

Quality Indicators of End of Life Care for Residential Aged Care Facilities: A Retrospective Cohort Study

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BACKGROUND

Residential aged care facilities (RACFs) house Australia's most vulnerable older adults, yet access to palliative care remains limited. The Royal Commission found that over 90% of residents who die have palliative needs, but only 6% are formally recognised. Although most (97%) wish to remain in their facility, 14% die in hospital and nearly 30% are hospitalised in their final month, exposing many to potentially avoidable hospital transfers.

Whether hospital transfer compromises goal concordant, comfort focused end of life care remains uncertain. This study compares quality indicators for RACF residents who died in place versus those who died in hospital.

AIMS

1. To compare end of life care quality for RACF residents who died in place versus in hospital
2. Primary outcome: Preference concordant death
3. Secondary outcome: Timing of specialist palliative care (SPC) referral, symptom burden (PCPSS, SAS), use of comfort focused medications, presence of advance care planning (ACP) or "not for transfer" directives, and the potentially avoidable terminal admissions.

DESIGN & POPULATION

- **Inclusion:** Residents ≥ 65 y; died 1 Jul 2022–30 Jun 2024 either in RACF with Cabrini Palliative Homecare or in hospital following transfer.
- **Final cohort:** $n = 478$ (RACF deaths = 378; hospital deaths = 100)
- **Transfer definition:** From RACF during final illness; death in hospital (ED/acute/PCU).
- **Terminal hospital admission:** Final hospitalisation culminating in death.
- **Potentially avoidable terminal admission:** On retrospective review, the presenting problem could reasonably have been managed in the RACF by an RN with GP support, and in line with documented ACP limits.
- **Adjudication:** Two physicians independently classified avoidability.

DEFINITIONS

- **Preference concordant death:** actual vs preferred place (ACP/Goals of Care).
- **SPC timing:** days from first SPC to death.
- **Comfort medications:** Continuous subcutaneous infusions (CSCI) or benzodiazepine; IV antibiotics ≤ 48 h before death.
- **Unavoidable terminal admission:** Acute, unexpected deterioration (e.g., fracture after fall, severe delirium, uncontrolled symptoms needing inpatient care) or transfer aligned with ACP.

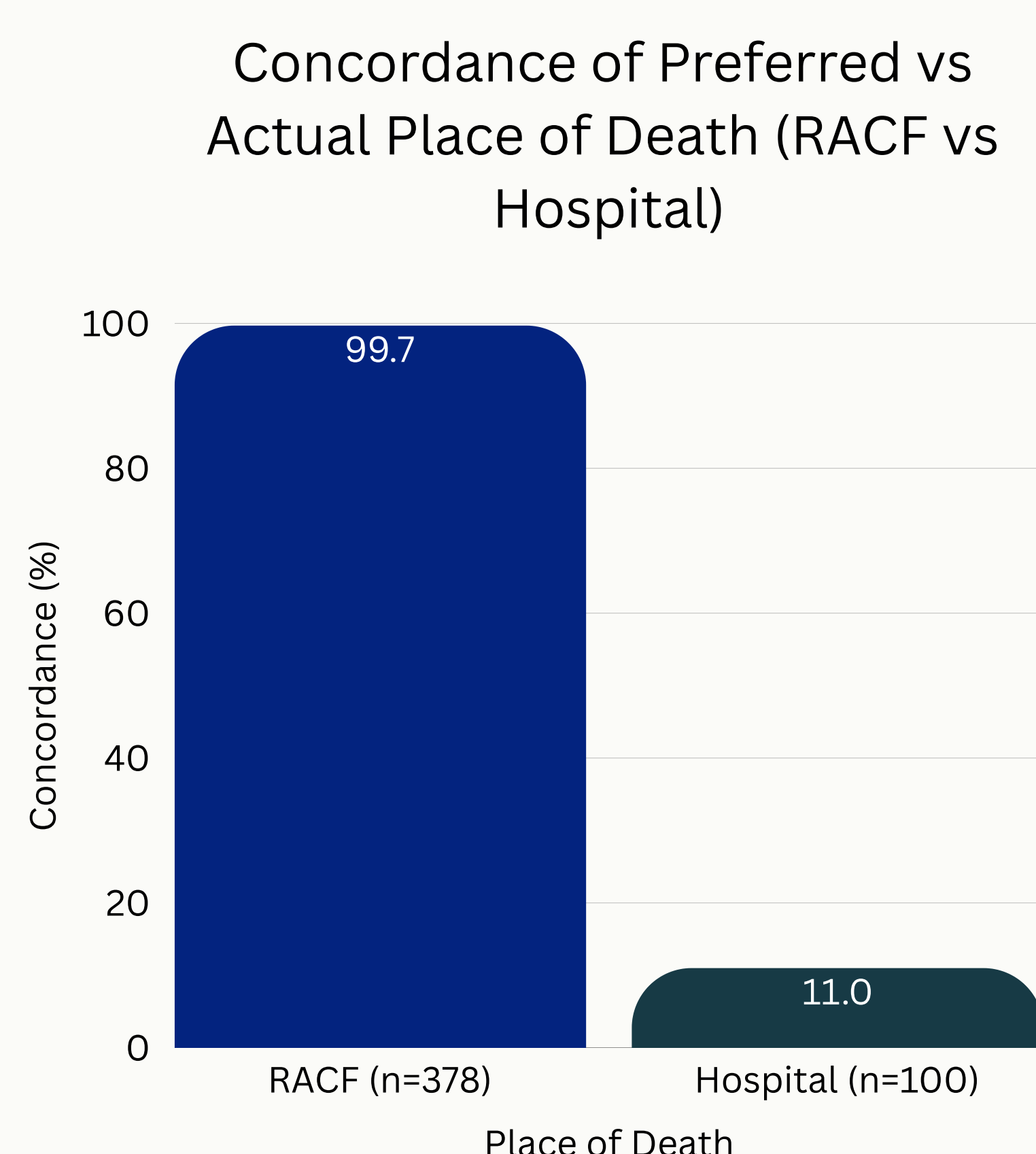


Figure 1: RACF (99.7%) vs Hospital (11%); 51 % hospital undocumented preference ($p < 0.001$).

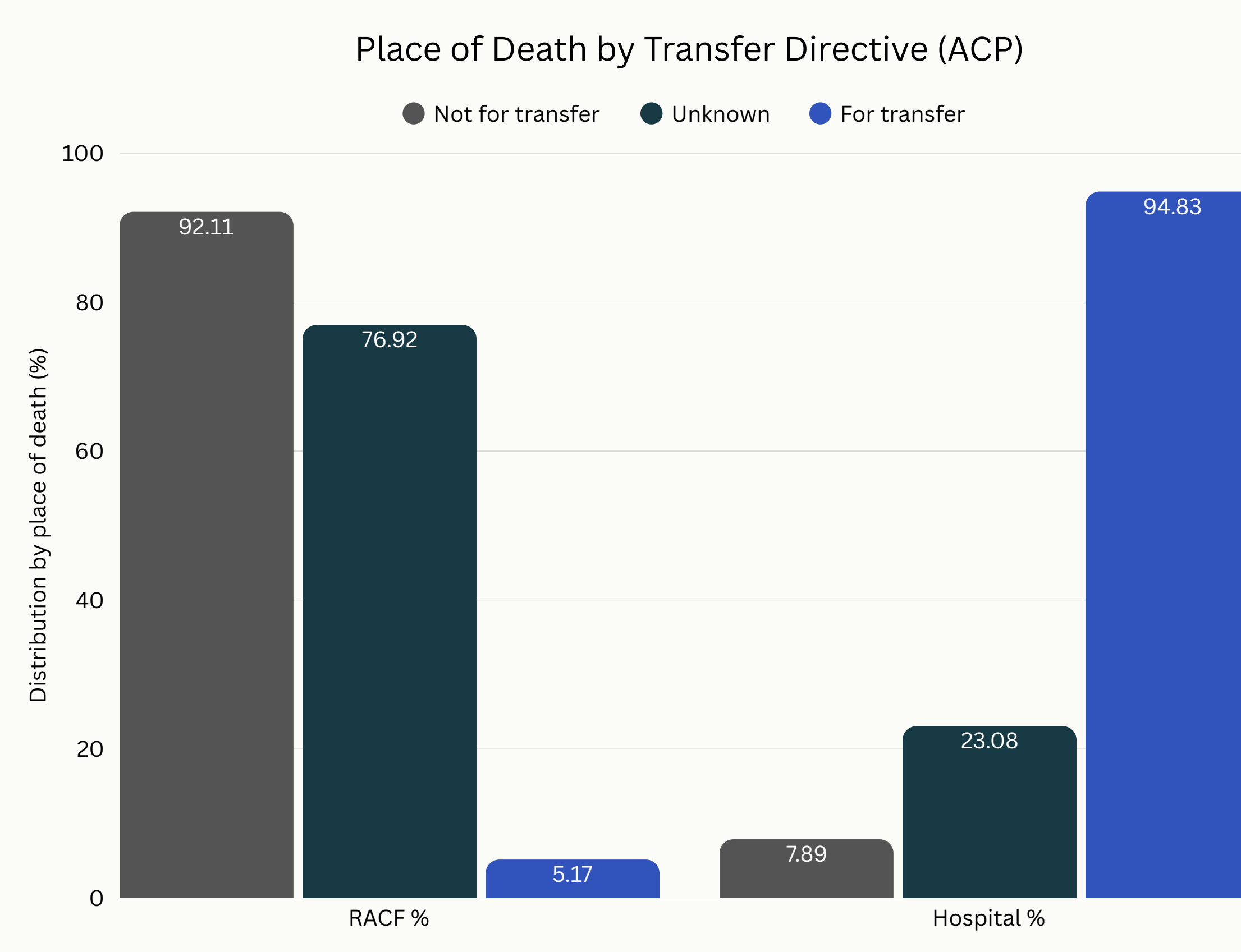


Figure 2: Hospital deaths mainly occurred among residents with "For transfer" directives; ($p < 0.001$).

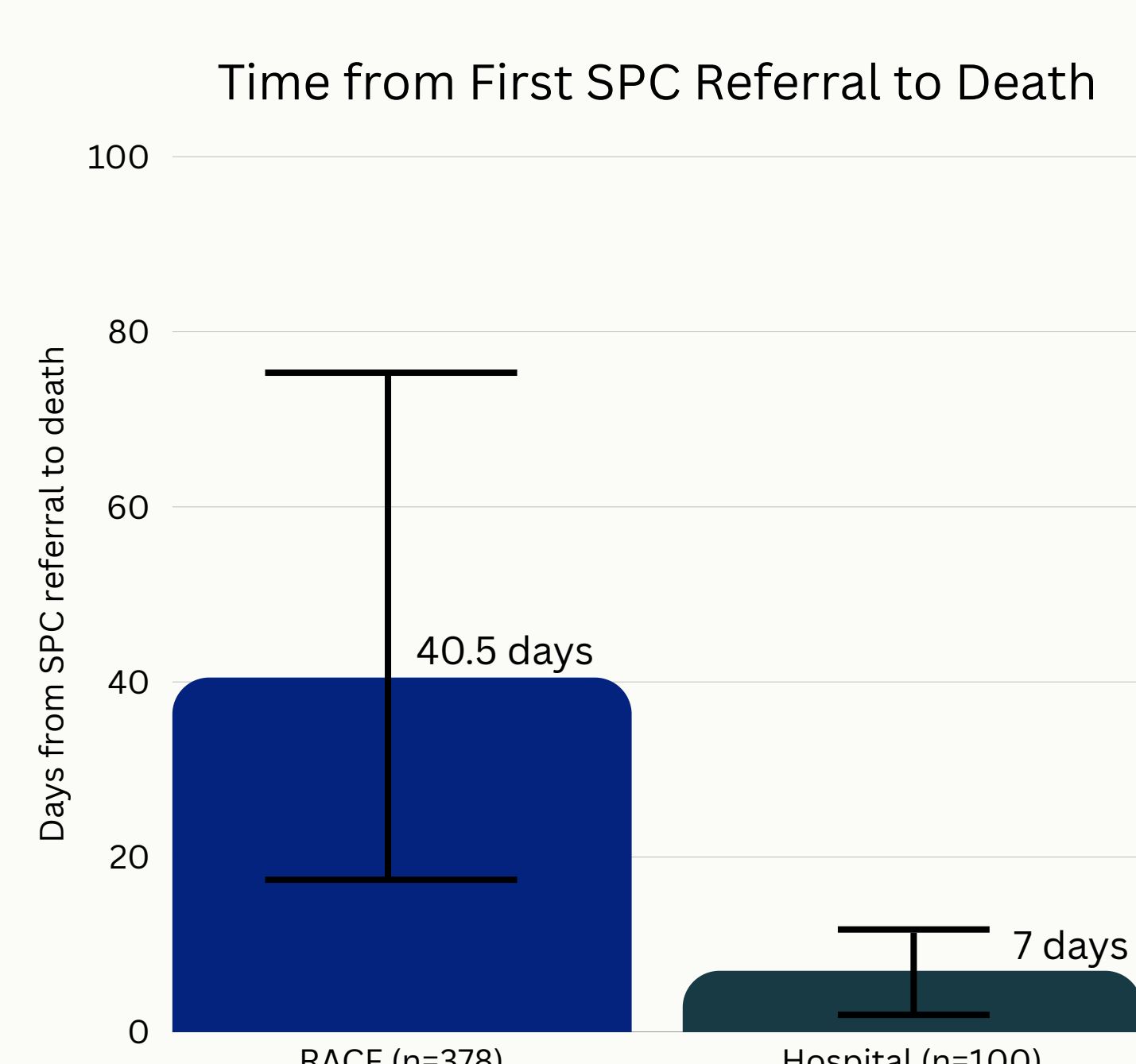


Figure 3: Median 40.5 days; RACF was referred earlier to SPC ($p < 0.001$).

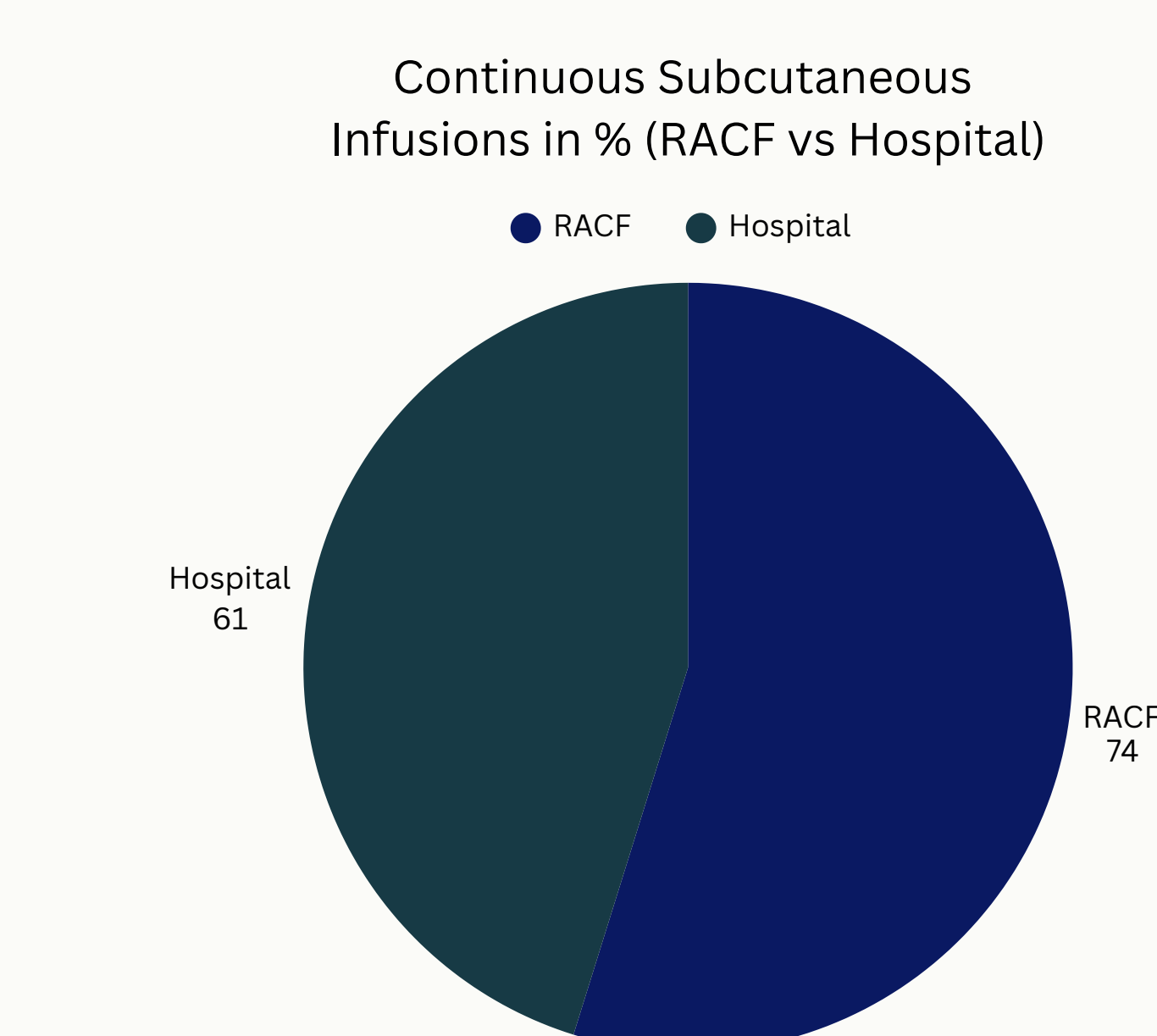


Figure 4: RACF 74.3 % vs Hospital 61.0 %; CSCI more frequent in RACF residents ($p = 0.012$).

RESULTS

- **Diagnosis:** More cancer (39.6% vs 27%) and neurological disease (11.1% vs 4%) in RACF; dementia/frailty higher in hospital (51% vs 25.3%).
- **Medications:** RACF had higher benzodiazepine use (97.6% vs 91%, $p=0.005$) and CSCI (74.3% vs 61%, $p=0.012$), while hospital had higher antipsychotic use (65% vs 36%, $p<0.001$) and IV antibiotics ($p=0.002$).
- **Terminal admissions:** We estimated that 24% of terminal hospital admissions at end of life could be avoided with earlier recognition of deterioration and proactive RACF end of life planning.

CONCLUSION

- RACF deaths were almost entirely preference concordant and associated with earlier SPC involvement.
- RACF residents received more comfort focused therapies (CSCI, benzodiazepines), while hospital deaths involved more antipsychotic and IV antibiotic use.
- Implications: Embedding timely SPC, structured ACP with explicit "not for transfer" directives, and RACF protocols for early recognition of deterioration may reduce the proportion of potentially avoidable terminal admissions and improve the quality of end of life care.