, practical skills, confidence, and resilience of the care team, change from an acute to palliative model of care, implementation of a palliative care framework, implementation of a person-centred model of palliiative care, the provision of accurate, relevant, up to date information, effective communication, and teamwork, grief and bereavement support for staff, families and carers and co-residents.

Five key concepts related to barriers, along with five key concepts related to enablers (both comprising various sub-concepts), were recognized concerning the implementation and long-term sustainability of a palliative care intervention:

- Barriers: Workforce challenges due to high staff turnover, staff shortages, and absences resulting in a high workload and time pressure; incompatibility of RAC systems and processes; resulting in participants experiencing a burden of redundant paperwork; manual processes and add- on workload without real benefit; failure to identify champions and key staff changes; weak GP relationships; organizational and financial barriers to the implementation of education and training; lack of support to implement acquired knowledge.
- Enablers: Organisational enablers; external and internal stakeholder involvement; intervention design; a blended model of both theoretical and hands on training, delivered in person and also via online modules; case-based education provided by a palliative care clinician; resilient and flexible training models to adapt to high staff turnover, high absenteeism, and time constraints, and varying staff experience; creating accountability and routine.

Conclusion

Three hypotheses were developed as to what factors enable and hinder the provision of palliative care in resiential aged care, and the successful implementation of a palliative care intervention, resulting in sustainable change. The key concepts will inform the development and/or selection of existing data collection tools:

- an audit tool for existing education resources, programs, and tools
- an organisational audit
- a Central Highlands Rural Health governance and procedural document audit tool to identify alignment, misalignment and gaps
- a residential aged care staff survey on the local barriers and enablers to the provision of palliative care
- a comprehensive palliative care intervention.

Furthermore, they provide a basis to formulate recommendations regarding organisational requirements to ensure the successful and sustainable implementation of the intervention, and quality improvemnt activities that are outside the scope of this project.

Key words: Residential aged care, palliative care, gaps, challenges, barriers, facilitators, intervention, implementation, sustainability

Table of tables

Acronyms

ACD	Advance Care Directive
ACP	Advance Care Planning
BHCI	Ballarat Hospice Care Inc.
CPCiAC	Comprehensive palliative care in aged care
EoL	End of life
EoLC	End of life care
GP	General practitioner
HCA	Healthcare assistant
PCA	Personal care assistant
RAC	Residential aged care
RACF	Residential aged care facility
RACFs	Residential aged care facilities
SPC	Specialist palliative care
UHCW	Unregulated healthcare workers

1 Background

This literature review was conducted as part of the collaborative Ballarat Hospice Care Inc. (BHCI), Grampians Regional Palliative Care Team (Grampians Health) and Central Highlands Rural Health Comprehensive Palliative care in Residential Aged Care (CPCiAC) project, sponsored by the Australian and Victorian Department of Health. The CPCiAC project aims to systematically improve palliative care support for all residents in aged care facilities and their families and carers, and improve access to specialist palliative care for residents with relevant needs. This literature review forms the basis for designing an evidenced-based best practice intervention and its implementation that will be piloted in the Central Highlands Rural Health residential aged care facilities.

As Australia's population ages and the number of people using aged care services increases, the demand for palliative care in aged care is also increasing. Almost one-third of people using residential aged care will die in the year that they enter care. Death is the most common reason for ceasing residential aged care. As the Royal Commission into Aged Care Quality And Safety Final Report (2021) states, not all people in aged care receive the evidence-informed end of life care (EoLC) that they need. This can result in

- avoidable hospitalisations towards or at the end of life
- suboptimal symptom management for residents
- difficult bereavement for family and carers
- and/or a significant burden for staff providing the care.

To change this, palliative care must be a core component of aged care service delivery. Ensuring the availability of high quality palliative care in aged care facilities will enable more older Australians to have a better death, receive better support for their families and carers during the dying and bereavement process, support the well-being of staff in RACFs, and facilitate improved allocation of limited health resources.

While many older people have predictable needs that can be met by aged care staff in conjunction with the person's usual health practitioners, some older people will develop more complex needs and will require support through specialist palliative care services. Aged care staff need to be able to identify when specialist palliative care is required and be able to access such specialist care when appropriate. The ongoing assessment and timely identification of (specialist) palliative care needs is critical to ensuring that appropriate palliative care is provided. High-quality palliative care requires a coordinated approach with frameworks for engagement between aged care and specialist palliative care services.

The CPCiAC project seeks to create an intervention designed to establish a comprehensive palliative care program for residential aged care facilities. This effort takes into account the existing barriers, and facilitators related to the delivery of comprehensive palliative care. Furthermore, it aims to ensure the enduring adoption of this palliative care model within RACFs. Against this background, a realist review was conducted to identify barriers and enablers to the provision of comprehensive palliative care in residential aged care, and the sustainable implementation of a palliative care intervention. A realist review poses the question "WHAT (…) works, for WHOM, in what CIRCUMSTANCES, in what RESPECTS and WHY?" (Pawson et al., 2005, p. 31, emphasis in original). It focuses on the mechanisms by which an intervention works or fails. The realist approach is fundamentally concerned with theory development and refinement (ibid.).

2 Objective

This realist review is conducted with the objective of:

1. Gaining an understanding of factors hindering and enabling the provision of comprehensive, high quality palliative care in residential aged care.
2. Gaining an understanding of factors enabling and hindering the implementation of a comprehensive model of palliative care in residential aged care and its sustainability.
3. Generating hypotheses based on these findings, which will support the design of an evidence-based, best practice comprehensive model of palliative care for residential aged care facilities.

3 Method

3.1 Identification of relevant studies

A search of literature was conducted in three ways:

(1) A key word search using Google Scholar, PuBMed, and Research Gate
(2) Snowballing upon the bibliographic references discovered through the research team's literature review
(3) Database searching by the research team.

See appendix for a description of the search themes.

3.2 Selection of relevant and reliable studies

A structured selection and decision-making process was followed to assess all search results:

Table 1: Selection and decision-making process

Process:
Step 1: Screening of titles and abstracts Step 2: Full text assessment
Inclusion criteria:
Papers in English language Representation of the concepts: Palliative care in residential aged care, Gaps, Barriers, Enablers, Implementation of palliative care intervention in residential aged care, Sustainability of palliative care intervention in residential aged care, Articles and posters Evidence based research Evidence based intervention Systematic literature reviews Hospitalisation at the end of life Nurse perspective Clinician perspective (GP, Specialist Palliative Care Physician, Specialist Palliative Care Nurse, Nurse Practitioner) Resident perspective Family/relative/carer perspective RAC staff perspective Intervention evaluation Qualitative and quantitative research Period: 2013-2023

Beyond these criteria, the authors' judgement was used to supplement the formal critical appraisal checklist, and 'fitness for purpose' was considered (Pawson et al., 2005). This for example applies to international studies in particular as there may be significant differences to Australia. Articles were excluded if it became evident that they do not fit the Australian context.

Vulnerable populations were included in the initial literature search. However, during the review it became apparent, that barriers for people identifying as LGBTQI+ lie in accessing residential aged care in the first instance. As the intervention this project aims to design is to systematically review *all* residents in aged care facilities, there are no particular barriers that became apparent for residents identifying as LGBTQI+. Also included in the initial literature search and review were residents with disabilities, i.e. cognitive impairment. As dementia is prevalent in aged care residents, this is a common challenge. Therefore, the review talks about residents with cognitive impairment, which includes residents with dementia, as well as residents with other forms of cognitive disorders. A further vulnerable population are residents from a culturally and linguistically diverse background, including people from Aboriginal and Torre Strait Islander communities. A core principal of palliative care is the provision of person-centred care, which takes into consideration psychosocial needs, i.e. mental, emotional, social, and spiritual needs. Therefore, we did not delve into the particular need of this population any further in the context of this literature review. Instead, this vulnerable group will be particularly relevant when selecting appropriate resources to support RAC staff in providing palliative care.

36 full-text publications were identified as potentially relevant and assessed for eligibility, of which 34 met the inclusion criteria.

3.3 Data extraction from included studies

An excel spreadsheet was created to support the standardised extraction of data from the research articles identified as relevant to the research question. The extraction framework included the following criteria:

- Country
- Period
- Setting:
  - RACF
  - Transfer to hospital
- Population:
  - Number of participants in the study (N)
  - Residents
  - Family / carers
  - Doctors/GP
  - RAC Registered Nurses
  - RAC Enrolled Nurses
  - RAC Health Care Assistants
  - RAC managers
  - Specialist palliative care clinicians
  - Allied Health
- Care aspects:
  - Diagnostic information
  - Palliative care phase
- Demographics:
  - Gender
  - Age

- Ethnic minorities
- Marital status
- Nurses' ward experience

- Methods
- Project Objectives:
  - Barriers and challenges to the provision of palliative care in RACFs
  - Gaps and education/training needs
  - Enablers and solutions to barriers to the provision of palliative care in RACFs
  - Training/ education methods that work well
  - ACP enabled
  - Increased engagement with families/carers
  - Hospital admission at the end of life avoided
  - Hospital stay towards the end of life shortened
  - Increased referrals to GP or SPC
  - Increased anticipatory prescribing
  - Death in RAC achieved
  - Increased RAC staff wellbeing
  - Identification of education, training and other resources for resident/family/carer as well as workforce
  - Identification of resources: policies, methodology, procedures, tools, maps, models of care, forms, guidelines, manuals, electronic web based information systems\
  - Identification of barriers to the implementation of a palliative care intervention
  - Identification of barriers to the sustainability of a palliative care intervention
  - Identification of enablers to the implementation of a palliative care intervention
  - Identification of enablers to the sustainability of a palliative care intervention
  - Evaluation plan/criteria

3.4 Collating, summarizing and reporting the findings

Information collated in the spreadsheet was critically appraised under four main categories:

1. Barriers to the comprehensive provision of palliative care in RAC.

2. Enablers to the comprehensive provision of palliative care in RAC.

3. Barriers to the implementation of palliative care intervention in RAC and its sustainability.

4. Enablers to the implementation of palliative care intervention in RAC and its sustainability.

To comprehensively capture the spectrum of information regarding barriers and enablers found in the literature, we adopted a descriptive analytical approach in our synthesis. As such, the following steps were taken:

1. Taking into account the context and the specific population in question, we extracted the barriers and enablers identified from the spreadsheet. These findings were subsequently transferred to a Word document and imported into MAXQDA1 for further analysis. .
2. In order to synthesize the broad data thematically, the data was fully coded in MAXQDA using in vivo codes. All in vivo codes were then reviewed on code level, sorted, and combined to create themes.
3. The themes were then organised into thematic key- and sub-categories.

[1] MAXQDA is a tool for qualitative and mixed methods data analysis (https://www.maxqda.com/).

4. A narrative account of the barriers and enablers to the provision of palliative care in residential aged care and the successful implementation of palliative care intervention with sustainable changes was prepared: For each key- and sub-category within the barriers, solutions to barriers and facilitators, the researcher read the codings. If the context of the coding was unclear, the researcher went back to the original source to retrieve the context. The codings were then sorted by hand to follow a logical sequence from macro barriers/enablers to micro barriers/enablers. If it became apparent that a coded passage did not fit into a category, it was moved into a more suitable one. A narrative was developed around the remaining codings. This approach was used for each key- and sub-category.

4 Results

4.1 Palliative care delivery in RACFs

4.1.1 Barriers to the delivery of palliative care in RACFs

4.1.1.1 Aged care funding for palliative care in RAC

It is acknowledged that residential aged care facilities operate within a system that sets the context. This includes funding for palliative care patients in residential aged care. As noted by Palliative Care Australia in 2021, a significant impediment to delivering comprehensive palliative care is the limitation of the Aged Care Funding Instrument (ACFI), which restricts the recognition and funding of palliative care to the very final stages of life, specifically defined as the last week or days of life. This does not match the definition of palliative care, where palliative care is defined as "(…) an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." (Word Health Organisation n.y.). Palliative care is not appropriately recognised for funding in residential care (Palliative Care Australia 2021). Recognising palliative care as encompassing the last six to twelve months of a person's life, and not just the last days of life, is a powerful barrier to the provision of comprehensive and optimal palliative care in residential aged care. Although this cannot be within the scope of this project, it is still worth mentioning.

4.1.1.2 Lack of support from other healthcare professionals, particularly GPs

The lack of support by other healthcare professionals was identified as a major barrier to the comprehensive provision of palliative care in RACFs from the perspective of RAC staff (Burgess et al 2015, Palliative Care Australia 2021). This is contributed to by a shortage of medical professionals, interoperability of software systems and health records, current funding models, and limited operating hours of primary care services and after-hours requirements (Johnston et al. 2016, Palliative Care Australia 2021).

The timely and variable access to General Practitioners (GPs) presents a particularly consequential barrier in this context (Vilapakkam Nagarajan et al. 2022, Lane et al. 2015, Johnston et al. 2016, Burgess et al 2015), compounded by the lack of GP response to follow-up requests for medication review, limitations in GP knowledge of palliative care (in end- of-life care in particular), and their reluctance to prescribe end-of-life medications (Vilapakkam Nagarajan et al. 2022, Juhrmann et al. 2023). This hinders anticipatory planning, which is critical to optimal palliative care, and makes the organisation of anticipatory medications very challenging. As there is commonly no after-hours pharmacy in semi-rural and rural, and possibly even in regional settings, anticipatory planning is required to ensure effective and safe medications are available when needed (Rainsford et al. 2019).

Based on focus groups with GPs, Burgess et al. (2015) find that the barriers to accessing GPs are to a large degree related to inadequate direct remuneration, opportunity cost, and unremunerated work, which causes some resentment for GPs. These barriers relate to the following challenges experienced by GPs:

- Caring for patients in RACFs demands greater out-of-hours service. This extra workload becomes burdensome over time.
- Relatively few patients can be seen at a RACF compared to the number of patients that could be seen in the same period at the clinic. This is both a question of resources and remuneration.
- Providing services to patients in RACFs is often more time consuming and difficult than providing the equivalent care to older people who attended the GP's clinic, primarily due to the complexity of their health needs.
- Poor information transfer from the hospital to RACFs presents an additional challenge as GPs spend a lot of time following up on discharge information including medications, tests, and care plans when a patient returns from hospital. This activity is not specifically funded through the MBS but is critical to good patient care.
- Updating medication prescriptions is particularly time consuming and not remunerated.
- Unremunerated is also the travel time from the clinic to the RACF, which is also viewed as lost time as little other productive work could be performed in transit.
- Providing care to patients in RACFs creates additional work due to the need to update RACF clinical notes in addition to their medical records, consultation with RACF nursing staff, and discussions with family members where patients have appointed a designated decision maker for their health care.
- Contact with RACF staff and family often occur subsequent to the consultation when the GP is no longer at the RACF, so are not remunerated.
- Each clinic consultation can be charged at the full Medicare Benefits Schedule (MBS) schedule fee (possibly accompanied by an additional patient fee), and such consultations are not subject to the MBS fee schedule that applies for multiple RACF patient consultations (ibid.)
- Due to the large number of residents in need of a consultation, GPs have limited time available for individual consultations (Lane et al. 2015).

These challenges result in GPs being unable to meet the current need (Johnston et al. 2016), sometimes resulting in residents being transferred to hospital at the end of life (Lam et al. 2018).

While timely and dependable access to general practitioners remains a significant barrier in delivering comprehensive palliative care, it's important to note that they are not the sole healthcare professionals essential for providing this type of care. In many cases, RACFs also experience limitations in achieving (timely) access to specialist palliative care services for clinical in-reach support (Johnston et al. 2016, Lane et al. 2015, Chapman et al. 2018), resulting in a lack of or suboptimal support by Specialist Palliative Care Services to assess residents for their (specialist) palliative care needs and support in the care for residents with relevant needs. An insufficiently defined model of interdisciplinary care may contribute to this, leading to a mismatch in expectations of both care model and the role of community palliative care services between RACF and community palliative care staff, which can result in a lack of support for residents in RACFs (Lane et al. 2015). The fact that access to specialist palliative care services for residents remains limited in Australia highlights the need for efficient models of palliative care provision.

4.1.1.3 Workforce shortage, time pressure and competing demands

The constraints on the capacity of the aged care workforce are substantial (Johnston et al. 2016). The number of nurses working in aged care in Australia are steadily declining. Staff shortages, high turnover, and staff inexperience make it challenging to provide appropriate care under significant time constraints, in particular as end of life significantly increases the resident care needs and the number of staff needed is increased (McVey et al. 2014). Resource constraints limit the capacity of staff to manage Advance Care Planning and provide end-of-life care, sometimes resulting in residents being transferred to hospital at the end of life (Lam et al. 2018). Government policy on 'ageing-in-place' does not equate to 'dying in place' (McVey et al. 2014, Lam et al. 2018).

Several authors point out the effect of time constraints on the provision of palliative care. The time constraints faced by RACF personnel are exacerbated by the lengthy administrative responsibilities, which hinder discussions related to goals of care, especially when it comes to administering PRN opioid analgesia to residents of the facility (Lane et al. 2015, Evenblij et al. 2019).

4.1.1.4 Lack of education and training

While the delivery of palliative care remains a fundamental aspect of the work of care staff in residential aged care, there is a significant deficiency in their formal training in palliative care. Undergraduate and vocational education and training (VET), including nursing and Certificate III in Individual Support and Certificate IV in Ageing Support, do not include palliative care as core units (Palliative Care Australia 2021, Norling et al. 2022). As a consequence, facilities are largely staffed by unregulated health care workers2 who have limited or no palliative care education and preparation to support people requiring palliative care. Despite UHCW providing 70 to 90% of direct resident care including the care provided in the final stages of life, compared with other members of the RAC workforce, UHCWs have the lowest palliative care knowledge and skills (Norling et al. 2022). Lane et al. (2015) report, that staff working in RACFs themselves see a need for palliative care education. As a result, unregulated health care workers may have knowledge gaps that hinder the recognition and reporting of subtle changes in health status, resulting in unmet palliative care needs for the resident. However, there is an expectation that unregulated health care workers will perform tasks for which they have minimal or no formal training (Norling et al. 2022).

Numerous researchers have pinpointed various knowledge and skill gaps due to the lack of education and training. These can contribute to unmet resident needs and can lead to reduced staff confidence in various areas. Additionally, those gaps may result in physicians lacking confidence in the staffs' ability to provide optimal end-of-life care. As a consequence, they may hesitate to document anticipatory medication and syringe driver orders (Johnston et al., 2016). Those knowledge and skill gaps may relate to the following:

- Palliative care tends to be erroneously associated only with 'end of life', resulting in opportunities for earlier support being overlooked

[2] The following applies in the context of this literature review in terms of different terminologies used: „The Australian College of Nursing (ACN) defines the Unregulated Health Care Worker (UHCW) as a health care worker who supports the delivery of nursing care by assisting people with personal care and activities of daily living. Confusion around the role exists due to varying titles used to describe this type of health care worker. Similar titles may include but are not limited to "Aged Care Worker (ACW), Personal Care Assistant (PCA), Care Support Employee (CSA), Auxiliaries or Auxiliary Nurses, and Health Services Assistant", and the term may vary in different jurisdictions (1).

- Unfamiliarity with standardised symptom assessments, particularly in dementia patients whose dementia related symptoms may be misinterpreted as pain, wrongly resulting in pain treatment, which causes new issues, or the withholding of pain medication, resulting in increased suffering.
- Symptom management, in particular mouth care, hydration, administering pain medications before personal care
- Communicating with general practitioners (GPs)
- Communication skills and techniques to speak with residents about advance care planning, changing to a palliative approach to care, and about sensitive end-of-life care issues. This includes addressing consequences of hospitalisation in the palliative phase
- Communication with dementia patients
- Information needs of families and carers:
  - frank and open communication about Advance Care Planning and end-of-life issues
  - information including the patient's/resident's changing condition, the process of dying, how symptoms will be managed and what to do at the time of death
  - concerns around physical and medical needs, pain, end-of-life care planning and nutrition and hydration causing anxiety and stress and unwanted hospitalizations during the palliative care phase. This includes addressing the consequences of hospitalisation in the palliative phase
- Preparation of (new) staff for grief. Emotional support for staff to build resilience around advance care planning.
- A lack of training and knowledge, particularly amongst non-registered care home staff and those with non-formal caring roles, inhibits the ability to engage in Advance Care Planning conversations with those living with dementia due to preconceived assumptions and communication barriers (McVey et al. 2014, Parker et al. 2015, Lane et al. 2015, Parker et al. 2015, Marcella et al. 2015, Johnston et al. 2016, Chapman et al. 2018, Evenblij et al. 2019, Koerner et al. 2021, Spacey et al. 2021, Norling et al. 2022, Harasym et al. 2020, Palliative Care Australia 2021, Spacey et al. 2021).

The provision of optimal palliative care requires clear agreed indicators for introducing the palliative approach (McVey et al. 2014), particularly as the complexity of the residents with multi-comorbidities make it difficult to diagnose the dying phase (Froggatt et al. 2014). The absence of such agreed indicators in combination with the lack of knowledge and confidence in the provision of palliative care as discussed previously, results either in the late or missed introduction of the palliative care approach or an inappropriate referral to specialist palliative care, and therefore suboptimal symptom management (Liu et al. 2019). Hence, RAC staff may generally only be seeking specialist palliative care input when a resident is dying, and is 'made palliative' either by the GP or a specialist. RAC staff often do not recognise their own palliative care skills, as they see palliative care as a specialist area (Lane et al. 2015). This potentially results in the failure to implement timely end-of-life plans (McVey et al. 2014).

On the other hand RAC staff are reported to be unsure of which residents to refer to specialist palliative care (Lane et al. 2015). Consequently, they may fail to prioritise care for those most at risk of unplanned dying with inadequately controlled symptoms (Forbat et al. 2018). The feedback from community palliative care staff is that they considered many referrals from RACFs to be inappropriate, as the referred residents did not have complex symptoms, and should be managed by the RACF staff (Lane et al. 2015).

The acquisition of knowledge requires knowledge translation into practice. However, a lack of support to implement knowledge leads to limited sustainability. The selection of inappropriate staff to participate in training presents an additional barrier to knowledge translation: if employees are too inexperienced, lack support from management, or fail to take ownership of

sharing the knowledge they've acquired, then the educational efforts are deemed ineffective, and no significant changes are initiated (Manson et al. 2020).

4.1.1.5 Lack of appropriate model of care

Research into hospitalisation of RACF residents estimates that between 8 and 44% of emergency department presentations are 'inappropriate'. The standard model of care for RACF residents is an acute medical model. However, this is generally combined with a low level of surveillance from medical and nursing staff and a low level of discussion with residents and families about expected disease course and goals of care. Therefore, hospitalization appears to be an inevitable outcome for many residents. The majority of RACF residents dying in hospital could receive end-of-life care in their RACF (Lane et al. 2015). Complex prognostication and lack of understanding by residents and families of the consequences of hospitalisation in the palliative phase contributes to avoidable hospitalisations (Chapman et al. 2018). A shift to an accepted model of palliative care that includes access to specialist care to enable people to live well and die in their preferred place is required (Forbat et al. 2018) with the focus on residents' palliative (last six months of life) and end-of-life (terminal or dying phase) care needs (Rainsford et al. 2019). In line with the palliative care approach, this also needs to include bereavement for the residents' families, which often is very limited (Parker et al. 2015).

4.1.1.6 Need for strengthening communication

Effective communication is critical to the delivery of person-centred care. A lack of effective communication results in suboptimal or poor outcomes for residents at the end of life. Furthermore, communication is critical to strengthening relationships, the use of assessment tools, palliative care mentorship, and physical and cultural change (Harasym et al. 2020).

Talking about death and dying, in particular with residents and families

A clinical culture resists open communication of death and dying, creating challenges to frank and informative discussions of the topic with residents and families. This is seen in the lack of death and dying communication among care staff, residents, care professionals (including doctors), and families as well as in how care staff manage residents' deaths (Davis et al. 2019). As a consequence, end of life conversations happen too late or not at all (Johnston et al. 2016). Even though various elements of a palliative approach are incorporated into the care of high level care residents, the palliative care discourse itself is not used (McVey et al. 2014). Research finds that staff in RACFs shy away from conversations about death and dying as they find it too confronting for families to hear their loved ones are actively dying, causing limited awareness among family. This situation of limited awareness might be created and reinforced by staff members' approach to end-of-life communication, particularly the preference for using euphemistic or softer language, which may not be understood by families (Omori et al 2020). There is evidence of the family's desire to talk frankly and openly about end of life issues, which is often not recognised by health professionals in long term care. Families require a formal communication process to minimize anxiety and dissatisfaction felt by the family, which can lead to inappropriate hospital transfers at the end-of-life and complicated grief due to poor resolutions regarding goals of care and family complaints about end-of-life care (Parker et al. 2015).

Poor documentation, handover and teamwork (ACP, care plan)

A lack of effective communication can result in hospital transfer, for example if it hadn't been communicated clearly enough that a patient prefers management in the residential aged care facility rather than a hospital transfer. Clear communication, in particular via documentation and handover, as well as good teamwork is required (Rainsford et al. 2019).

Communication among healthcare workers and professionals

Another obstacle identified in the literature is the diminished confidence among staff when it comes to interacting with professionals, resulting in communication impediments. (Macgregor et al. 2023). There is also evidence of a strong professional hierarchy among staff in residential aged care being a barrier to effective communication and therefore a barrier to the provision of optimal palliative care. This refers to a lack of acknowledgement of the expertise and knowledge of Health Care Assistants by the wider multi-disciplinary team, who typically viewed them as 'just a caregiver'. The professional hierarchy may have led to a situation where the apprehensions expressed by healthcare assistants (HCAs) regarding the well-being of residents nearing the end of life were largely disregarded by more senior staff. One study finds that Unregulated Health Care Workers believe their role is neither recognised nor valued, they report feeling unsupported and unheard by RNs and management (Norling et al. 2022). Additionally, this leads to communication barriers, resulting in adverse outcomes for residents. (Fryer et al. 2016).

4.1.1.7 Lack of or inadequate Advance Care Planning

Uptake of ACP and Advance Care Directives remains low and rates of death in hospitals remain high. ACP uptake is particularly suboptimal for the dementia cohort (Chapman et al. 2018). One study shows disproportionate numbers between staff who have received formal ACP training and the large majority, who believe all aged care staff should be competent when it comes to these discussions (Lam et al. 2018). Even though a standard form for documenting residents' resuscitation and hospitalization preferences may be available, neither medical nor nursing staff necessarily considered themselves skilled in undertaking these discussions (Lane et al. 2015).

The timing and process were identified as major barriers to advance care planning in RACFs. Moving into a RACF is a difficult time for many people, causing RACF staff to consider this an inappropriate time to start conversations about goals of care. Often this results in conversations about goals of care and developing Advance Care Plans too late, i.e. during medical emergencies in a time of crisis (ibid, Johnston et al. 2016). In addition, an ACP form as a fixed document requiring completion on admission contrasts with the view of advance care planning as an evolving conversation about a person's priorities, goals and wishes, with allowance for change over time (Lane et al. 2015). Inadequate advance care planning, ambiguous goals of care, and conflict within families, and between families and health care providers created challenges to the provision of care (Rainsford et al. 2019).

Uptake of advance care planning and advance directives remains a challenge particularly for patients with dementia, resulting in high rates of death in hospital (Chapman et al. 2018). This goes for residents with cognitive impairment in general. Some barriers in this context are related to communication issues. In certain instances, the perceptions held by care home staff can hinder residents with dementia from actively participating in and making contributions to their own care (Spacey et al., 2021). Residents with dementia may have diminished capacity to make informed decisions, if they also lack a supportive family, those residents are most at risk (Lam et al. 2018), having a greater chance of being unnecessarily admitted to hospital at the end of life.

4.1.1.8 Emotional burden and lack of support for staff

Staff in aged care facilities form emotional connections with the residents they care for. These connections exist between staff, residents and family members, and are often referred to as being 'like family' and 'homelike' (McVey et al. 2014). Therefore, they experience significant emotional challenges and burdens when conducting end of life conversations with residents and their families (magnified by the feeling of being underprepared for those conversations due to a lack of education and training), when delivering the end-of-life care, and particularly when a resident dies (Froggatt et al. 2014, Boerner et al. 2017, Handley et al. 2022). For

example, staff find it emotionally challenging to clear a room and welcome new patients immediately after a resident has died, as this highlights the business side of residential aged care to staff, making their own bereavement process more difficult (Fryer et al. 2016).

While care staff are tasked with a substantial emotional workload and face considerable challenges, there is often a notable absence of adequate mechanisms in place to address the emotional well-being of care home personnel, leading to unaddressed emotional needs.One of the consequences is compassion fatigue, which results in the staff's reluctance to discuss death and dying as part of Advance Care Planning. They may also refrain from conversations about death and dying in order to protect their own emotional wellbeing. This can result in potentially detrimental effects for residents (Omori et al. 2020, Spacey et al. 2021, Handley et al. 2022). It is also known that unresolved loss can contribute to staff experiencing burnout and job dissatisfaction. The lack of support becomes particularly evident after a resident's death as there is often a lack of provision of time for informal and for formal bereavement support for staff (Fryer et al. 2016). Care professionals often distance themselves from the residents' deaths by concentrating on their tasks and routine. Institutional non-disclosure of death and dying can have a negative influence on both professional carers and family carers too, and therefore compound the emotional burden RACF staff experience (Omori et al. 2020).

4.1.1.9 Physical environment: Lack of appropriate space for EoL

RACF staff have identified the lack of space in a residents room as being a barrier to the provision of optimal end-of-life care (McVey et al. 2014). Also, most RACFs do not have dedicated spaces for residents nearing end of life, and for staff to grieve with dignity (Harasym et al. 2020).

4.1.2 Enablers to the delivery of palliative care in RACFs

4.1.2.1 Wider system enablers

Wider system enablers are outside of the scope of this project. However, care homes are operating within complex systems, and a whole system approach is required to sustainably improve the quality of care (Macgregor et al. 2023). Focusing solely on individuals obscures the reality, as system enablers are an important factor to the provision of comprehensive and optimal care in a residential aged care setting. System enablers include an alignment of accreditation standards with the Government's National Palliative Care Strategy 2018, which includes Priority 7.5 indicators for quality palliative care that need to be reflected in the accreditation processes of all care settings (Palliative Care Australia 2021). Furthermore, systemic industry change that supports ongoing education, manageable workloads, and a collaborative health care team that strives for best practice is required to achieve sustainable optimal palliative care in RAC (Norling et al. 2022). Another critical system enabler is the modification of current funding models (Rainsford et al. 2020). Furthermore, changes at a policy level to ensure GP engagement would make a significant difference. In Germany, for example, policy mandates GP involvement in case conferences. In the Netherlands, GPs are employed by RAC, and provision of care in residential aged care is included in the professional standards for physicians (Luckett et al. 2017).

4.1.2.2 Organisational enablers

Governance, workforce engagement, and culture of learning and self-care

Critical enablers on an organizational level include organisational policies, which are required to guide staff on how to identify and manage residents with palliative care needs. This must include detail on how to operationalise palliative care. Many policies include a mandate for hospital transfer in the case a resident has a fall or shows functional or physical decline. However, hospitalisation decisions should be part of anticipatory planning conversations with residents and families. Workforce engagement stands as another key organizational responsibility that greatly empowers the delivery of optimal palliative care. Managers and key staff need to be strongly engaged in order to send a signal to staff about the importance of taking the time for the identification of palliative care needs and subsequent actions (Koerner et al. 2021). Workforce engagement also helps inform and implement best practice palliative and end-of-life care within care homes (Johnston et al. 2016). Furthermore, a supportive organisational culture is a vital enabler to the strengthening of palliative care. It needs to aim to educate to empower staff (Juhrmann et al. 2023). This includes fostering a culture of learning (Collingridge Moore et al. 2020), for example by mentoring less experienced staff (Harasym et al. 2020), enabling staff to participate in education and training, and allowing staff time to translate their learnings into practice and share with other staff. Another aspect of a supportive organizational culture is the promotion of self-care and its importance among staff in order to manage the challenges of working in this emotionally and physically burdensome context. As the nature of aged care work can cause a significant amount of stress, the promotion of self-care is a key principle of promoting staff well-being. In order to take the best care of others, one has to take care of themselves. (Juhrmann et al. 2023).

Improving the physical environment

Improving the physical environment to allow for the optimal provision of palliative care may include adapting the physical environment when and as needed to enable dying and grieving with dignity. This may include:

- Creating ad hoc end-of-life care beds and establishment of a palliative care room for the dying resident (including a palliative care kit for the provision of end of life care)
- Filling the area ‘with life’
- Inviting families and carers to personalize the resident’s room
- Ensure 24/7 visitor access to care homes (Juhrmann et al. 2023, Harasym et al. 2020).

Be prepared for end of life care

A further enabler on an organizational level is to ensure that end-of-life medications and equipment are always readily available on site in case of unexpected resident deterioration, and a trained nurse is available to administer (Juhrmann et al. 2023).

Staffing and continuity of care when a resident is nearing the end of life

When a resident approaches the end of life, care needs are increased, requiring more time from staff to attend to those care needs. Allocating an extra staff member on shift when a resident is nearing end-of-life is critical to the provision of optimal end of life care. Particularly important during this phase is the continuity of care. Rostering regular staffing patterns promotes continuity of care in these situations (ibid.).

4.1.2.3 Education and training

Education and training play a pivotal role in enhancing the knowledge and practical skills of the care team (Forbat et al. 2018, Chapman et al. 2018, and Norling et al. 2022). These initiatives also contribute to boosting the proficiency and self-assurance of RACF staff when engaging in conversations regarding critical topics like palliative care, end-of-life care, and Advance Care Planning (Lane et al. 2015).Enablers to the provision of optimal, comprehensive palliative care includes palliative care knowledge (Collingridge Moore et al. 2020) as well as staff awareness of palliative care and end of life care needs, and capability in supporting residents in their final months of life. However, education is not only about the acquisition of

knowledge and practical skills, but also self-efficacy, which is important to build a resilient workforce. For example, formal education and training were found to be significant determinants of high self-efficacy in end-of-life communication (Evenblij et al. 2019).

Education and training needs to be tailored to the specific circumstances and challenges in residential aged care to be successful and impactful. Due to the challenges faced in residential aged care, in particular the high staff turnover, high absenteeism, and time constraints staff experience, flexible and resilient training models are required (Davis et al. 2019). Inter-profession education programs result in participants having a clearer understanding of the roles, responsibilities, and challenges of their colleagues and result in a team-based approach to care (Norling et al .2022).

All new staff members need supportive and sustainable structures to be entrenched, for example enabling access to advice through mentoring (Manson et al. 2020). Education and support for care staff needs to normalise death and dying in residential care through increased exposure to the principles and practices of health-promoting palliative care (Johnston et al. 2019). (New) Staff also need to be provided with the opportunity to observe a positive and accepting death. This is an essential tool to successfully integrate staff into the workplace (Juhrmann et al. 2023).

Furthermore, palliative care education needs to assist unregulated health care workers to understand the importance of their role and how to provide care that focuses on holistic resident care rather than being task-focused (Norling et al. 2022).

Training should be customised to care workers' learning needs for better reach and engagement. In order to increase the uptake of intervention tools, participants need to understand the purpose of the tools, their benefits and how they could be embedded within their workflow (Vilapakkam Nagarajan et al. 2022).

An education and training program to strengthen palliative care in residential aged care should include (but not be limited to) the following aspects topics:

- Culture sensitive training to recognise that cultures can influence how they approach death and dying in the care home (Spacey et al. 2021)
- Improve the knowledge of local non-acute service options and referral pathways (Davis et al. 2019)
- Specific education and training to be able to sensitively engage in discussions about death and dying with a diverse range of residents, including those with dementia (Spacey et al. 2021, Juhrmann et al. 2023).
- Shadowing method to train less experienced staff to engage in advance care planning discussions with residents and relatives. This method is found to be effective for PCAs in particular due to the 'practical' nature of their job rather than having a more formal education (Spacey et al. 2021). Educational workshops are beneficial to include more staff with non-caring roles in advance care planning training
- Increasing death literacy[3] among families and carers: It requires families' and carers' active engagement in critical learning about knowledge and skills necessary to care for dying family members. Institutionalised death often prevents family carers from developing appropriate death literacy due to communication barriers (Noonan et al., 2016).

[3] Death literacy is "a set of knowledge and skills that make it possible to gain access to, understand, and act upon end-of-life and death care options" (Noonan 2016: 32).

4.1.2.4 Change from acute to palliative approach with a framework and assessment tools

The formal decision to change from an acute medical model to a palliative approach to care, shifting the focus of care to symptom management and psychosocial support, significantly contributes to staffs' confidence in providing this care (Lane et al. 2015), and shifts the focus to resident comfort and needs of families. This is one of the most important enablers to the provision of optimal palliative care. One of the fundamental aspects of a palliative approach is the understanding of when this approach should be implemented (McVey et al. 2014). Staff require a systematic framework with formalised procedures that guides ongoing assessment and symptom management in order to be able to proactively identify deterioration and palliative care needs, and escalate issues (Juhrmann et al. 2023, Chapman et al. 2018, Norling et al. 2022). Ensuring that all staff can recognize deterioration in the resident and escalate issues to appropriate clinical staff is an important aspect (Juhrmann et al. 2023). The framework also needs to include GP engagement, address medication reviews and medication management, and the availability of psychosocial supports (Johnston et al. 2016, Juhrmann et al. 2023). The framework needs to comprise a toolkit, including pain and symptom assessment tools for people with frailty, including among those with cognitive impairment (Harasym et al. 2020, Luckett et al. 2017). Critical enablers are processes to triage and identify residents who require review, and clinical actions that arise (Koerner et al. 2021). The framework also needs to include a transition plan to meet the residents' changing needs at the end of life in their preferred place of care setting (McVey et al. 2014).

Having such a framework in place is also critical

- for effective service planning and delivery
- to help avoid unplanned hospital admissions
- to help families understand the goal of providing comfort and palliation to their loved ones
- to recognizing palliative care as an essential component of quality aged care provision (Chapman et al. 2018, Vilapakkam Nagarajan et al. 2022).

4.1.2.5 Person-centred model of palliative care

A person-centred approach strives to make the whole person visible and prioritizes the satisfaction of spiritual, existential, social, and psychological needs to the same extent as physical needs. It is a key enabler to the provision of optimal palliative care. Person-centred care in aged care includes knowing the individual (Juhrmann et al. 2023), providing individualised care that is relationship-focused, and collaboration and shared decision making between the resident, family, and staff (McVey et al. 2014), which is a key aspect of optimal supportive end-of-life care in RACFs (Harasym et al. 2020). A person-centred approach reduces the taboo nature of ACP for older people, and empowers them to reflect on their life and make decisions (Batchelor et al. 2019).

4.1.2.6 High quality, systematic Advance Care Planning

Advance Care Planning offers residents the opportunity to make their preferences known. Proactively engaging in a conversation about preferences and writing them down in an advance care plan enables care home staff to provide person-centred end of life care. Evidence shows that healthcare workers find that ACDs provide a large benefit in optimising care for their patients (Lam et al. 2018, Johnston et al. 2016, Liu et al. 2019), including the reduction of hospitalisations (Lane et al. 2015). Up to date and accurate understanding of residents' care wishes may also help to build trust and improve inter-disciplinary relationships (Macgregor et al. 2023).

The provision of time and having the skills to discuss ACP are key facilitators (Batchelor et al. 2019). In addition to training and professional experiences to acquire or strengthen relevant skills, organisational processes and paperwork may support staff to initiate end of life conversations by providing a structure that forms part of the fundamental information gathering for care planning. However, it is important that documentation is meaningful to care planning and that completion of documentation does not become the motivation for end of life discussions (Handley et al. 2022). Formalised structures to document, communicate and implement ACDs where completed are required (Lam et al. 2018, Macgregor et al. 2023).

Evidence found that RACF nurses are well suited to perform ACP conversations due to their exposure to patients requiring end-of-life planning. Beyond this, multi-disciplinary teams are a valuable forum for advance care planning discussions, with responsibility shared among multiple practitioners. This is particularly the case if a patient's ability to communicate effectively is impacted and conversations with the resident are unlikely to lead to an ACP (Lam et al. 2018). Additionally, families and substitute decision makers need to be supported to participate in ongoing advance care planning discussions when the resident no longer has the capacity (Juhrmann et al. 2023).

4.1.2.7 Effective communication and teamwork

Additionally, enhanced communication necessitates the delivery of precise, pertinent, and current information (Macgregor et al. 2023). Effective communication also relies on strong communication skills and teamwork, (McVey et al. 2014 and Collingridge Moore et al. 2020). Comprehensive palliative care further requires improved communication, which relies on the provision of accurate, relevant, up to date information (Macgregor et al. 2023), good communication skills and team work (McVey et al. 2014, Collingridge Moore et al. 2020). This includes a care constellation that in the literature is referred to as 'relational care'. This means that both professional and family carers contribute to form holistic care for dying residents and contribute to the identification of what is meaningful to a patient's last stage of life. Families are significant because they often act in an advocacy role for the residents or play an important role in determining what is meaningful and significant in residents' lives, particularly for residents living with dementia. Therefore, quality end-of-life care in residential aged care requires family involvement and collaboration in care planning in order to identify social, emotional, spiritual, and interpersonal needs of people approaching and at the end of life. Quality end-of-life care and conversations that are family-centred enable care professionals to provide person-centred care. This relies on effective, i.e. open, honest and clear communication with the residents' families about death and dying. To establish a collaborative care planning approach that involves care staff, residents, and families, it is essential for care staff, family members, and caregivers to possess the necessary skills and confidence to engage in discussions regarding the process of transitioning towards the end of life and death. A lack of communication contributes to a family's poor understanding of what is happening to their aging family members and why physicians choose particular types of care (Omori et al 2020). It hinders families from acquiring the necessary skills and knowledge to care for a dying person, which often results in unrealistic care expectations or distrust in professional care by families. This makes end-of-life education for families imperative (Noonan et al. 2016). Partnering in care and setting expectations are contributors to family acceptance that their loved one is dying (McVey et al. 2014, Juhrmann et al. 2023). As carers and families need to be considered as partners in care, carers also need support to assist them in providing care in a manner that also promotes their health and wellbeing (Palliative Care Australia 2021).

In addition to fostering collaboration and ensuring effective communication with families, it is equally vital to promote collaboration and maintain effective communication among specialized palliative care personnel, care facility staff, residents, and general practitioners (McVey et al. 2014, Koerner et al. 2021).Building stronger and more sustainable partnerships between aged, primary and specialist palliative care services is a priority to strengthening palliative care

(Juhrmann et al. 2023, Palliative Care Australia 2021). Improved communication between professional groups leads to a better understanding of roles and responsibilities and may assist in building a collaborative cohesive workforce overall (Norling et al. 2022). Building trust between GPs and the registered nurses at the facilities also leads to GPs having the confidence to write-up anticipatory medications for end of life, knowing that they would be used appropriately (Johnston et al. 2016).

4.1.2.8 Acknowledging the role of HCA's

Healthcare Assistants establish personal relationships with residents, which strengthen over time. These relationships hold significant value, empowering them to deliver what they perceive as high-quality care. This connection enables them to offer personalized assistance that caters to the individual needs and preferences of the residents, including at the end of life, particularly when the resident is no longer able to communicate.

This also includes supporting residents' families at this point in time as Health Care Assistants play a key role in ensuring that the family's practical and emotional needs are met. Against this background, Health Care Assistants need to be acknowledged as expert members of the end of life care team and it needs to be ensured they receive sufficient support to fulfil this crucial role. This will enable them to recognize their expertise in end-of-life care management, resulting in empowerment. Furthermore, promoting the sharing of skills amongst Health Care Assistants and mentoring and supporting new colleagues was identified as an enabler (Fryer et al. 2016). Acknowledging the role of Health Care Assistants also promotes collaborative and equitable relationships between RAC nursing and care aide staff, which are facilitators in the face of symptom assessment concerns (Harasym et al. 2020).

4.1.2.9 Multidisciplinary approach

A multidisciplinary team is a group of healthcare professionals of varied disciplines and roles, working together towards a common goal of providing optimal care for a patient. Multi-disciplinary approaches bring together expertise from health and aged care professionals to assist with advance care planning and planning goals of care, sharing responsibility for decision-making, managing symptoms, and providing education (Batchelor et al. 2019, Lane et al. 2015). Besides care staff and RAC nurses, general practitioners (GPs) play a central role in multidisciplinary teams (Davis et al. 2019). Furthermore, proactive Specialist Palliative Care involvement to supplement the palliative approach to residents' care is proven to be very beneficial as this provides clinical input and case-based education. The integration of specialist palliative care also improves education, communication, co-ordination, and planning (Chapman et al. 2018, Rainsford et al. 2019).

4.1.2.10 Anticipatory care planning and prescribing

Proactive and anticipatory care planning discussions are established pathways to improving end-of-life care and reduce hospitalizations (Liu et al. 2019, Rainsford et al. 2021). Anticipatory prescribing of medicines to control symptoms in the last days of life has been shown to improve end-of-life symptom control, but requires good interdisciplinary communication (ibid).

4.1.2.11 Grief and bereavement support

For staff

Due to the high emotional labour and burden in care homes, finding ways to support bereaved care home staff is important (Handley et al. 2022). Effective bereavement support plays a vital role in assisting care home personnel in addressing the emotional difficulties stemming from

their profession. By doing so, it aids in fostering resilience, thus fostering emotional well-being and mitigating the risk of burnout (Boerner et al. in 2017). Since there exists a correlation between elevated burnout rates and a reduced inclination to partake in palliative care education within the aged care workforce, it is imperative for them to cultivate resilience in order to guarantee the provision of optimal end-of-life care, (Fryer et al. in 2016). Addressing grief at orientation to prepare new staff for what to expect, and also provide them with information on who to contact if further support is needed, has been identified as an enabler to coping with the emotional burden of the work. Allowing staff to express their grief is an important enabler to dealing with grief (Juhrmann et al. 2023). While having an opportunity to discuss the death of a resident informally with peers appeared fundamental in helping Health Care Assistants deal with their repeated exposure to death and dying, there is a lot of evidence that staff also benefit from more standardised and consistently provided formal support, for example through pastoral care (Fryer et al. 2016, Juhrmann et al. 2023).

Rituals play an important role in grief and bereavement. Therefore, enabling staff to participate in cultural rituals related to residents dying helps them 'move on' from a resident's death, supporting the grief and bereavement process (ibid., Handley et al. 2022). For example, being able to give the resident a dignified 'goodbye' by attending to the deceased body in a respectful manner was considered very important (Fryer et al. 2016).

For families and carers

Comprehensive palliative care includes grief and bereavement support for families and carers. Therefore, support sessions for families and carers to facilitate early bereavement are an enabler to comprehensive palliative care (Juhrmann et al. 2023). Residents and families need to be supported by staff who are both knowledgeable and skilled in palliative care throughout their journey (Norling et al. 2022).

For co-residents

The need for acknowledging each resident's death within the home was identified. Co-residents need to be informed of a resident's death, and grief and bereavement support needs to be provided (Marcella et al. 2015).

4.2 Successful implementation of intervention and sustainable change

4.2.1 Barriers to the successful implementation and sustainable change

4.2.1.1 Workforce challenges

High staff turnover, staff shortages, absences, and a high workload are some of the top reasons affecting staff engagement with an intervention (Davis et al. 2019, Manson et al. 2020, Koerner et al. 2021, Vilapakkam Nagarajan et al. 2022). High workload was also highlighted as a barrier for sustained best practice (Norling et al. 2022).

4.2.1.2 Incompatibility of RAC systems and processes

Furthermore, current RAC systems and processes may not be compatible with requirements of the intervention, and participants may experience a burden of redundant paperwork, manual processes and add- on workload without real benefit, presenting a barrier to implementation (Vilapakkam Nagarajan et al. 2022, Moore et al. 2020). Further implementations barriers may be a lack of site- based needs analysis to identify necessary systems to support the

intervention, and the absence of clear policies and procedures related to palliative care and Advance Care Planning (Vilapakkam Nagarajan et al. 2022).

4.2.1.3 Context barriers

Barriers to the implementation of a palliative care framework and toolkit in particular include failing to identify champions, key staff changes, and weak GP relationships (Davis et al. 2019).

4.2.1.4 Organisational barriers

Additionally, there could be various obstacles, both organizational and financial, hindering the execution of educational and training initiatives (Spacey et al. 2021). Moreover, the process of acquiring knowledge necessitates a smooth translation of knowledge into practice. Nonetheless, a deficiency in support for knowledge implementation can result in restricted long-term viability (Manson et al. 2020).

4.2.2 Enablers to the successful implementation and sustainable change

4.2.2.1Organisational level

4.2.2.2 Readiness for change

Recognizing the role of palliative care within a RACF and recognizing that the provision of palliative care needs strengthening is critical for (management) engagement with any intervention. It is important to conduct an internal assessment in order to recognize that palliative care needs strengthening in order to both support the intervention and sustaining change after implementation. An audit of current practices at the end of life helps identify gaps and allows future progress to be measured (Manson et al. 2020, Vilapakkam Nagarajan et al. 2022).

4.2.2.3 Organisational commitment and support

A key enabler to the successful and sustainable implementation of a palliative care intervention is the organisational commitment to supporting staff to incorporate a palliative approach (McVey et al. 2014). This includes:

- A strong and stable leadership, along with supportive organisational culture are essential for ensuring effective implementation. This refers to support and enthusiasm from management for example through developing a vision for palliative care. A shared vision between management and RACF staff with regard to what the intervention is aiming to achieve facilitates implementation. It needs to include clear parameters such as payment of staff outside of their shifts or allowing them to attend education and training sessions during their shift, and awarding certificates or continuing professional development credits (Collingridge Moore et al. 2020, Vilapakkam Nagarajan et al. 2022).
- The organization ensuring adequate resources by allocating protected time and resources for education and training, thereby promoting high attendance and establishing a sustainable critical mass of trained staff to address the challenges of staff recruitment and retention. This also applies to resources required for effective knowledge transfer (Manson et al. 2020, Vilapakkam Nagarajan et al. 2022, Collingridge Moore et al. 2020).
- Considering suitable space for training in the facility, physical resources to complete the intervention, access to online training, and the consistent management promotion of the

intervention. Aids to training such as a resource folder, note pads, decisions aids, or reference material require also need to be considered (ibid.).

- Ensuring that key organisational policies, processes, and customized local procedures align with best practices in palliative care. These guidelines offer clarity regarding staff expectations, delineate responsibilities, and offer robust support for confident decision-making (Hudson et al. 2023, Norling et al. 2022, Davis et al. 2019, Batchelor et al. 2019).

4.2.2.4 External stakeholder and staff involvement

Engaging with care homes from the beginning of a program ensures that the intervention meets their needs in terms of structure and delivery (Manson et al. 2020). Raising awareness among stakeholders involved in the care for residents is another important enabler to the successful and sustainable implementation of a palliative care intervention in residential aged care. It ensures that the intervention being delivered is congruent with the wider care of the resident. Locating the intervention within the current context and into the delivery of everyday practice with existing processes within the facility is critical, otherwise the risk is run that the intervention would cause unnecessary work/doubling up. An understanding of the involvement of external stakeholders is required as well as adaptation of interventions to suit context and existing patterns of working (Collingridge Moore et al. 2020).

RACF staff should receive (a) a comprehensive orientation, (b) clear communication of the purpose, expected benefits to staff and residents, and (c) tailored education/training to meet individual site needs (Vilapakkam Nagarajan et al. 2022). A whole home approach is also beneficial: Not only care staff but all staff throughout the facility should have awareness of the intervention as this is important to ensure improved understanding of palliative care among all staff. This is important especially for staff, who do not provide direct care. It also helps understand how they can be involved within their roles and responsibilities and helps them build confidence. Identifying informal leaders in the RACF can also help the intervention (Collingridge Moore et al. 2020). For example, there is evidence of disproportionate numbers between staff who have received formal ACP training (approximately half of respondents) and the large majority, who believe all aged care staff should be competent at performing these discussions (Lam et al. 2018). Another study suggests that there is an urgent need to consider ways of ensuring that the unique information health Care Assistants hold about residents is able to inform their end of life care. Therefore, tools that are used should be able to be used by anyone (Fryer et al. 2016).

4.2.2.5 Intervention

Facilitator

A site and project-related internal or external facilitator assisting with the implementation is a further important enabler. They are required to support, educate, mentor, and guide practice (Davis et al. 2019, Collingridge Moore et al. 2020). Facilitation needs to be consistent, regular and provided by an experienced individual in order to combat staff turnover (Manson et al 2020).

Flexibility

High staff turnover creates a challenge for the implementation of an intervention and its sustainability. A critical mass of motivated staff is required to complete training. Therefore, flexibility is needed to maximise opportunities for education and to bring changes to practice. This can be achieved through the flexible timing and frequency of education, the mode of delivery, and flexibility with regard to the training location (Collingridge Moore et al. 2020).

Education, training, and specialist support

Simply providing palliative care knowledge may not sufficiently empower staff and boost their confidence. Instead, a more effective approach involves continuous education coupled with ongoing support. This includes affording front-line staff opportunities to acquire practical experience and engage in discussions about end-of-life care in an encouraging educational environment. This approach is proven to enhance the sustainability of the intervention (Norling et al. in 2022 and Juhrmann et al. in 2023).

There is also evidence that a multi-facetted approach to education is most effective and sustainable. Classroom type workshops, on-line learning, simulation training, reflective discussion groups, and self-directed learning packages may be utilized (Norling et al. 2022). A blended model of both theoretical and hands on training is recommended to ensure different learning styles are being catered for. While e-learning is convenient allowing staff to integrate training with their patterns of working, provision of face-to-face teaching is often preferred as it allows participants to ask questions and participate in discussions, as well as providing emotional support due to the end of life training content (Manson et al. 2020). Case-based education provided by a palliative care clinician was identified as a key enabler to successful training and the sustainable implementation of a palliative care intervention (Koerner et al. 2021).

There is also evidence that care staff generally have a preference for hands on education delivered by peers, rather than the didactic education. A classroom-based approach is a barrier to learning in this context, as care staff are used to being very practice focused (Lam et al. 2018). Being able to access recorded lectures ensures that staff can access the content despite being unable to attend the session (Manson et al. 2020). Shorter training sessions are preferred by RACF staff (Manson et al. 2020).

Specialist palliative care clinicians play an important role as educators (Koerner et al. 2021) as they are experts in assessing and managing palliative care needs. Hence, the involvement of a specialist palliative care clinician working with care home staff to provide person-centred end of life care is one of the most important enablers in this context as it supports knowledge translation. Evidence shows that home care staff find that the input of specialist palliative care clinician supports flexible approaches and gives permission for staff to prioritise residents' preferences and needs over care home routines and usual practice (Handley et al. 2022). Debriefing groups facilitated by a specialist palliative care nurse is found to be beneficial as it focuses on learning at three different levels – being taught, developing understanding and critical thinking (Froggatt et al. 2014). Facilitating personal support workers to visit an in-patient hospice setting and experience the culture and clinical care within the hospice is also useful (Froggatt et al. 2014).

However, allowing time for reflection and debriefing, staff discussion and confidence building through face-to-face workshops, role-play, and on the job training to facilitate transition from education into practice were also found to be a significant enabler to the sustainability of a palliative care intervention (Collingridge Moore et al. 2020). Evidence also shows that the adoption of formalised procedures result in sustained learnings (Norling et al. 2022).

Nonetheless, there is substantiating evidence suggesting that not only RACF personnel, but also general practitioners could receive enhanced support for delivering high-quality palliative and end-of-life care within care homes by means of dedicated training programs.

4.2.2.6 Creating accountability and routine

Pal care champion team and clinical champion

A further enabler to the sustainability of a palliative care intervention is the development of a palliative care committee of champions in the care home with representation across all staff roles (ibid.). This ensures staff engagement on all levels and leads to a whole home approach. This committee also includes clinical champions, which has been shown to have a positive effect on sustainability (Luckett et al. 2017).

Embedding intervention into everyday practice

Moving from the intervention into everyday practice is a key enabler to the sustainability of a palliative care intervention. Integrating the new framework, along with its tools and processes, into current workflows is crucial to prevent an increase in workload and the potential for duplication of efforts.

This also connects with the educational component of the intervention since the application of knowledge in routine care is crucial for driving practice change.

In some cases, this may require changing organizational structures or adapting the intervention to sit within current structures, for example, changing documentation to reflect new approaches (Collingridge Moore et al. 2020).

5 Discussion

Ten key concepts of barriers and seven key concepts of enablers (both including several sub-concepts) to the provision of comprehensive palliative care in residential aged care were identified in the reviewed literature:

Table 2: Summary table 'Barriers to the optimal provision of palliative care in RAC'

Key concept	Sub-concepts
Key concept 1: Wider system barriers (outside the project scope)	**Sub-concept 1:** Aged care funding for palliative care in RAC. Lack of appropriate funding for palliative care in RAC due to narrow definition of palliative care as the last week or days of life
	Sub-concept 2: Shortage of medical professionals, interoperability of software systems and health records, current funding models for GPs, and limited operating hours of primary care services and after-hours requirements
Key concept 2: Lack of support from other healthcare professionals	**Sub-concept 2:** timely and variable access to General Practitioners (GPs), and lack of GP response to follow- up requests for medication review
	Sub-concept 3: limitations in GP knowledge of palliative care (in end- of- life care in particular)
	Sub-concept 4: GP reluctance to prescribe (anticipatory) end-of-life medications
	Sub-concept 5: Limitations in achieving (timely) access to specialist palliative care services for clinical in-reach support
Key concept 3: Time pressure	**Sub-concept 1:** Lack of timely and/or clear conversation and ACP resulting in EoL conversation, crisis decision making and family preparation and education under time pressure
	Sub-concept 2: Care staff dilemma due to simultaneous routine care tasks, Advanced Care Planning, discussion of goals of care, and the provision of palliative care, in particular at the end of life
Key concept 4: Lack of formal palliative care education and training for RAC staff, and for UHCWs in particular	**Sub-concept 1:** Lack of knowledge, skills and confidence with regard to the following topics • Advance Care Planning for all staff, including staff in non-caring roles • Definition and understanding of palliative care • Identification of deteriorating patients with agreed indicators for introducing the palliative approach and recognising specialist palliative care needs • Standardised symptom assessment particularly in dementia • Symptom management, in particular mouth care, hydration, administering medications (opioids in particular) and pain relief medication before personal care • Communicating with residents, families and carers, GPs,

	• Preparation for loss
	Sub-concept 2: Lack of knowledge translation resulting in acquired knowledge not being applied in practice due to a lack of support, inappropriately chosen staff (too junior, not supported by management, or perceived a lack of ownership towards dissemination of the information learnt)
Key concept 5: Communication barriers (staff inherent and cultural)	**Sub-concept 1:** Lack of or failing communication, in particular around ACP discussions with residents, families and carers due to taboo of talking about death and dying and indirect communication
	Sub-concept 2: Poor communication between RAC staff and GPs, as well as between staff in RACFs (RN, EN, UHCW**s**), including poor documentation and handover practices
	Sub-concept 3: Communication among healthcare workers and professionals due to professional hierarchy (lack of teamwork)
	Sub-concept 4: Poor or lack of communication with co-residents when a resident has died
Key concept 6: Lack of appropriate model of care	**Sub-concept 1**: Failing to recognise palliative care needs and RAC policies mandate hospital transfer represents a medical model. A shift to an accepted model of palliative care is required.
Key concept 7: Lack of or inadequate Advance Care planning, in particular for patients with dementia	**Sub-concept 1:** Lack of staff skill and confidence to initiate and conduct ACP discussions
	Sub-concept 2: Challenges regarding the timing and process of ACP discussions lead to a lack of and inadequate Advance Care Planning
Key concept 8: Patient & carer(s)/family barriers	**Sub-concept 1:** Inherent patient difficulties (e.g. cognitive impairment)
	Sub-concept 2: The patient and their family struggle with grasping the resident's current phase, comprehending the implications of hospital admission, and encounter challenges when it comes to accepting end-of-life decisions. This often leads to conflicts.
Key concept 9: Emotional burden and lack of support for staff	
Key concept 10: Lack of appropriate space for EoLC	

Table 3: Summary table 'Enablers to the optimal provision of palliative care in RAC'

Key concept	Sub-concepts
Key concept 1: Wider system enablers (outside the project scope)	**Sub-concept 1:** Alignment of accreditation standards with the Government's National Palliative Care Strategy 2018, to reflect Priority 7.5 indicators for quality palliative care
	Sub-concept 2: Industry change to support ongoing education, manageable workloads, and a collaborative health care team that strives for best practice
	Sub-concept 3: Modifications to current funding models
	Sub-concept 4: Changes on policy level to ensure GP engagement
Key concept 2: Organisational enablers	**Sub-concept 1:** Management engagement and support, workforce engagement, and supportive organizational culture which promotes and supports learning and self-care
	Sub-concept 2: Organisational policies to guide staff on how to identify and manage residents with palliative care needs, and guide decision-making
	Sub-concept 3: Improving the physical environment by • Creating ad hoc end-of-life care beds and establishment of a palliative care room for the dying resident (including a palliative care kit for the provision of end of life care) • Filling the area 'with life' and personalizing it • Enabling 24/7 visitor access for residents approaching the end of life
	Sub-concept 4: Increasing staffing and ensuring continuity of care (regular staffing patterns) when a resident is nearing the end of life
	Sub-concept 5: Be prepared for end of life care by having end-of-life medications and equipment readily available on site in case of unexpected resident deterioration, and a trained nurse is available to administer medication
Key concept 3: Education and training to improve staff knowledge, practical skills, confidence and resilience of the care team	**Sub-concept 1:** Palliative care knowledge, awareness and capability: knowledge of the definition of palliative care and palliative care training tailored to the specific circumstances and challenges in residential aged care, focussing on the holistic resident - not tasks. Education and support of normalising death and dying in residential care through increased exposure to the principles and practices of health-promoting palliative care, and opportunity to observe a positive and accepting death.

	Sub-concept 3: Inter-profession education resulting in a team-based approach to care as well as internal mentoring
	Sub-concept 4: Education and training to be customised to needs and workflow
	Sub-concept 5: Education to include: • Culture sensitive training to recognise that cultures can influence how they approach death and dying in the care home • Improve the knowledge of local non-acute service options and referral pathways • Sensitively engaging in discussions about death and dying with a diverse range of residents, including those with dementia • Shadowing method to train less experienced staff to engage in advance care planning discussions with residents and relatives. Educational workshops to include more staff with non-caring roles. • Increasing death literacy[4] among families and carers
Key concept 4: **Change from an acute to palliative approach to shift the focus of care to symptom management and psychosocial support, and therefore to resident comfort and needs of families**	
Key concept 5: **Implementation of a comprehensive palliative care framework**	**Sub-concept 1:** Framework to include • Formalised and standardised procedures that guide the proactive identification of deterioration and palliative care needs, clinical actions that arise, and escalation of issues to appropriate clinical staff • Formalised procedures that guide ongoing assessment and symptom management, including medication reviews and medication management • A toolkit, needs assessments, clinical assessments including pain and symptom assessment tools for people with frailty, including among those with cognitive impairment • Clear outline of roles and responsibilities
	Sub-concept 2: Multi-disciplinary approach, bringing together expertise from health and aged care professionals (HCA's, ENs, RNs, GPs, SPC clinicians) to assist with advance care planning and planning goals of care, sharing responsibility for decision-making, manage symptoms including anticipatory prescribing of medicines to control

[4] Death literacy is "a set of knowledge and skills that make it possible to gain access to, understand, and act upon end-of-life and death care options" (Noonan 2016: 32).

	symptoms in the last days of life, and provide education. Availability of psychosocial supports
Key concept 6: Person-centred model of palliative care	**Sub-concept 1:** High quality, systematic Advance Care Planning to offer residents the opportunity to make their preferences known
	Sub-concept 2: Individualised care that is relationship-focused, and collaboration and shared decision making between the resident, family, and staff
	Sub-concept 3: Time and skills to discuss ACP, related organisational processes and paperwork to provide structure and high-quality documentation
	Sub-concept 4: Multi-disciplinary teams as forum for advance care planning discussions, particularly if a patient's ability to communicate effectively is impacted and conversations with the resident are unlikely to lead to an ACP, and no family or and substitute decision maker is available to advocate for the resident
Key concept 7: Provision of accurate, relevant, up to date information, effective communication, and teamwork	**Sub-concept 1:** Family involvement and collaboration in care planning in order to identify social, emotional, spiritual, and interpersonal needs of people approaching the end of life, particularly for residents living with dementia
	Sub-concept 2: End-of-life education for families, and open, honest and clear communication with the residents' families about death and dying
	Sub-concept 3: Building stronger and more sustainable partnerships between aged, primary and specialist palliative care to enable collaboration and effective communication between specialist palliative care staff, care home staff, residents, and GPs
	Sub-concept 4: Acknowledging HCA's as expert members of the end of life care team based the personal knowledge they have of residents and their families and carers and the role they play in the care for residents approaching the end of life and, ensuring they receive sufficient support to fulfil this crucial role, and promoting collaborative and equitable relationships between RAC nursing and care aide staff to empower them to voice symptom management concerns and ensure they are acted on
Key concept 8: Grief and bereavement support	**Sub-concept 1:** For staff - addressing grief at orientation to prepare new staff for what to expect, allowing staff to express their grief, enabling staff to participate in cultural rituals related to residents dying, having an opportunity to discuss the death of a resident informally with peers, standardised and consistently provided formal grief and bereavement support
	Sub-concept 2: For families and carers - support sessions for families and carers to facilitate early bereavement

	Sub-concept 3: For co-residents - acknowledging each resident's death within the home; informing co-residents of a resident's death; grief and bereavement support.

Based on these concepts, the following hypotheses were developed:

Hypothesis 1:

Residential aged care facilities will be providing comprehensive, evidence-based best practice palliative care if

1. Organisational key policies and processes are adapted to include a palliative care model of care in order to change from an acute to palliative approach where clinically indicated to shift the focus of care to symptom management and psychosocial support, and therefore to resident comfort and family needs
2. Death and dying is normalised and discussed openly
3. Strong relationships, in particular GPs and the specialist palliative care team, but also other allied health and pastoral care professionals
4. High quality and systematic Advance Care Planning is embedded and followed through, giving residents the opportunity to reflect on their wishes and make their preferences known,
5. A standardised, comprehensive palliative care framework including processes and tools is in place that facilitate the identification and communication of deterioration, palliative care needs and specialist palliative care needs with guidance for decision-making, clearly outlined actions, roles and responsibilities
6. Management promote a culture of learning, motivating and supporting staff to participate in education and training to acquire palliative care and end of life knowledge and relevant skills,
7. Knowledge transfer within the organisation and the application of acquired skills in the organisation is supported
8. Residents and their families / carers have access to educational, advisory, and emotional support throughout the resident's palliative care journey
9. An appropriate space for the provision of end of life care (creating ad hoc end-of-life care beds or establishment of a palliative care room for the dying resident which can be personalised, enabling 24/7 visitor access for residents approaching the end of life)
10. Necessary end of life care equipment and a palliative care kit are in place when needed
11. Staffing is increased and continuity of care ensured (regular staffing patterns) when a resident is nearing the end of life
12. Staff are prepared for grief and loss, commencing from orientation
13. Staff are not only given the time to debrief and informally support each other after a resident has died, but also receive *regular formalised* grief and bereavement support
14. Rituals are implemented to support staff to deal with the emotional burden of their work and repeated experiences of dying residents and the loss they experience
15. It is communicated to co-residents when a resident has died, and rituals are in place to support co-residents in their grief and bereavement process
16. Management promotes and supports a culture of self-care.

Hypothesis 2:

A resident in an aged care facility who is deteriorating or reaching the end of their life, and their family/carer(s), will receive evidence-based best practice palliative and end of life care if

1. Deterioration is recognised using standardised assessment tools for all residents, including specialised tools for residents with cognitive impairment, communicated, and acted on
2. A high quality ACP based on open discussions with the resident about their end of life preferences over a period of time is in place and filed appropriately
3. It is recognised and communicated to the care team when the resident is deteriorating
4. Open and honest communication takes place with the resident's family or carer(s) when the resident is deteriorating
5. Residents and their families / carers have access to educational, advisory, and emotional support, including support sessions for early bereavement
6. The resident's family or carer is involved and collaborating in care planning in order to identify social, emotional, spiritual, and interpersonal needs of people approaching the end of life, particularly for residents living with dementia
7. Staff have palliative care knowledge, skills, and confidence, and take a holistic, patient-centred approach, providing individualised, relationship focused care, they take appropriate actions at the appropriate time
8. A multidisciplinary team is involved in the patient assessment and care once deterioration is identified (or a life limiting illness diagnosed), including different RAC care staff (RN, EN, and/or HCA's), GP and specialist palliative care clinician
9. All RAC staff involved in patient care as well as the multidisciplinary team work together as a team and communicate well
10. Symptoms are well managed
11. It is recognised that a resident is approaching the EoL, and communicated to the care team
12. Staff have had open and honest discussions with families with regard to the resident's end of life
13. An end of life care plan/pathway is activated and anticipatory medications are in place
14. Staff provide end of life care in situ if this is the resident's preferred place of death
15. Dying residents receive end of life care without time pressure and competing demands on the nurse to complete other tasks
16. Dying residents receive care from the same staff as much as possible (continuity of care)
17. After the resident has died, families and carers receive grief and bereavement support.

Five key concepts of barriers and five key concepts of enablers (including several sub-concepts) to the implementation of a palliative care intervention and its sustainability care were identified:

Table 4: Summary table 'Barriers to the implementation of a palliative care intervention and its sustainability'

Key concept
Key concept 1: Workforce challenges due to high staff turnover, staff shortages, absenteeism, resulting in a high workload and time pressure
Key concept 2: Incompatibility of RAC systems and processes, resulting in participants experiencing a burden of redundant paperwork, manual processes and add- on workload without real benefit
Key concept 3: Failure to identify champions and key staff changes,
Key concept 4: Weak GP relationships
Key concept 5: Organizational and financial barriers to the implementation of education and training, lack of support to implement acquired knowledge

Table 5: Table 5: Summary table 'Enablers to the implementation of a palliative care intervention and its sustainability'

Key concept	Sub-concepts
Key concept 1: Organisational enablers	**Sub-concept 1:** Internal assessment to recognize that palliative care needs strengthening - audit of current practices to identify gaps and establish baseline for the evaluation of the intervention
	Sub-concept 2: Organisational commitment to supporting staff to incorporate a palliative approach by • Management developing a vision for palliative care • Management and staff developing a shared vision as to what the intervention is aiming to achieve and how (clear parameters) • Providing adequate resources, in particular protected time for education and training, knowledge translation, and the creation/adaptation of key policies, processes, and formalised local procedures to reflect best practice principles within the palliative approach that provide clarity around the expectations of staff and responsibilities, and provide support and certainty in decision making • Providing physical space and resources to complete the intervention

	• Establish and sustain a critical mass of trained staff to mitigate the challenges of staff recruitment and retention
Key concept 2: External and internal stakeholder involvement	**Sub-concept 1:** Raising awareness among stakeholders involved in the care for residents to ensure that the intervention being delivered is congruent with the wider care of the resident, All RAC staff (whole home approach) should receive (a) a comprehensive orientation, (b) clear communication of the purpose, expected benefits to staff and residents, and (c) tailored education/training to meet individual site needs
	Sub-concept 2: Locating the intervention within the current context and into the delivery of everyday practice with existing processes within the facility
Key concept 3: Intervention design	**Sub-concept 1:** Facilitator to support, educate, mentor, and guide practice - facilitation needs to be consistent, regular and provided by an experienced individual in order to combat staff turnover
	Sub-concept 2: Flexibility to maximise opportunities for education and to bring changes to practice (flexible timing and frequency of education, the mode of delivery, and flexibility with regard to the training location)
Key concept 4: A blended model of both theoretical and hands on training, delivered in person and also via online modules is recommended. Case-based education, provided by a palliative care clinician, is best practice when it comes to offering a combination of knowledge acquisition, practical experience and the opportunity to debrief and discuss end-of-life care in a supportive educational manner. Resilient and flexible training models to adapt to high staff turnover, high absenteeism, and time constraints staff experience.	
Key concept 5: Creating accountability and routine	**Sub-concept 1:** Establish a Pal care champion team and clinical champion
	Sub-concept 2: Embed intervention into everyday practice

Based on these concepts, the following hypothesis was developed:

Hypothesis 3:

A palliative care intervention will be successful and successfully implemented with sustainable effects if

1. It is recognised on an organisational level that palliative care needs strengthening and current practices are audited to identify gaps
2. Key policies, processes, and formalised local procedures are adapted to reflect best practice principles within the palliative approach that provide clarity around the expectations of staff and responsibilities, and provide support and certainty in decision making
3. Management are committed to supporting staff to incorporate a palliative approach by
   - developing a vision for palliative care
   - developing a shared vision as to what the intervention is aiming to achieve and how (with clear parameters)
   - providing adequate resources, in particular dedicated time for education and training, knowledge transfer, and the implementation/application of knowlegde and skills in everyday practice
4. A physical physical space and resources to complete the intervention are provided
5. A critical mass of trained staff is established and sustained to mitigate the challenges of staff recruitment and retention
6. Stakeholders (GPs in particular) involved in the care for residents, are aware of the intervention, understand the benefits, and are willing to partcipate
7. All RAC staff (whole home approach) receive (a) a comprehensive orientation, (b) clear communication of the purpose, expected benefits to staff and residents, and (c) tailored education/training to meet individual site needs
8. The intervention is located within the current context and integrated into the delivery of everyday practice with existing processes within the facility, thus ensuring compatibility, and non-duplication of work and no add-on workload without real benefit
9. An internal or exteranl facilitator is available to support, educate, mentor, and guide practice,
10. Facilitation is consistent, regular and provided by an experienced individual in order to combat staff turnover
11. The intervention is flexible (timing and frequency of education, the mode of delivery, and location) to maximise opportunities for education and to bring changes to practice
12. A blended model of both theoretical and hands on training, delivered in person and also via online modules is applied, and case-based education is provided by a palliative care clinician,
13. Staff recognise the need to strengthen palliative care
14. Staff are motivated and feel supported to participate in education and training, and embrace the opportunity to receive input from an external facilitator
15. A Pal care champion team including clinical champions are established, and key staff changes are identified and resolved
16. The intervention is embedded in everyday practice and routine.

6 Conclusion

Key concepts of barriers and enablers to the provision of palliative care in residential aged care, and the successful and sustainable implementation of a palliative care intervention were identified. Hypotheses were generated based on these findings as to:

1. What elements are required to provide comprehensive palliative care in residential aged care from an organisational perspective as well as the resident's perspective
2. What the organisation needs to consider for the intervention to be able to be successful and sustainable
3. What criteria the intervention itself needs to meet in order to be able to be successful and sustainable

The key concepts will inform the following:

- An organisational audit,
- An audit tool for existing education resources, programs, tools,
- A Central Highlands Rural Health governance and clinical document audit tool to identify alignment, misalignment and gaps,
- A residential aged care staff survey on the local barriers and enablers to the provision of palliative care and their needs,
- A comprehensive palliative care framework for residential aged care.

Appendix

Literature search strategy

1. Search terms for Google Scholar, Research Gate, and PuBMed:

- palliative care
- specialist palliative care
- residential aged care
- barriers
- problems
- challenges
- gaps
- enablers
- facilitators
- end of life or end-of-life
- dementia
- acute hospital
- GP
- CALD or culturally or linguistically diverse populations
- Ethnic minorities or Ethnicity
- Language barriers
- Inclusion
- Disability
- LGBTIQ+
- Family
- Staff
- Residents
- Nurses
- Dying or death
- Education
- Training
- Practice
- Needs rounds
- Case conference or case conferences

2. Database search:

- Data base: MEDLINE
- Publication period: 2013 – 2023
- Search in titles and abstracts
- Inclusion: Qualitative and quantitative studies
- Search terms:

- palliative care
- specialist palliative care
- residential aged care
- Nursing home
- barriers
- problems
- challenges
- gaps
- enablers
- facilitators
- end of life or end-of-life
- CALD or culturally or linguistically diverse populations
- Disability
- LGBTIQ+
- Family
- Staff
- Residents
- Nurses
- Dying or death
- Education
- Training
- Practice

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