Management of Palliative Care in Acute Hospitals: Findings from a qualitative study with medical and nursing staff in the UK

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Background

• In the UK 90% of patients spend time in hospital in the final year of life, and 56% of patients die in hospital.

• The proportion of patients dying in acute hospitals is set to increase.

• National Audit Office Report (2008) identified ‘the standard of hospital care was below what had been expected’ for dying patients.

• End of Life Care Strategy (2008) - aims to promote high quality care across the UK for all adults approaching the end of life.
Background

• Study exploring the management and organisation of palliative care in acute hospitals.

• Part of a wider study investigating transitions to palliative care in acute hospitals.

• Study aims:
  
  – Explore the nature and extent of palliative care need and provision in acute hospitals.
  
  – Explore how generalist palliative care is currently managed and organised in acute hospitals.
  
  – Explore barriers and facilitators to optimum palliative care in acute hospital settings.
Methods

- 58 health professionals involved in the care of patients reaching the end of life participated in eight focus groups and five interviews.
- Recruited from primary (n=28) and secondary care (n=30) in Sheffield and Lancaster.
- Focus group/interview guide aimed to explore perspectives on current management and organisation of palliative care in UK hospitals.
- Audiotapes transcribed and analysed using thematic analysis.
Descriptive information for participants

<table>
<thead>
<tr>
<th>Male</th>
<th>12 (20.7%)</th>
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<tbody>
<tr>
<td>Mean age</td>
<td>46.3yrs (SD = 9.92)</td>
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<td>Age range</td>
<td>28 – 69yrs</td>
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<tr>
<td>Job title</td>
<td>Consultant 4 (6.9%)</td>
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<td></td>
<td>Junior doctor 9 (15.5%)</td>
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<td></td>
<td>GP 6 (10.3%)</td>
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<td></td>
<td>Practice nurse 4 (6.9%)</td>
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<td></td>
<td>Clinical Nurse Specialist 11 (19.0%)</td>
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<td></td>
<td>Other nurse 19 (32.7%)</td>
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<td></td>
<td>Allied health professional 5 (8.6%)</td>
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<tr>
<td>Place of work</td>
<td>GP practice 28 (48.3%)</td>
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<td></td>
<td>Hospice 15 (25.9%)</td>
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<td></td>
<td>Specialist palliative care unit 5 (8.6%)</td>
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<td></td>
<td>Acute hospital 10 (17.2%)</td>
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N=58
Results

• Participants reported different understandings of the terms ‘palliative care’ and ‘end of life care’.

• Definitions of palliative care: symptom management, quality of life, and comfort focussed care for patients with life-limiting illness.

• End of life care was seen as the care of patients in the last few days or hours of life.

“Palliative care is when somebody has reached the end of active treatment and any measures within that care are not with the intention to cure but to keep as comfortable as possible until they die. End of life I regard as being further on, right when people have started to die.”
Results

• Most participants agreed that many inpatients in acute hospitals have palliative care needs.

• Understandings amongst health professionals differed regarding what constitutes specialist and generalist palliative care provision.

“but for me palliative care is not only the business of specialist teams ....everyone should be able to deliver the basic, generic palliative care”
Results

• Differing understandings of whose responsibility it is to provide palliative care in acute hospitals.

  “Talking to people respectfully, talking to their families and keeping them updated, tending to the basics of symptom management is everybody’s responsibility. Quite often we get asked to see people and it’s really very straightforward stuff that should have been dealt with. So I think it’s that kind of barrier, it’s not really our business, we refer to a team to do that…” [Palliative care nurse]

• Difficulties encountered with the ‘overspecialisation’ of palliative care.

  “I think we have to be careful that when we create a speciality, as in specialist palliative care, that in some ways we’re not partly responsible for taking away peoples involvement in generalist palliative care.” [Palliative Med Consultant]
Results

• Generalists can be reluctant to provide palliation as don’t perceive themselves as having appropriate expertise.

  “I’ve just had a phone call from a GP asking me about pain control in a man who is end of life and it was fairly simple, fairly routine, and I thought I’m sure he could do this if this patient wasn’t labelled palliative care, dying.” [hospice nurse]

• Generalists can lack confidence in adopting a palliative care approach.

  “I think also to be a generalist, and to do nothing takes a lot of guts actually. A frail elderly person at home has got a chest infection, do you send them in or let them die naturally at home? I think it takes quite a lot of guts to say no we’ll just keep him here for fear of litigation and what have you.” [GP]
Results

• Some recognition of the increasing relevance of generalist palliative care within the role of acute hospital staff.

  “Surely we have some specialism in dying, in older people dying, we have a bit of experience of that? Again where do you fit that into your programme...to do it justice and do it properly “ [Care of the Elderly Registrar]

• Good relationships between specialist and generalist palliative care providers crucial for provision of optimum care.

  P1:  I think here the palliative care nurses on this site, are actually very accessible.
  P2:  And you know they will nearly always come the same day or the next day.
  P1:  At least we you know who to speak to, if you go to the district generals we don’t even know who is palliative care [Junior doctors]
Results

Various barriers & facilitators were identified to providing optimum palliative care in acute hospitals.

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<thead>
<tr>
<th>Barriers</th>
<th>Facilitators</th>
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<tr>
<td>Lack of resources e.g. equipment, staff</td>
<td>Timely access to SPC</td>
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<td>Attitude of staff</td>
<td>Good relationships between SPC and generalist providers</td>
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<tr>
<td>Focus on interventionist/curative care</td>
<td>Good continuity of care &amp; relationships with HCPs</td>
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<td>Inadequate staff training</td>
<td>Good communication between HCP’s</td>
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<td>Non-cancer diagnoses</td>
<td>Standardised pathways e.g. LCP</td>
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<td>Older patient age</td>
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Conclusions

• Inpatient palliative care needs in UK acute hospitals are high.
• Understandings of what constitutes specialist and generalist palliative care are not uniform.
• ‘Overspecialism’ of palliative care can be detrimental.
• Further barriers included lack of resources, focus on acute care, staff attitude, diagnosis, and age.
• Facilitators recognised and included: use of pathways, good communication, MDT approach, education.