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Clinical staff perceptions on the quality of end-of-life care in an Australian acute private hospital: a cross-sectional survey

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Abstract.

Objective. To explore the perceptions of clinical staff on the quality of end-of-life care in an acute private hospital.

Methods. A descriptive cross-sectional study with a convenience sample of clinical staff in an acute private hospital were surveyed using a validated end-of-life survey. Data from the surveys were analysed using descriptive statistics for quantitative responses and inductive content analysis for the open-ended responses.

Results. Overall, 133 staff completed the survey. Of these, 107 had cared for a dying patient in the hospital. In total, 87.6% of participants felt confident in their ability to recognise a dying patient and 66.7% felt confident in their ability to talk to the patient and family. Almost one-third had not received specific training in the area.

Conclusions. Hospitals need to take the lead in ensuring end-of-life care processes are embedded across clinical areas. This includes providing staff with end-of-life care education and support in the delivery of end-of-life care. These strategies will facilitate safe and quality end-of-life care, including better collaboration between patients, families and staff.

What is known about the topic? Key to providing quality end-of-life care in hospitals are strategic guidelines that support good clinical governance and adequately trained staff to deliver the care.
What does the paper add? This study highlights the importance of clinical staff in all areas having skills and confidence in providing care to dying patients and their families.
What are the implications for practitioners? It is important that all health practitioners implement strategies to overcome gaps in staff education and support, to ensure all patients and families receive quality end-of-life care.

Keywords: hospitals, private; nursing, health professional, hospital; mixed-methods, end-of-life care, palliative care, terminal care.

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Introduction

It is often a challenge to deliver good-quality, end-of-life care in acute settings due to the focus on the needs of acutely unwell patients. However, the quality and safety of end-of-life care for patients, families and for the staff delivering care is essential.[1] This is particularly pertinent as dying in an acute hospital is common worldwide, with over half (54%) of deaths across 45 populations occurring in hospital.[2] Japan reported the highest number of deaths in hospital (78%) despite 60% of Japanese older adults stating they want to die at home.[2] Similarly, in

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Canada (60%), the United Kingdom (UK) (57%) and in the United States of America (USA) (45%), significant proportions of deaths occurred within hospitals.[2,3] In Australia, most people state they would prefer to die in their own home; however, each year more than half of the people who die do so in acute hospitals (54%).[4]

Patients, bereaved family and staff report variable perceptions of end-of-life care in hospitals, but engaging with them is important to inform end-of-life care.[5–8] Key to providing care in hospitals are strategic guidelines that support good clinical governance and adequately trained staff to deliver the care. Global and national guidelines have been developed to inform the delivery of end-of-life care in hospitals.[9] Other countries including the UK,[10] Ireland,[11] Canada,[12] Singapore[13] and New Zealand[14] have also reported the implementation of national strategies and the need for an adequately trained workforce for end-of-life care in acute settings.

In Australia, national and state-wide strategies have been developed to guide health services to respond to the needs of patients at the end of their life. The Australian Commission on Safety and Quality in Healthcare (ACSQHC) developed a National Consensus Statement, 'Essential elements for safe and high-quality end-of-life care' and also included end-of-life care as part of the comprehensive care standard in the National Safety and Quality Health Service (NSQHS) Standards.[1,15] These standards provide a nationally consistent statement of the quality of care expected from health service organisations, including hospitals.[15] In Western Australia (WA), the WA End of Life and Palliative Care Strategy (2018–28) provides strategic state-wide direction.[16] Key to these state and national requirements is the prerequisite that hospitals have processes to recognise and provide end-of-life care, including staff with the knowledge and skills to provide quality and safe care for support of patients at the end of their life.[16]

Achieving excellence in end-of-life care is recognised as challenging, though is a key part to achieving safety and quality. Examining the delivery of end-of-life care from the perspectives of staff, patients and families can inform clinical practice, resource allocation and planning decisions. This study reports on the perceptions of clinical staff on end-of-life care in a private acute hospital. It was part of a wider study that utilised a multifaceted methodology using a retrospective clinical file review to examine the end-of-life care that had been delivered; and bereaved family and clinical staff member perceptions of end-of-life care during the last 3 days of life.

Methods

Study design, setting and participants

A descriptive cross-sectional study using a survey was undertaken at a large (700+ beds) private acute hospital in Western Australia, averaging 300 deaths per year. The hospital has a policy for end-of-life care and provides a 24-h chaplaincy service, dedicated palliative care beds, palliative care team and dedicated volunteer support.

Clinical staff (medical consultants, junior doctors, registered nurses, enrolled nurses and allied health staff) were informed of the study via the Nurse Unit Managers and flyers posted on wards. Staff were invited to participate in an online or paper-based anonymous survey distributed to all wards. Completed paper-based surveys were returned to a secure collection box based on each ward, collected weekly by a research team member.

Data collection

The 'End-of-life care clinician survey tool', consisting of 36 six-point Likert scale (ranging from strongly agree to strongly disagree) questions developed by the ACSQHC, was utilised.[17] The tool asked questions addressing demographic details; experience in providing end-of-life care; expertise of clinical team; end-of-life care delivered; communication with team members, patients and families; communication about death and dying with team members, patients and families; education and training; experiences of end-of-life care; and quality of care provided.[17] Two open-ended questions were added to the survey to explore staff perceptions of areas for improvement and additional feedback.

Data analysis

Data were entered into Microsoft Excel (Microsoft Corporation) and checked by a second researcher. Descriptive statistics, frequencies and percentages, were used to analyse the quantitative data using Stata SE 15 (StataCorp, 2017).[18] Due to the small sample sizes of non-nursing profession participants, no further statistical analysis was conducted; however, descriptive statistics between nurses (registered and enrolled nursed), doctors (all levels) and allied health has been included in the tables to demonstrate potential differences between professions. Fisher's exact test was conducted to explore the association between survey questions. Inductive content analysis was used to identify categories for open-ended responses.[19]

Ethical approval

The study was approved by the Hollywood Private Hospital Research Ethics Committee (HPH518) and Edith Cowan University Human Research Ethics Committee (20179). Participants were provided with participant information forms and consent was implied by completion of the survey.

Results

One-hundred and thirty-three clinical staff responded to the survey, with the majority nurses ($n = 111$), plus allied health staff ($n = 13$), medical staff ($n = 8$) and one respondents did not specify their profession. The majority of participants (80.5%) had experienced caring for a dying patient at the hospital and almost half (48.9%) of the participants had over 10 years of clinical experience (Table 1).

One-hundred and seven participants with experience in delivering end-of-life care completed survey questions specific to their experience. Table 2 contains the response to questions relating to staff experiences in end-of-life care delivery, overall and by profession. From their experience at the hospital, most staff perceived that care was usually or always done well (77.9%); however, the majority of staff reported sometimes (65.0%), usually (8.0%) or always (8.0%) finding end-of-life care distressing (Table 2).

Table 1. Participant demographic characteristics
Note: one participant did not provide information on their profession

	Overall ($n=133$)	Doctor ($n=8$)	Nurse ($n=111$)	Allied Health ($n=13$)
Gender, *n* (%)				
Female	121 (91.0)	5 (62.5)	104 (93.7)	12 (92.3)
Male	10 (7.5)	3 (37.5)	6 (5.4)	1 (7.7)
Missing	2 (1.5)	0	1 (0.9)	0
Years of experience, *n* (%)				
≤5	46 (34.6)	2 (25.0)	42 (37.8)	2 (15.4)
6–10	21 (15.8)	0	19 (17.1)	2 (15.4)
>10	65 (48.9)	6 (75.0)	50 (45.1)	9 (69.2)
Unknown	1 (0.7)	0	0	0
Have you cared for a dying patient at this hospital? *n* (%)				
Yes	107 (80.5)	8 (100.0)	86 (77.5)	12 (92.3)

Table 2. Staff experiences in end-of-life care delivery
N/A, not applicable; –, N/A was not a response option

Survey question	Job role	Response *n* (%)					
		Always	Usually	Some-times	Rarely	Never	N/A
End-of-life care is done well on my ward	Overall ($n=104$)	26 (25.0)	55 (52.9)	17 (16.4)	5 (4.8)	1 (0.9)	
	Doctor ($n=8$)	1 (12.5)	7 (87.5)	0	0	0	–
	Nurse ($n=84$)	24 (28.6)	40 (47.6)	15 (17.8)	4 (4.8)	1 (1.2)	–
	Allied health ($n=12$)	1 (8.3)	8 (66.7)	2 (16.7)	1 (8.3)	0	–
Dying patients on my ward receive timely withdrawal of acute treatment	Overall ($n=102$)	11 (10.8)	50 (49.0)	31 (30.4)	9 (8.8)	1 (1.0)	–
	Doctor ($n=8$)	3 (37.5)	4 (50.0)	0	1 (12.5)	0	–
	Nurse ($n=83$)	7 (8.4)	38 (45.8)	29 (34.9)	8 (9.7)	1 (1.2)	–
	Allied health ($n=11$)	1 (9.1)	8 (72.7)	2 (18.2)	0	0	–
i. Causes me some distress	Overall ($n=100$)	8 (8.0)	8 (8.0)	65 (65.0)	17 (17.0)	2 (2.0)	–
	Doctor ($n=8$)	1 (12.5)	1 (12.5)	3 (37.5)	3 (37.5)	0	–
	Nurse ($n=80$)	5 (6.3)	7 (8.7)	56 (70.0)	10 (12.5)	2 (2.5)	–
	Allied health ($n=12$)	2 (16.7)	0	6 (50.0)	4 (33.3)	0	–
ii. Is professionally satisfying	Overall ($n=99$)	11 (11.1)	44 (44.4)	30 (30.3)	10 (10.1)	4 (4.1)	–
	Doctor ($n=8$)	2 (25.0)	4 (50.0)	2 (25.0)	0	0	–
	Nurse ($n=79$)	8 (10.1)	33 (41.8)	25 (31.6)	9 (11.4)	4 (5.1)	–
	Allied health ($n=12$)	1 (8.3)	7 (58.4)	3 (25.0)	1(8.3)	0	–
How often do you have to ask to clarify your patients' resuscitation decisions documented in the notes?	Overall ($n=100$)	20 (20.0)	16 (16.0)	32 (32.0)	18 (18.0)	4 (4.0)	10 (10.0)
	Doctor ($n=8$)	3 (37.5)	1 (12.5)	1 (12.5)	0	0	3 (37.5)
	Nurse ($n=80$)	17 (21.3)	14 (17.5)	31 (38.7)	15 (18.7)	2 (2.5)	1 (1.3)
	Allied health ($n=12$)	0	1 (8.3)	0	3 (25.0)	2 (16.7)	6 (50.0)
How often are the palliative care consultants consulted in the care of your dying patients?	Overall ($n=101$)	17 (16.8)	42 (41.6)	27 (26.7)	9 (8.9)	3 (3.0)	3 (3.0)
	Doctor ($n=8$)	0	4 (50.0)	2 (25.0)	1(12.5)	1 (12.5)	0
	Nurse ($n=81$)	16 (19.8)	29 (35.8)	23 (28.4)	8 (9.8)	2 (2.5)	3 (3.7)
	Allied health ($n=12$)	1 (8.3)	9 (75.0)	2 (16.7)	0	0	0

One-third of staff (36.0%) reported usually or always having to clarify documented resuscitation orders (Table 2). Resuscitation documentation orders were explored further, with participants stating the majority of resuscitation orders are documented by palliative care consultants (29.7%), followed by other consultants (24.75%), intensive care/medical emergency team members (10.9%), and the palliative care team (7.9%).

Table 3 refers to the responses of participants that relate to the recognition of a dying patient. The majority of staff (88.6% agreeing or strongly agreeing) felt confident in their ability to recognise when a patient is dying. This was not associated with years of experience since graduation (Fisher's exact, $P=0.319$). This question was explored further by asking about each specific profession, with the majority (71.2%) acknowledging that palliative care consultants on their ward were skilled at recognising when a patient is dying. Comparatively, 59.6% reported that non-palliative care consultants, 40.0% of junior doctors, 59.6% of enrolled nurses, 41.0% of allied health professionals, and notably 92.4% of senior registered nurses and other registered nurses (87.5%) were skilled at recognising when a patient was dying.

Timeliness of end-of-life care decision-making was also explored by the different professions, with the majority strongly agreeing/agreeing that timely decision-making was undertaken

Table 3. Recognition of a dying patient
N/A, not applicable

Survey response	Job role	Response n (%)					
		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	N/A
I am confident in my ability to recognise when a patient is dying	Overall ($n = 105$)	50 (47.6)	43 (41.0)	11 (10.5)	1 (0.9)	0	0
	Doctor ($n = 8$)	5 (62.5)	3 (37.5)	0	0	0	0
	Nurse ($n = 85$)	44 (51.8)	34 (40.0)	7 (8.2)	0	0	0
	Allied health ($n = 12$)	1 (8.3)	6 (50.0)	4 (33.4)	1 (8.3)	0	0
I would like to call the palliative care consultants earlier when patients are dying	Overall ($n = 101$)	33 (32.7)	34 (33.7)	21 (20.7)	5 (5.0)	2 (2.0)	6 (5.9)
	Doctor ($n = 8$)	1 (12.5)	2 (25.0)	2 (25.0)	3 (37.5)	0	0
	Nurse ($n = 81$)	26 (32.1)	29 (35.8)	17 (21.0)	2 (2.5)	1 (1.2)	6 (7.4)
	Allied health ($n = 12$)	6 (50.0)	3(25.0)	2 (16.7)	0	1 (8.3)	0

Table 4. Communication with staff, patients and families
N/A, not applicable

Survey question	Job role	Response n (%)					
		Yes	No	Unsure			
It is part of my role to talk to doctors about the care of patients who I think might be dying	Overall ($n = 103$)	90 (87.4)	4 (3.9)	9 (8.7)			
	Doctor ($n = 8$)	8 (100.0)	0	0			
	Nurse ($n = 83$)	73 (88.0)	4 (4.8)	6 (7.2)			
	Allied health ($n = 12$)	9 (75.0)	0	3 (25.0)			
It is part of my role to talk to patients and their families about death and dying	Overall ($n = 101$)	73 (72.3)	17 (16.8)	11 (10.9)			
	Doctor ($n = 8$)	8 (100.0)	0	0			
	Nurse ($n = 81$)	62 (76.5)	9 (11.1)	10 (12.4)			
	Allied health ($n = 12$)	3 (25.0)	8 (66.7)	1 (8.3)			
		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	N/A
I am confident in my ability to talk to patients and their families about death and dying	Overall ($n = 102$)	21 (20.6)	47 (46.1)	18 (17.6)	14 (13.7)	0	2 (2.0)
	Doctor ($n = 8$)	5 (62.5)	3 (37.5)	0	0	0	0
	Nurse ($n = 82$)	16 (19.5)	40 (48.8)	17 (20.7)	8 (9.8)	0	1 (1.2)
	Allied health ($n = 12$)	0	4 (33.3)	1 (8.4)	6 (50.0)	0	1 (8.3)

by palliative care consultants (68.3%), non-palliative care consultants (37.2%) and junior doctors (27.2%).

Responses to the survey on communication with staff, patients and families are outlined in Table 4. Nearly all participants (87.4%) felt it was part of their role to talk to the doctors about the care of patients who they think might be dying. Almost three-quarters of the cohort (72.3%) agreed it was part of their role to talk to patients and their family about death and dying, with two-thirds (66.7%) reporting they felt confident talking to patients and families about death and dying (Table 4). There was no association with personal experience of being involved in the care of the dying (that causes some distress) and confidence in recognition of a dying patient (Fisher's exact, $P = 0.130$) or confidence in the ability to talk to patients and their family about death (Fisher's exact, $P = 0.052$). Staff agreed or strongly agreed that other disciplines on their ward were skilled at talking about death and dying with patients and their families including: palliative care consultants (74.3%), non-palliative care consultants (50.5%), junior doctors (27.5%), senior registered nurses (83.3%), other registered nurses (62.7%), enrolled nurses (40.2%) and allied health professionals (25.5%). There was no association with years of clinical experience and confidence to talk to patients and their families about death (Fisher's exact, $P = 0.948$).

Staff training specific to end-of-life care is highlighted in Table 5. Overall, 32% of participants stated they had completed no training. Staff who had training on how to recognise when patients are dying were associated with more confidence in their ability to recognise when a patient is dying (Fisher's exact, $P = 0.001$), whereas there was no association with staff who self-reported they had training on how to care for dying patients and distress when caring for dying patients.

Content analysis of the 67 open-ended responses identified six categories: need for more education ($n = 7$); need for more timely end-of-life care ($n = 13$); need for improved documentation ($n = 6$); need for staff with end-of-life caring skills ($n = 6$); need for more involvement of the palliative care team ($n = 26$); and other comments ($n = 9$). Table 6 provides exemplars highlighting each category.

Discussion

Examining the perceptions of clinical staff on end-of-life care delivery identified that from their experiences, end-of-life care

Table 5. Staff access to end-of-life care training

I have received formal education/training on:	Overall ($n = 102$)	Doctor ($n = 8$)	Nurse ($n = 82$)	Allied Health ($n = 12$)
How to recognise when patients are dying	50 (49.0)	5 (62.5)	43 (52.4)	2 (16.7)
How to care for dying patients	62 (60.8)	6 (75.0)	51 (62.2)	5 (41.7)
How to communicate with patients and families regarding end-of-life care	48 (47.1)	8 (100.0)	36 (43.9)	4 (33.3)
How to communicate with patients who are dying	42 (41.2)	7 (87.5)	30 (36.6)	5 (41.7)
No training completed	32 (31.4)	2 (25.0)	25 (30.5)	5 (41.7)

Table 6. Participant exemplars from open-ended questions
EoLC, end-of-life care

Category	Participant job role	Exemplar
Need for more education	Physician	… *We usually move patients to a medical ward if they are dying. The only problem is that if they do need to die on our ward due to bed block, the nurses are not 'deemed competent' to run a subcut[aneous] infusion.*
	Registered Nurse	*Palliative care consultants should take over more care of patients who are dying rather than other consultants, as I believe this would reduce the incidences of discomfort suffered by some patients, and stress experienced by staff needing to follow treatment ideas they don't believe are helpful/comforting for the patient.*
	Enrolled Nurse	*Staff being educated more and feel more comfortable about death and dying and the ability to talk to patient's and family. Also looking for signs and symptoms of* [a] *dying patient.*
Need for more timely end-of-life care	Allied Health professional	*Earlier recognition of the end-stage patient and more focus on symptom relief/control. Having the discussions with patients about their terminal conditions and wishes/ resuscitation status early in admission.*
	Registered Nurse	*EoLC commenced more promptly and with a team approach.*
	Registered Nurse	*If doctors could make decisions earlier regarding care of patients and listen to nursing staff's concerns re*[garding] *treatment.*
	Enrolled Nurse	*Better clarification of resus*[citation] *statuses, earlier intervention by non-palliative consultants for dying patients.*
Need for improved documentation	Allied Health professional	*Clear documentation of expected timeline of life from diagnosis.*
	Registered Nurse	*Discuss resus*[citation] *status earlier for patients' pre-procedure.*
Need for staff with EoLC skills	Registered Nurse	*Having more staff equipped to deal with these situations.*
Need for more involvement of the Palliative Care team	Registered Nurse	*Needs to be recognised earlier to refer to palliative team.*
	Registered Nurse	*Transfer of care to palliative team. Consultants like to keep patients under their care.*
	Registered Nurse	*Although the palliative care team is usually involved, they are sometimes referred to a lot later than I would expect in some cases.*
Other comments	Registered Nurse	*Counselling of all staff post the death of a patient should be done after each bereavement and it is not done. It's a disgrace especially if death has been unexpected or traumatic.*
	Enrolled Nurse	*We have had very few to no deaths on my ward, we usually transfer them to a more appropriate palliative care ward.*

is overall performed well. The results identified a clear need for staff training in end-of-life care and understanding of strategies to reduce stress when caring for dying patients, and improving communication with team members and families. These findings were further identified in the content analysis that highlighted the need for better and more timely written and verbal communication; and need for staff with skills to provide end-of-life care.

The Australian pilot study of the Clinician Survey commissioned by the ACSQHC, found similar results that not all end-of-life care was meeting the required standard and there were concerns from clinical staff about their confidence in delivery of care.[20] Similarly, a national study of end-of-life care in hospitals across the UK found considerable differences in care relating to documentation of clinical decision-making, staff education and communication to patients and families, resulting in recommendations to improve the quality of end-of-life care.[21] Other studies have also reported nurses' experiences of end-of-life care in acute hospital settings and found a lack of knowledge; access to training; communication barriers across the multidisciplinary team and with patients and families; and insufficient organisational support, including adequate staffing levels, all impacted on the delivery of quality end-of-life care.[7,22,23] Nurses working in intensive care areas also reported the challenges with providing end-of-life care.[23] Another study of nurses' experiences of delivering end-of-life care in medical units described their experience as 'battling a tangled web', referring to the complexities of care delivery and the challenge of supporting dying patients and their families in environments not always set up for it.[24] In a qualitative study of health

professionals in the UK, delay in diagnosing dying was seen as a barrier to good end-of-life care.[25] These studies show that exploring staff experiences can assist in examining end-of-life care delivery.

This study identified the distress that providing end-of-life care can cause to staff, and other studies have also found that end-of-life care causes distress, highlighting the importance of adequate access to emotional and spiritual support, including individual and group peer debriefs.[26] Educating staff on the importance of self-care can assist in providing support for themselves and indirectly enhance professional relationships with patients and families. Where workplaces encourage and support self-care practice, it has been found to assist with staff stress.[27]

Timely and effective communication is part of safe and quality end-of-life care. This study demonstrated that skill level varied across professions regarding talking about death and dying with patients and their families, with allied health staff perceived to be the least skilled. Low levels of confidence by allied health professionals in Australia have been reported elsewhere.[20] These are valuable findings, as even though doctors often lead end-of-life care communication, a multidisciplinary approach is important to quality end-of-life care and communication is key.[28] In other studies, staff have also identified the need to improve communication within the multidisciplinary team, and family perceptions of end-of-life care.[29,30] This perceived gap in communication also relates to the necessity for staff training in end-of-life care, with the World Health Organization and national guidelines emphasising the importance of training as part of delivering quality end-of-life care.[1,9]

Perceptions and confidence in end-of-life care can inform staff educational needs; however, staff knowledge and skills in end-of-life care cannot be overlooked. This study found that staff felt confident in some aspects of care delivery, but as over one-third had no formal training in end-of-life care, this may have contributed to the findings and staff recognition of the need for training and skilled staff. Knowledge, attitudes and confidence have been reported as important factors to address in educational programs[31] and can contribute to improving end-of-life care for patients and families in hospitals.[32] In this study, staff reported varied training related to the different components of end-of-life care and identified the 'need for more education' and 'need for staff with end-of-life care skills'. Low rates of education in end-of-life care have also been reported in several other studies.[20,33,34] This highlights the need for healthcare organisations to evaluate training needs of all clinical staff, implement training programs and evaluate competence.[31,35] Other research has emphasised the importance of training for staff that focuses on communication with family and the dying patient.[22,24,36,37] Additionally, end-of-life care content needs to be included in entry to practice health professional curriculums.[33,34,38] A key part of educating staff is promoting free online resources such as End-of-Life Essentials – Education for Acute Hospitals, which can assist with student and staff training.[39]

Limitations

First, as the study was conducted in a private hospital, the findings of the study may not be generalisable to other hospitals where the cohort of patients requiring end-of-life care may be distinctively different. Second, the low response rates from doctors and allied health practitioners affects the ability to draw conclusions on the difference between professions in end-of-life care perceptions. Further studies in a private hospital with strategies to recruit a larger sample size should be conducted to validate the differences in professions.

Conclusion

Given the number of patient deaths that will occur in acute hospitals, this study highlights the importance of clinical staff in all areas having skills and confidence in providing care to dying patients and their families. The staff perceptions of end-of-life care, including the recognised value of early recognition of impending patient death, and particularly the need for education in this study mirror the findings of other studies. The findings will contribute to healthcare providers' understanding of end-of-life care and the importance of supporting staff adequately to assist with optimal collaboration between staff, families and patients in care delivery. It is crucial that healthcare providers implement strategies to overcome gaps in staff education and support, to ensure all patients and families receive quality end-of-life care. The importance of having staff who feel equipped, knowledgeable and supported in end-of-life care delivery cannot be underestimated.

Competing interests

The authors declare no competing interests.

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