# Nurses' opinions of EOLC at Austin Health

**Juli Moran, Shaun O'Neill, Lorraine Jordan, Daryl Jones**

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# Background

- An increasing proportion of people are dying in acute hospitals rather than at home
- Anecdotally this is often not done well
  - Goals of care are poorly documented
  - Patients are receiving active treatment despite the fact that they are dying
  - Doctors not recognising that patients are dying
  - patient symptoms not being well managed
  - Families aren't well informed of patient's condition
  - Limitations of medical treatment are not being implemented
- How much of this happens in our hospital?

# Aim & Methods

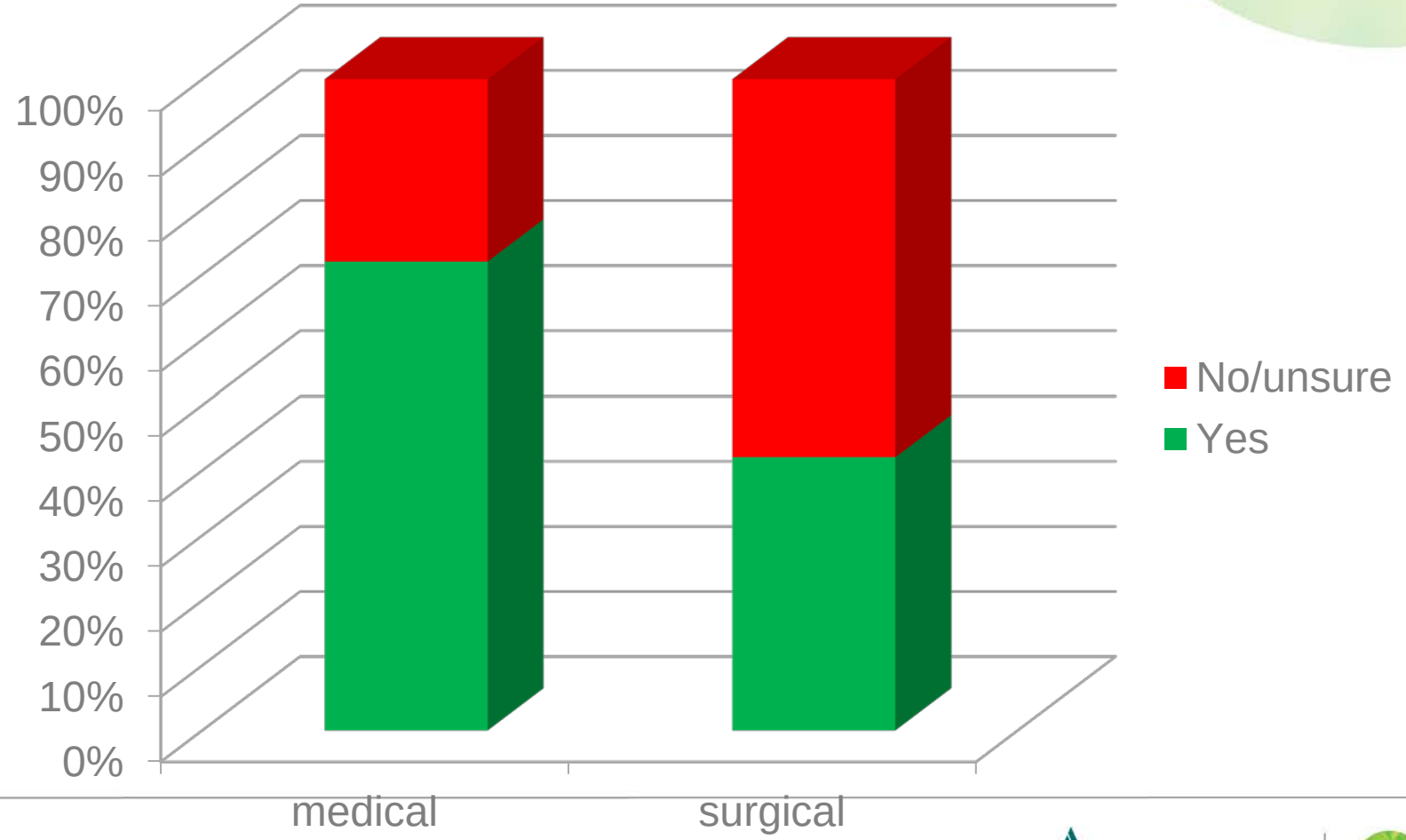
- To assess ward nurses' attitudes about the quality of end of life care in Austin hospital.
- Surveys taken to handover on specific wards of hospital
  - 12 questions about planning for end of life care and rated on 5-point scale
  - 4 free-text questions
- 210 forms returned (80% response rate)

# Results

- Ward of nurses:
  - Medical 113 (52%)
  - Surgical 84 (38.5%)
  - Mixed 21 (9.6%)
- Medical
  - General, renal, respiratory, cardiology, neurology, spinal, haematology, oncology
- Surgical
  - General, Git, orthopaedic, thoracic, cardiac, plastics

# End of life care is done well in our ward*

*difference stat significant

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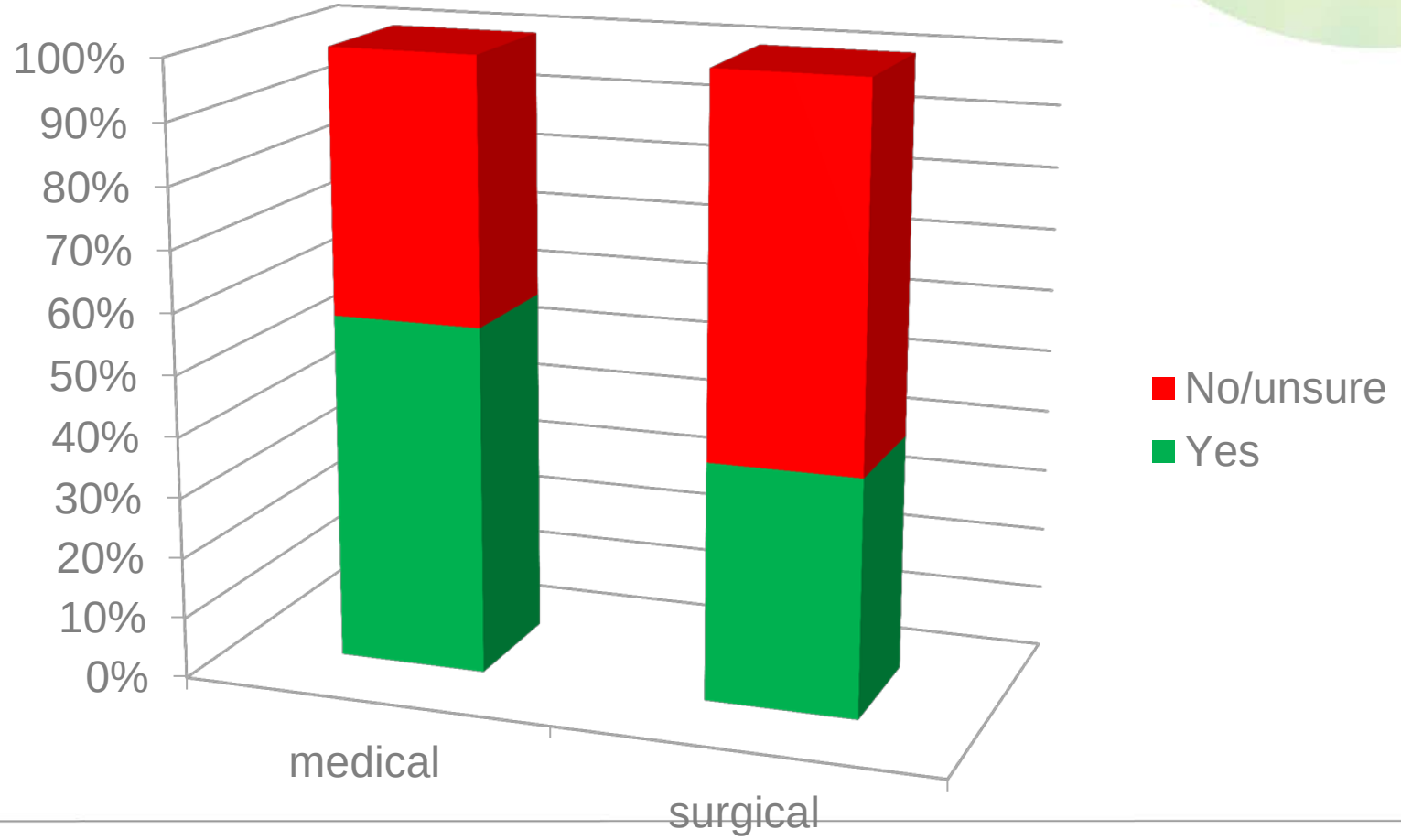
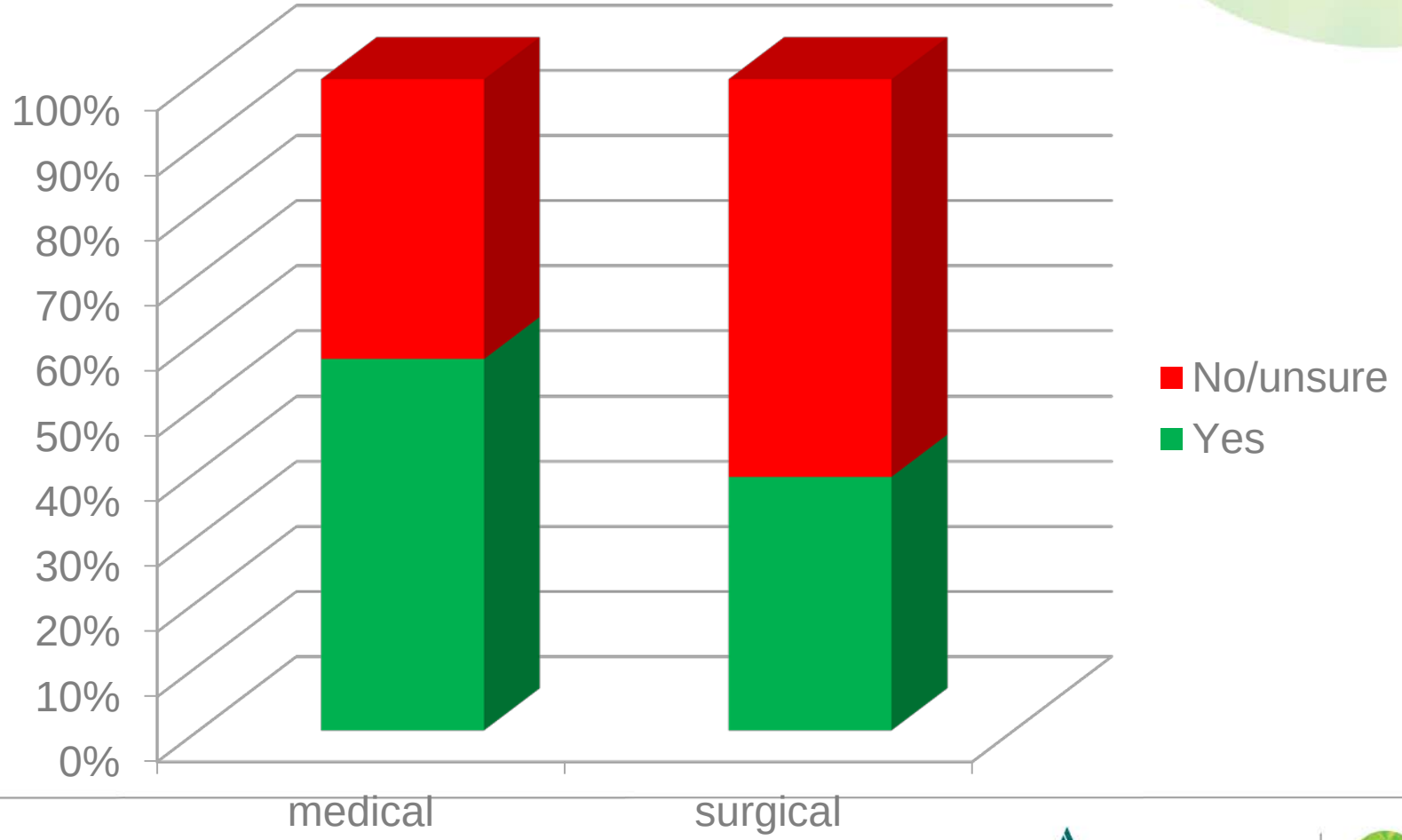
# Our doctors are good at identifying when a patient is dying *



# The resuscitation form is regularly filled out*

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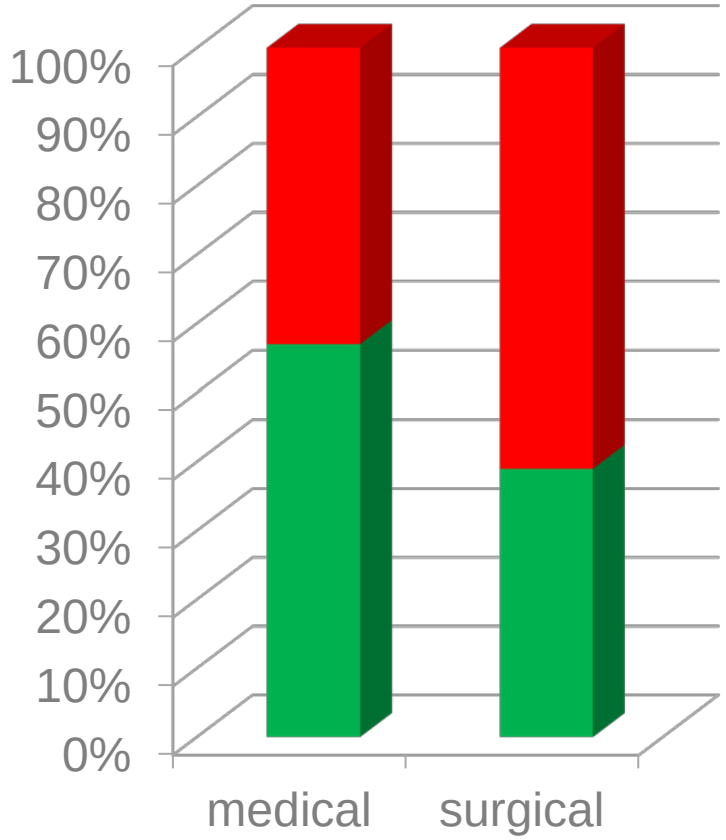
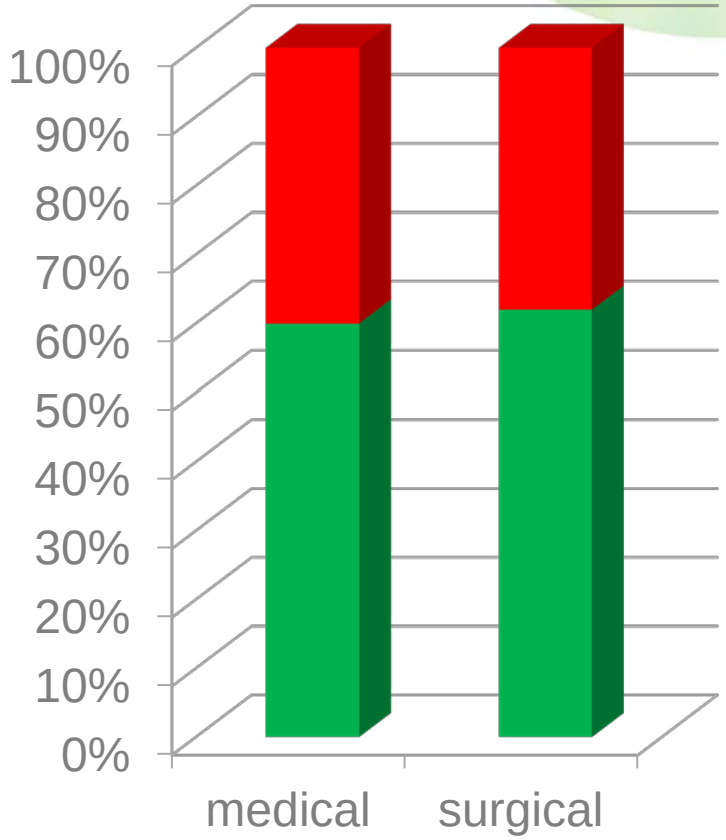
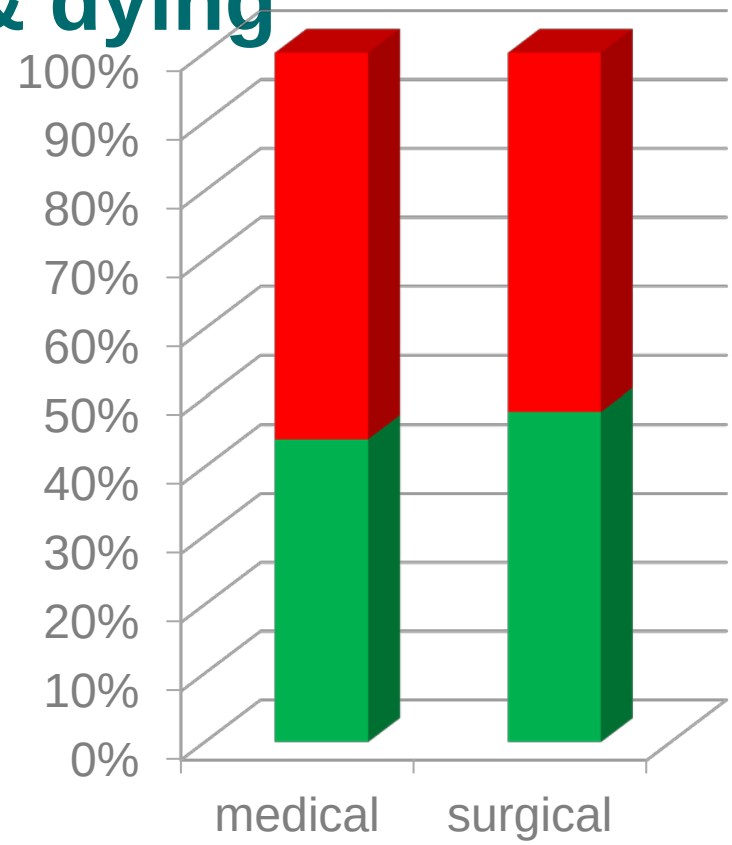
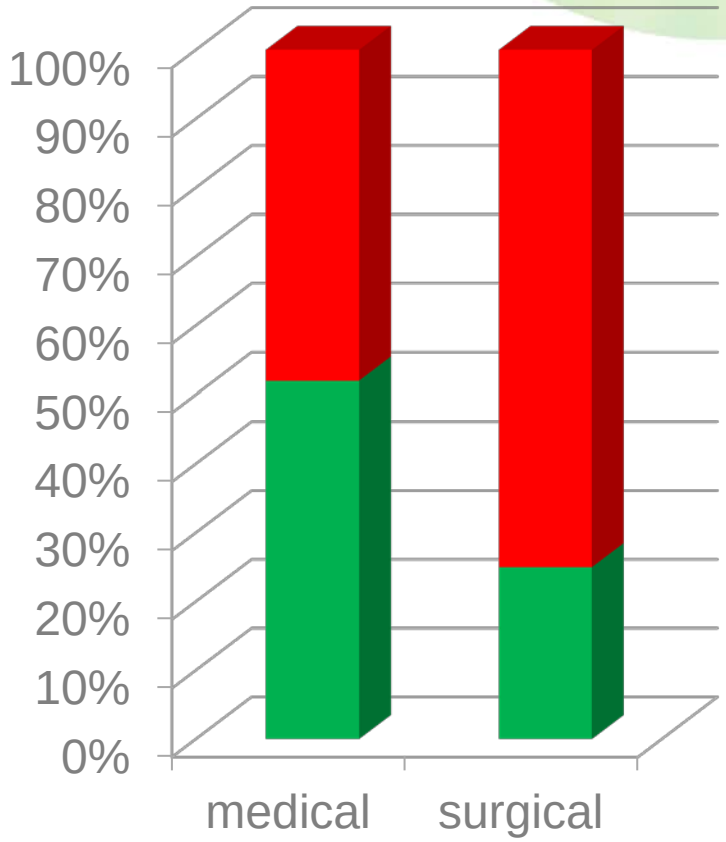
# The resuscitation plan is (1*) filled out regularly and (2) clear



# Doctors on our ward are good at talking with (1) families & (2*) patients about death & dying

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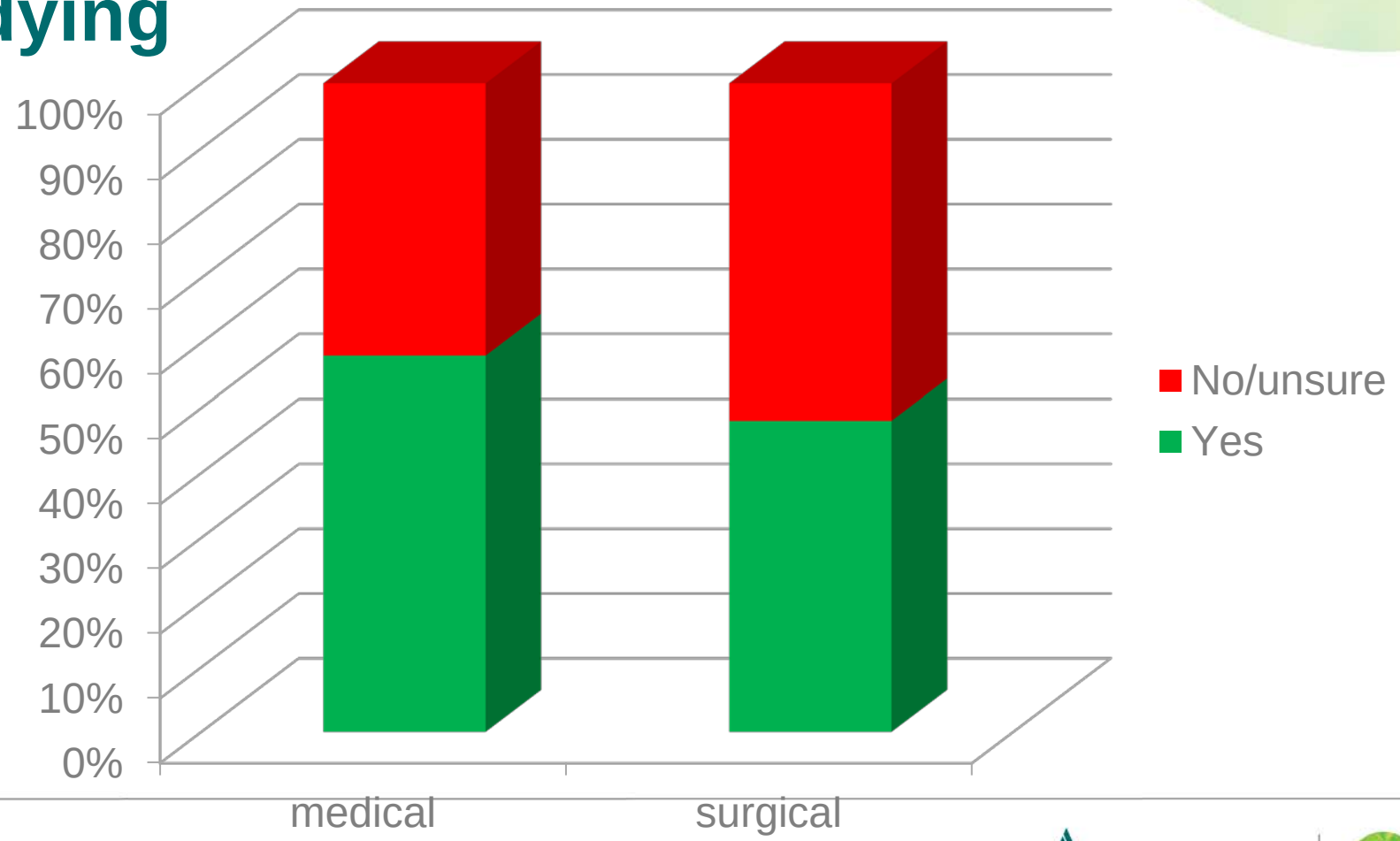
# Doctors on our ward continue aggressive treatment for too long in patients who are dying

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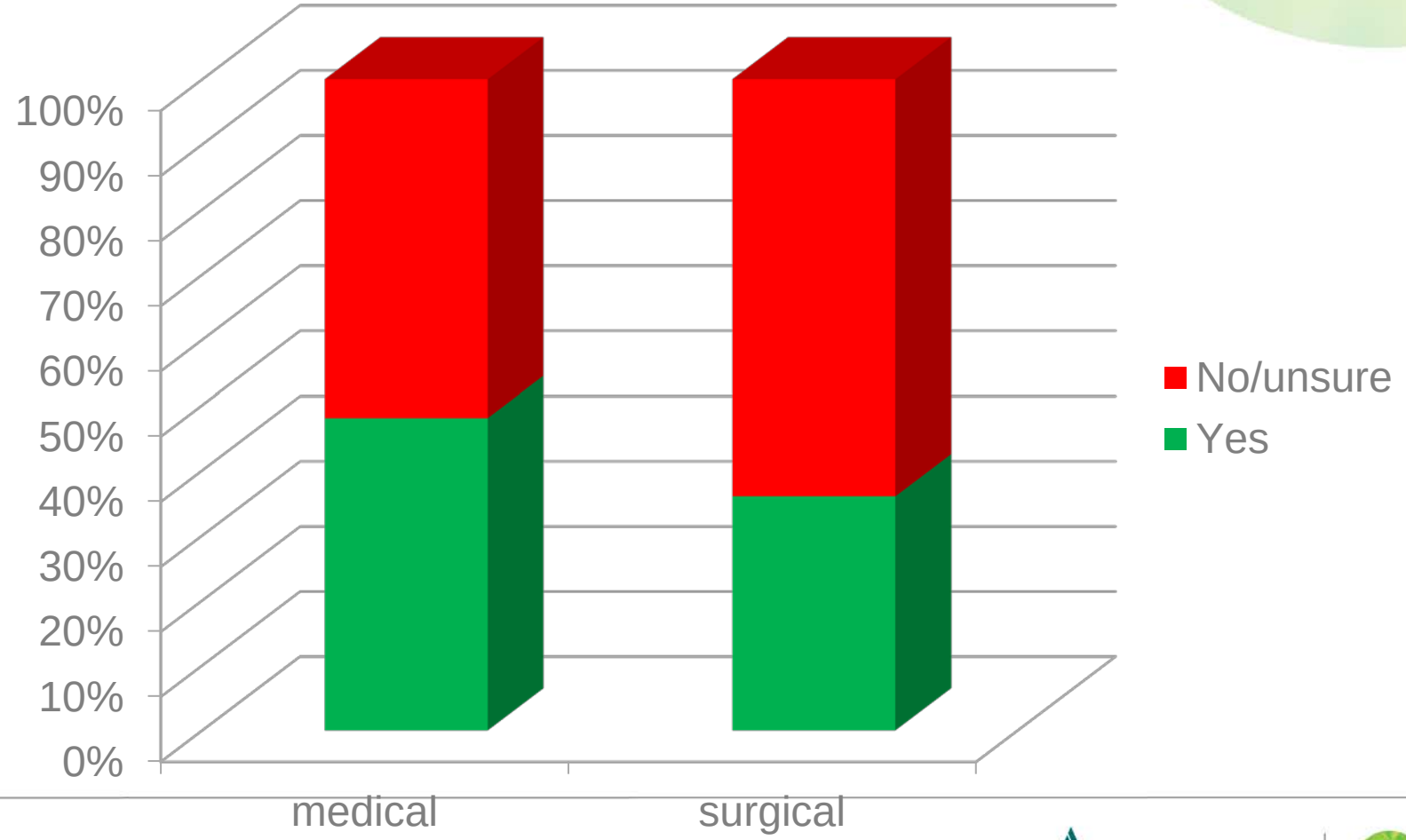
# Doctors on our ward are good are making decisions about NFR orders

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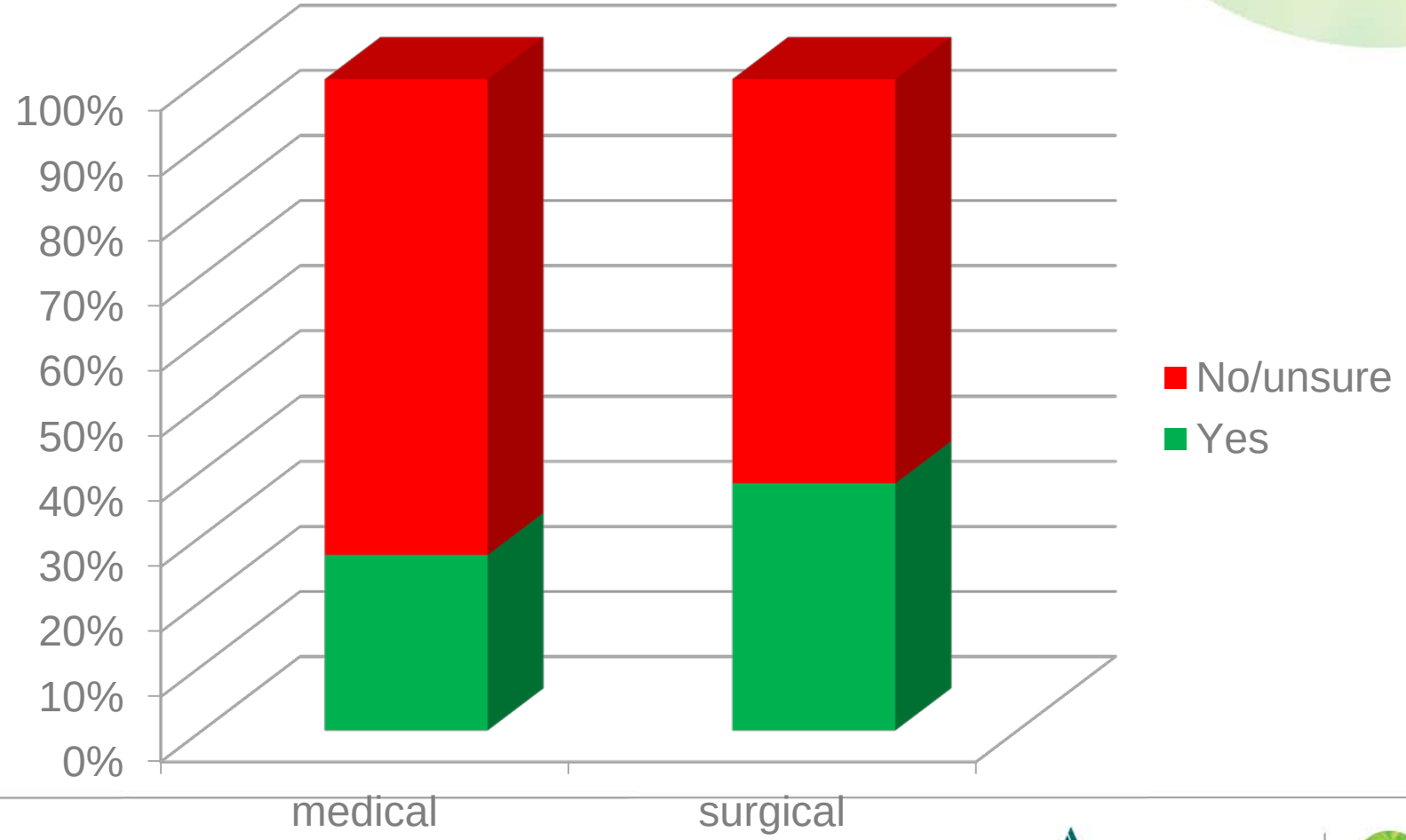
# The Medical Emergency Team is overused in making end of life decisions on our ward

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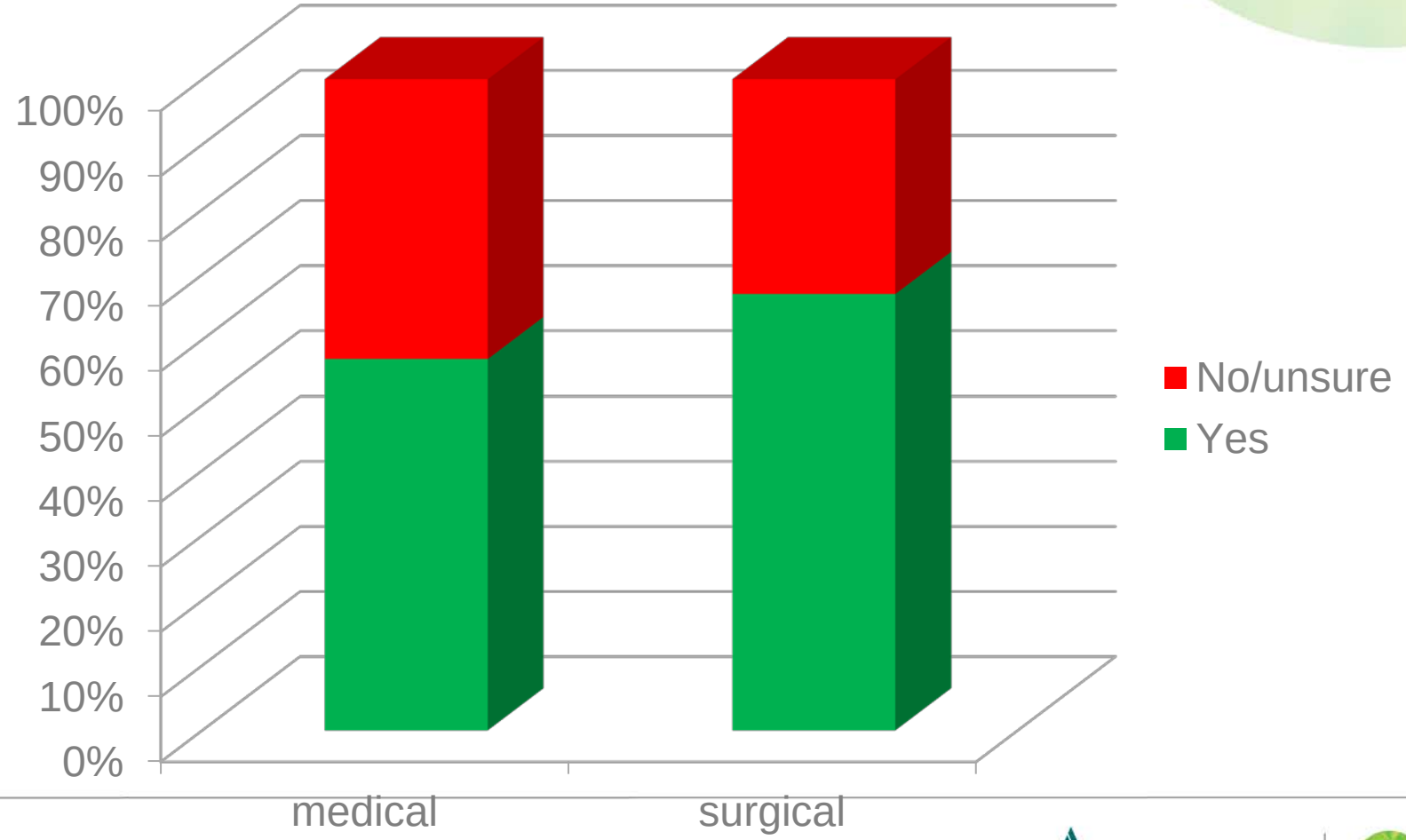
# I would like to call the palliative care nurse more often than I do now

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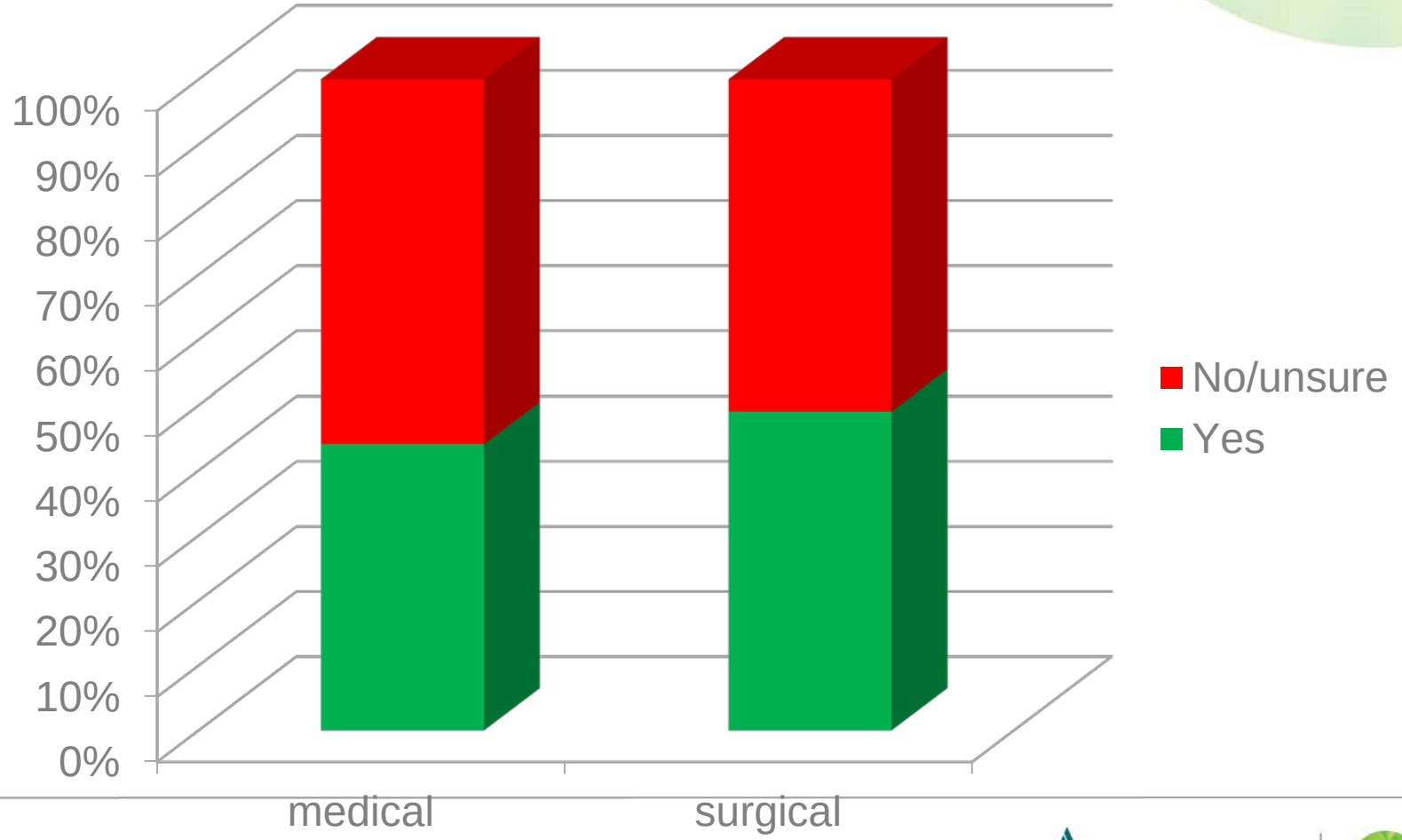
# Our doctors refer patients to palliative care too late

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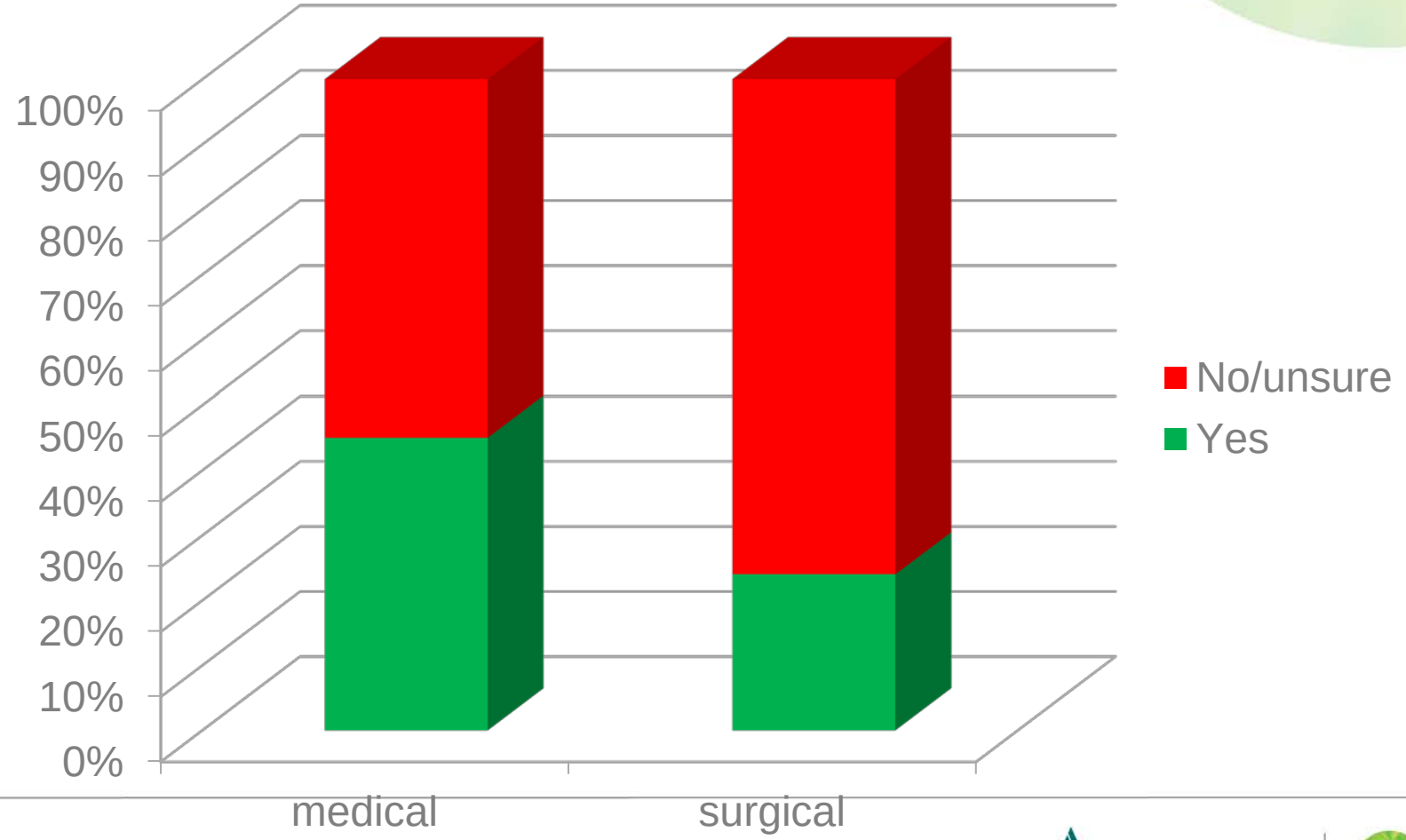
# Our doctors are good at updating families about progress & prognosis*

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# 1. How is end of life care planning and care done well in your ward?

- Nurses proud of the way they deliver EOL
  - Symptom management
  - Quality of care – pt centred
  - Practical issues
  - Family - support & keep informed
- Nurses advocate for patients
  - Recognise dying
  - Adequate medications / symptom management

# 1. How is end of life care planning and care done well in your ward?

- Not done well = 20
- Good EOLC limited by doctors
- Decision making needs to be better
  - Recognising dying
  - Ceasing active Rx (clearly) & early
  - Resuscitation Plans
  - Charting appropriate drugs
  - Clear treatment plans
- Need better communication skills

# 2. Who does EOL planning?

- Nurses 73
  - Nurses asking doctors 28
- Doctors 101
  - Consultants 9
- Unknown 6
- Pall care 15
- MET / RRS 14
- ACP team 6
- Other 12

# 3. How can end of life planning & care be improved in your ward?

- Communication (59)
- Education (53)
- Earlier Treatment limitations (36)
- Goal setting (34)
- Practical (29)
- Palliative care service (25)
- Clinical skills (18)
- Better care of families

# Communication

- Better & more frequent communication with patient & families (42)
- Doctors more comfortable talking about dying / poor prognosis (8)
- Improved team communication (8)

# Education

- Staff:
  - Doctors & nurses
  - Wide range of topics identified
  - Doctors need education around treatment limitations, symptom management
  - Accessible information, e.g. posters
- Families
  - Need to be educated by staff
  - Better resources

# Treatment limits & goal setting

- Doctors need to look at whole patient
- Involve patients & families
  - Give clear information to ensure realistic expectations and fully informed of likely outcomes
- Work with the nurses & allied health to
  - Recognise risk of dying early
  - Make active medical decisions to stop curative care and start EOLC when becomes clear that deteriorating,
  - Document decision clearly to ensure consistent message
  - Set time limits on treatment
  - Avoid prolonged futile treatment &patient suffering

# Palliative care service

- Earlier referral
- Allow PCS to help with team planning
- More beds PCU

- Note: Some consultants not keen PC

# Clinical skills

- Recognise patients are at risk of dying
- Recognise patients aren't improving
- Adequate medication orders
- Better symptom control

# 4. Are people reluctant to refer to palliative care?

- Yes 100
- No 44
- Unsure 10

- Reasons:
  - Seen as only EOLC
  - Palliative care is confronting / negative
  - Unaware of how or when to refer
  - Only doctors can refer
  - Don’t know what palliative care can offer
  - Family resistant – unrealistic expectations
  - Don’t want to upset family
  - Seen as having failed / giving up
  - Don’t realise how unwell patient is

# Results of this survey

- Presented across the hospital
- CLEARx decisions project
  - SMS forums held in conjunction with senior nursing staff and model of improved empowerment being explored
- EOL care committee involved more nurses and allied health
- Palliative care study days held across hospital
- Further survey being conducted this year to assess team work and specific education needs of medical, nursing and allied health staff

# Questions?