Western society is ageing. The population of the world in general and in Europe in particular, is growing older. If the current trends continue, then by the year 2050 more than a quarter of the people living in developed nations will be over 65 years old.

Quality end-of-life care increasingly has to be understood as quality care for old and very old persons, as most people who die in our society are well advanced in years. The German database Gerostat indicates that, in the year 2008, more than 75.2% of all men and women who died in Germany were 70 years and older, 50% were 80 years and older, and 14.3% were 90 years and older. Similar figures exist in the UK for England and Wales.

In 2008, 65.5% people who died were 70 years and older, 53% were 80 years and older, and 14% were 90 years and older. The German database Gerostat indicates that, in the year 2008, 2050 more than a quarter of the people living in developed nations will be over 65 years old.

It has been increasingly recognised, over the last 10 years, that older people need palliative care in a variety of living situations. Three issues are of particular concern:

1. When should palliative care start with an older person?
The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness”. Whereas, by this definition, palliative care starts when an “incurable” diagnosis is confirmed, this is not necessarily applicable for old age. Old age itself is not a life-threatening illness. However, older people are in need of palliative care when multiple conditions and/or dementia pose a burden upon individuals in terms of pain and symptoms (physical, psychological, social or spiritual). In certain cases, palliative care for older people can therefore be applicable years before death.

2. Persons with dementia
For many older people, dementia becomes a part of their experience of ageing and dying. Specific challenges in providing palliative care for this group of people include the assessment and management of pain and other symptoms, care when people can no longer eat or drink and the processes of care and treatment decision-making. Alongside these practical challenges lie more fundamental questions about the nature of self and the preservation of personhood, which shape the values that underpin the care provided to people with dementia towards the end of life.

3. Persons in long-term care institutions
Long-term care institutions, such as nursing homes, care for increasing numbers of dying residents and this trend will continue. Many obstacles hinder the successful implementation of palliative care in...
these settings. The challenge of how to overcome these obstacles has been widely discussed within the German-speaking realm and a number of different approaches have been pursued in recent years.4,14

Managers of nursing homes have involved themselves with this issue through measures to raise awareness and provide special training, activities involving nursing home residents, cooperation with relevant partners, such as undertakers and doctors on-call, or through comprehensive development projects. In these projects palliative care is not seen as an isolated action, as would be the setting up of a training programme. Far more common is the scenario in which various tools are developed and used to promote a palliative culture. Well-documented examples of such interventions feature in the discussions carried out by staff with nursing home residents about their needs with respect to dying and death.14

**COOPERATION BETWEEN CARE PROVIDERS**

In addition to such project-based approaches to implementation, another Germanic model centres on cooperation between care providers from hospices or specialised palliative care services and nursing homes. In most cases, this involves the collaboration with volunteers of the hospice movement. In the UK, the national End-of-Life Care Strategy promotes the use of particular tools, such as end-of-life care pathways and the Gold Standards Framework for Care Homes,15 (GSFCH) which, when supported by educational initiatives, require attention to wider systems by structured management of individual’s care planning and management. The experience of implementing end-of-life care strategy in hospices and palliative care in long-term care settings has demonstrated that collaboration between geriatrics, gerontology as well as palliative care and hospice work is essential.

The responses to the situations and contexts outlined above have been increasingly innovative and collaborative. The recent WHO booklet, *Better Palliative Care for Older People: Better Practice,*1 provides not only a comprehensive overview of key issues but also examples of good practice that seek to address the whole system for care provision. In order to maximise the knowledge, skills and resources to the benefit of older people, living and dying with whatever condition or conditions, ongoing collaborations are required across the fields of gerontology, geriatrics and palliative care, and hospices and across national boundaries. This can only be to the benefit of older people and their families.

Details of the references cited in this article can be accessed at www.cancernurse.eu/communication/eons_newsletter.html

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**Some key features of the GSFCH programme**

- A ‘culture shift’ of greater staff confidence, competence and awareness of patient needs
- Perceived better quality of care provided for all residents from admission to death or discharge
- Advance Care Planning discussions for all residents from time of admission, and identification of their need and stage of illness, using coding assessment
- Improved collaboration with visiting GPs and out of hour’s doctors
- Fewer crisis hospital admissions, leading to more dying peacefully in the home
- Better coordinated organisation and recording of care
- Better communication and collaboration with GPs + others
- Improved support and involvement of families
- ‘Learn-as-you-go’ education focussed on needs of staff, supported by specialists
- Better preparation for dying and use of protocol/pathway.

(from a briefing paper by the GSFCH central team)