Press release from the British Sociological Association

Busy NHS staff 'failing to communicate with elderly dying patients', research says

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Busy NHS staff are often failing to communicate with elderly patients dying in hospital or their relatives, new research says.

The British Sociological Association's medical sociology conference in York heard today [Friday 13 September] that staff contact with patients tended to be "brief" and "functional," and that acute wards were unsuitable places for the dying.

Dr Kristian Pollock, of the School of Health Sciences at the University of Nottingham, reported findings from a study of four acute wards in a large Midlands hospital. This involved 245 hours of observation, and interviews with 38 doctors, nurses and other medical staff and 13 bereaved relatives.

Dr Pollock worked with Dr Glenys Caswell and Professor Rowan Harwood, of the University of Nottingham, and Professor Davina Porock, University of Buffalo, US.

Summarising the research, funded by Alzheimer's Society, Dr Pollock told the conference: "We found that although staff were aware of the importance of talking to families and patients about decisions regarding care, communication about these issues was often poor.

"Staff lacked awareness of family concerns and responses, or the extent to which relatives' understanding of the situation differed from their own. Families did not feel adequately informed, particularly about what they should expect to happen in the last days and hours before the patient's death. Patients were rarely involved in discussions about care decisions or prognosis.

"There was very little conversation between staff and patients about anything not related to the task. Staff contact with dying patients also tended to be brief, functional and focused on the task in hand, with little interaction even when the patient was conscious and able to communicate.

"However, a few respondents described the occurrence of the patient's death in hospital as a positive experience. This shows that the hospital can be a good place of death, but that considerable changes – and resources – will be required to make this routine, rather than exceptional."

Dr Pollock also said many patients died in the semi-public open wards, and while side-rooms conferred privacy, which was important for some families, these left patients alone and isolated from the rest of the ward. "The acute hospital ward does not provide an appropriate environment to support dying patients and their families."

"Staff were efficient, and generally pleasant, but overall, rather little interaction was observed with patients, and very little which extended from the instrumental to a person-centred domain. Most communication tended to be functional and rather perfunctory, and rarely encompassed a discussion or apparent interest in the personal details of patient's lives. It was

common for staff to close or open curtains, check notes, deliver meals, administer medicines and carry out observations without making any, or only minimal, acknowledgement of the patient's presence or awareness and without giving any explanation of what they were doing.

"While some patients could be uncooperative, disruptive or challenging to manage, many were not. They tried hard to be cooperative patients, and to maintain good relationships with the staff who cared for them. Patients clearly tried to minimise the trouble and inconvenience they caused and to maintain or restore the good will of staff. They did this from a position of great vulnerability and insecurity."

The research highlighted the variability of families' experiences of care, even on the same ward: "At best, family carers believed that their relative received excellent care. In other cases, carers felt that their relative had been abandoned and was not receiving sufficient attention or adequate care from staff."

Dr Pollock also noted the heavy workload medical staff that said they had. "The sheer pace and volume of work was challenging. Respondents reported frustration when they felt lack of adequate resources prevented them from providing high quality care, and giving each of their patients enough time and attention. The consequences of frequently being understaffed were a recurring issue."

One nurse told the researchers about lack of time: "You can go round feeling very guilty because you just feel like you haven't done everything you should have done, or you've neglected people. And obviously, elderly people are very, really vulnerable and scared a lot of the time, so you've got somebody who's really upset and you really want to spend a bit of time with them, and help them, but you just can't. It's difficult, it's quite sad."

The researchers noted how difficult it was to recognise that elderly patients were dying and how this posed a major challenge for acute wards. Acute wards would need considerable changes to their environment, staffing and processes if they were to meet the needs of dying patients properly.

Dr Pollock said: "Approximately 500,000 people die in the UK each year. Two-thirds of deaths occur among people over the age of 75, and one-third of these are over 85. The character of dying is changing, tending to become slow and gradual: the transition between life and death becomes blurred and difficult to recognise. Older people (over 65) account for 70% of the total health budget, 70% of hospital bed days and 80% of hospital deaths." He said that that most deaths were in hospital.

The research found no difference in the care of dementia patients, who constitute many of the elderly dying in hospital. Dementia is considered to be a major or contributory factor in a third of all deaths.

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1. The British Sociological Association's medical sociology conference takes place from 11 - 13 September 2013 at the University of York.

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