

# END OF LIFE CARE: A SERVICE EVALUATION IN A HOSPICE IN-PATIENT UNIT

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## Background

The Scottish Government published new guidance in 2014 to support clinical and care staff planning and providing care at the end of life. "Caring for people in the last days and hours of life". The four principles are:

- Informative, timely and sensitive communication should be an essential component of care, both to the person receiving the care, and their relatives or carers
- Significant decisions about a person's care, including diagnosing when someone is approaching their last days or hours, should be based on a multi-disciplinary discussion
- Each person's physical, psychological, social and spiritual needs should be recognised and addressed as far as possible
- Full consideration must be given to the wellbeing of relatives or carers

## Methodology

A retrospective case note analysis of 30 consecutive patients who died in a 24-bedded in-patient unit over an 8-week period was undertaken. Selected evidence of documentation of care in keeping with each principle was sought.

## Data Collection Methods

The data collection tool was piloted by the two medical staff to ensure inter-observer consistency. Adjustments were made to the data collection tool to reduce inconsistencies.

## Demographics

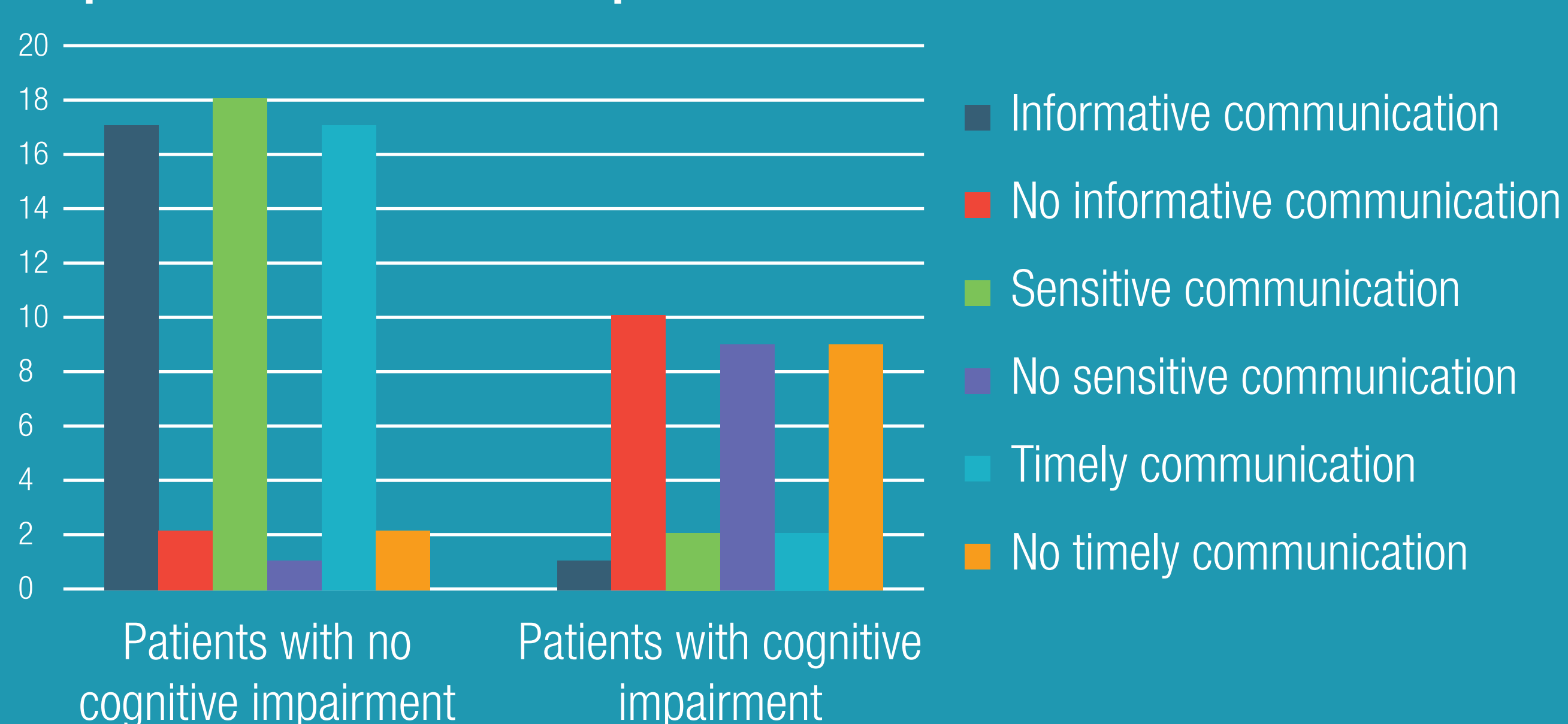
- Median age 72 (range 39 to 98).
- 40% (12 patients) male.
- 93% had cancer; 7% neurological condition.
- 40% admitted for likely end-of-life care.
- Median number of full days in Hospice 12 (range 0 to 102).

## Communication with patients

- 60% (18 patients) had documentation of informative communication with staff about the fact that they were dying.
- 66% (20 patients) had documentation of sensitive communication with staff (eg exploring fears, concerns, goals, wishes, etc.)
- 63% (19 patients) had timely communications with the staff.

However 11 patients (37%) had cognitive impairment that may have impacted on their ability to have discussions with staff - Graph 1

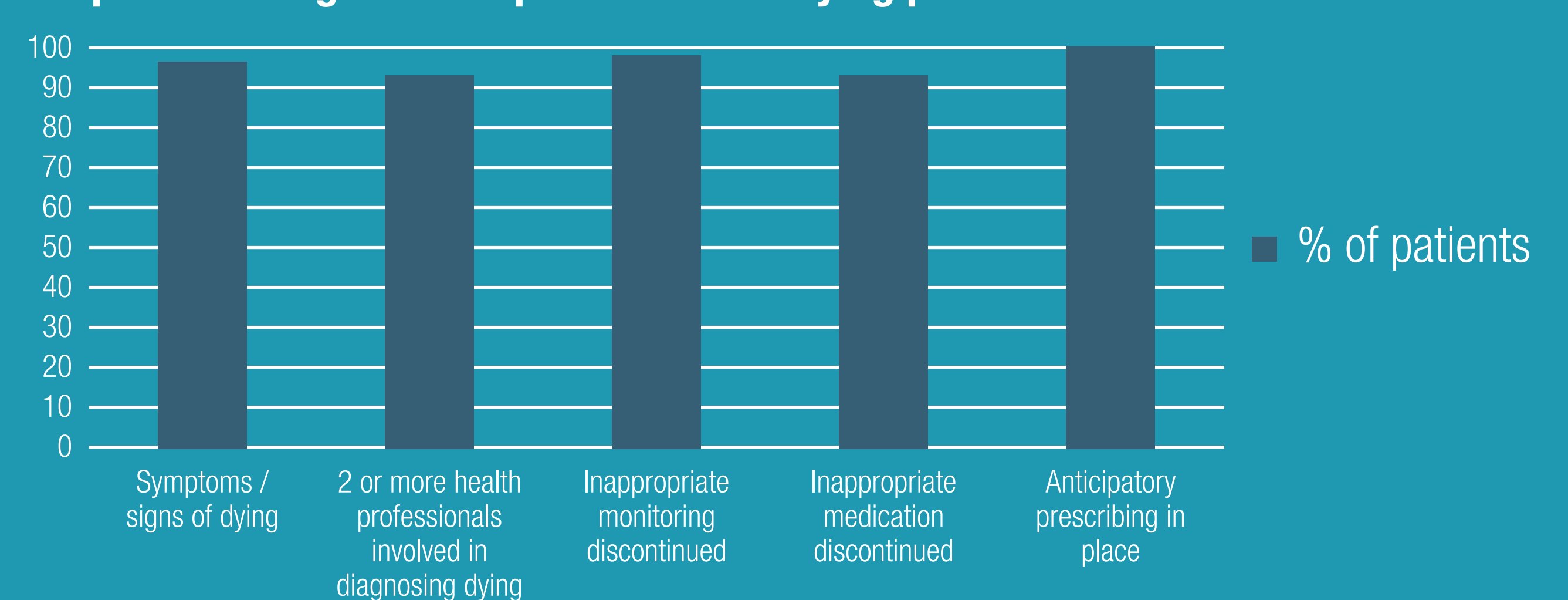
Graph 1 - Communication with patients



## Management of Patients in the dying phase

Recognition of dying by the multidisciplinary team, and decisions regarding prescribing and monitoring in the terminal phase are shown in Graph 2.

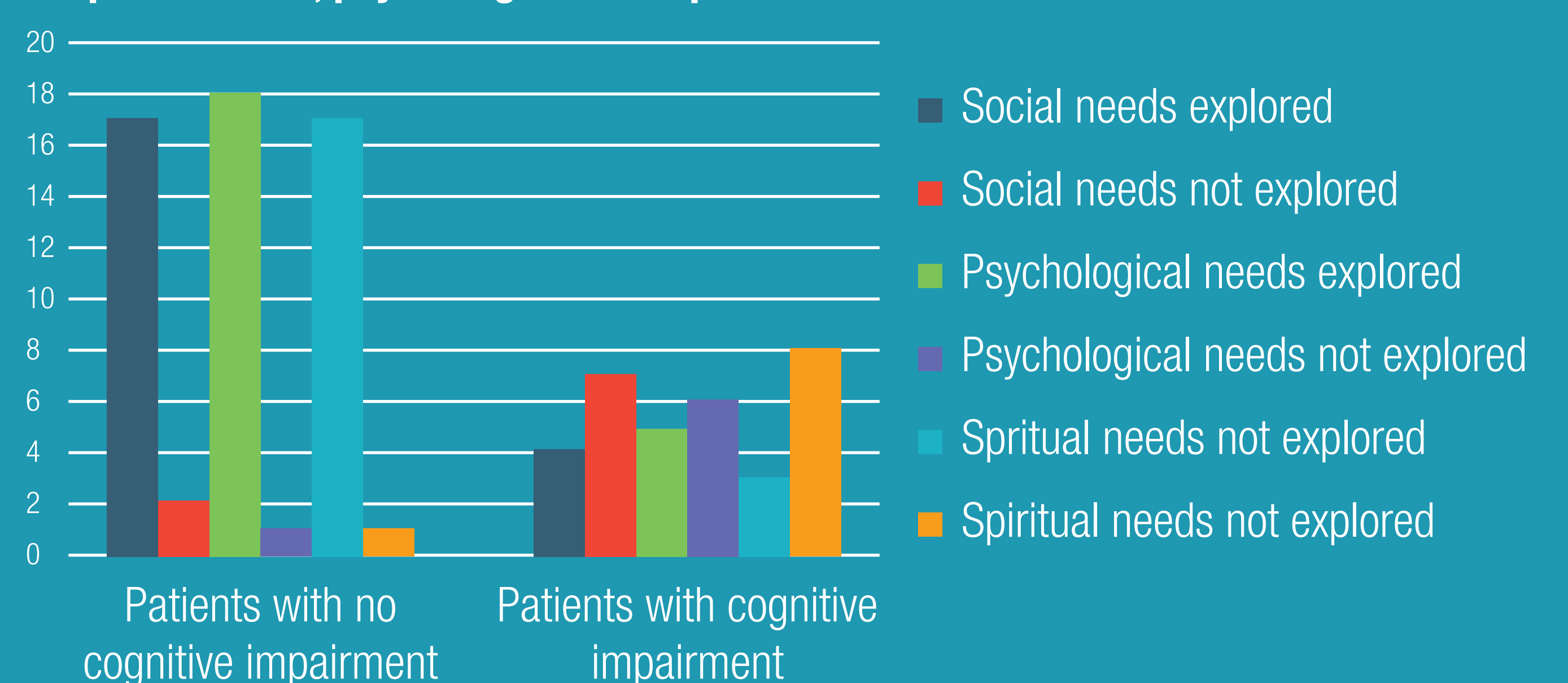
Graph 2 - Management of patients in the dying phase



## Social, psychological and spiritual needs

- Social needs:** Social needs were explored in 70% (21 patients) and all those patients with needs identified had those needs addressed.
- Psychological needs:** Psychological needs were explored in 77% (23 patients). All but one of those patients with needs identified had those needs addressed.
- Spiritual needs:** Spiritual needs were explored in 66% (20 patients) and all but one of those patients with needs identified had those needs addressed.
- However, those with cognitive impairment were less likely to have these needs explored – Graph 3

Graph 3 - Social, psychological and spiritual needs



## Communication with relatives/carers

- Informative and timely communication with relatives/carers, and evidence that advice was given regarding bereavement support was documented in 100% of cases.
- Evidence that practical advice was given before or after death was documented in 97% of cases (29 patients).

## DNACPR

- A DNACPR form was in place in 100% of cases
- Documentation of a discussion with the patient at any time about a DNACPR decision occurred in 80% (24) of patients and 96% of all patients without cognitive impairment. One patient did not have any cognitive issues that would preclude such discussions.
- Documentation of discussion with the relative or carer regarding a DNACPR decision occurred in 83% cases. This included the 5 patients who did not have capacity to discuss a new DNACPR decision during their hospice admission.

## Discussion

The documentation gave no measure of the quality of discussions that took place other than evidence of the topics that were discussed. Discussions with patients about dying and addressing their social, psychological and spiritual needs were less likely to occur for patients with cognitive impairment. However, even if a person is unable to communicate their concerns and needs because of cognitive impairment, they might be identified by other means. A further study is planned to ascertain from clinical staff factors that prevent or facilitate exploration and documentation of the holistic needs of those with cognitive impairment.