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Research paper

Barriers, enablers and challenges to initiating end-of-life care in an Australian intensive care unit context

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ABSTRACT

Background: Patients admitted to Australian intensive care units are often critically unwell, and present the challenge of increasing mortality due to an ageing population. Several of these patients have terminal conditions, requiring withdrawal of active treatment and commencement of end-of-life (EOL) care.
Objectives: The aim of the study was to explore the perspectives and experiences of physicians and nurses providing EOL care in the ICU. In particular, perceived barriers, enablers and challenges to providing EOL care were examined.
Methods: An interpretative, qualitative inquiry was selected as the methodological approach, with focus groups as the method for data collection. The study was conducted in Melbourne, Australia in a 24-bed ICU. Following ethics approval intensive care physicians and nurses were recruited to participate. Focus group discussions were discipline specific. All focus groups were audio-recorded then transcribed for thematic data analysis.
Results: Five focus groups were conducted with 11 physicians and 17 nurses participating. The themes identified are presented as barriers, enablers and challenges. Barriers include conflict between the ICU physicians and external medical teams, the availability of education and training, and environmental limitations. Enablers include collaboration and leadership during transitions of care. Challenges include communication and decision making, and expectations of the family.
Conclusions: This study emphasised that positive communication, collaboration and culture are vital to achieving safe, high quality care at EOL. Greater use of collaborative discussions between ICU clinicians is important to facilitate improved decisions about EOL care. Such collaborative discussions can assist in preparing patients and their families when transitioning from active treatment to initiation of EOL care. Another major recommendation is to implement EOL care leaders of nursing and medical backgrounds, and patient support coordinators, to encourage clinicians to communicate with other clinicians, and with family members about plans for EOL care.

1. Background and literature review

Patients admitted to Australian intensive care units (ICUs) are critically unwell and present challenges related to increased mortality. Several ICU patients require withdrawal of active treatment and commencement of end-of-life (EOL) care.[1,2] To provide optimal EOL care ICU clinicians must be sufficiently prepared and supported by healthcare organisations.[3] Many barriers exist in transitioning patients to EOL care, including a lack of education and limited emotional and organisational support for clinicians.[4–7] A challenge involves difficulties in achieving consensus and acceptance across healthcare teams of futility of treatment and transitioning to EOL care.[8,9] The literature also highlights enablers to providing optimal EOL care, including opportunities for open communication,[10] and availability of collaborative interdisciplinary teams.[8] Current

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challenges include limited guidance on how to manage discussions around transitions of care from active treatment to EOL care.[11] When open and clear communication between patients, their families and clinicians occurs, timely EOL discussions and decisions are made.[7,9] Improved communication between health professionals, as well as improved communication with family members, would therefore greatly enhance EOL care practices in the ICU.[12,13]

It is important to learn more about the specific barriers, enablers and challenges in ICUs in terms of the particular contextual characteristics relating to the environment of the ICU being investigated, and to the opportunities for interprofessional engagement, education and communication. Contextual characteristics include the physical environment and human interaction.[14] Insights on these contextual characteristics should help provide more localised strategies for improvement in delivering EOL care.

2. Aims

The aim of the study was to explore the experiences and perspectives of physicians and nurses when providing EOL care in the ICU. The study addressed the following research question: What are the barriers, enablers and challenges that clinicians encounter when initiating and delivering EOL care within the ICU? An enabler is defined as something that enables achievement of an end point. A challenge is a problem or difficulty associated with initiating and delivering EOL care, whereas a barrier is an obstacle that prevents EOL care.

3. Methods

An interpretative, qualitative inquiry framework was employed. Focus groups were conducted, with a semi-structured format. A focus group approach was used as it was perceived that deep reflections and discussion among clinicians who provided EOL care in ICU would be encouraged. This study was granted ethics approval by the participating health service.

3.1. Setting

The study was undertaken in a major referral ICU, located in a tertiary metropolitan hospital in Melbourne, Australia, which included a workforce of 188 permanent nurses, 26 medical registrars, and 18 permanent intensivists. The ICU consisted of 24 beds, and provided level three support to trauma, cardiothoracic, neurosurgical and general medical patients.

3.2. Sampling method and sample

Intensive care physicians and registered nurses who had experience in providing EOL care in ICU were invited to participate, with the aim of attaining detailed interdisciplinary opinions. The sample frame focussed on generating a sample size that would produce high quality data, which was achieved with purposive sampling, with participants recruited from a large group of experienced clinicians. Purposive sampling allowed the researchers to select participants who were able to provide perspectives that specifically related to the topic of inquiry.[15] Nurses with a postgraduate certificate, or higher qualification, in intensive care, and intensive care consultants and physicians in training were recruited. Due to their relative lack of experience of caring for ICU patients at EOL, resident medical officers, and nursing staff contracted to complete postgraduate education in intensive care, were excluded. All eligible staff were sent an email that included a consent form and letter of invitation.

Table 1
Focus group questions.

Question number	Question
1	Can you provide details about the end-of-life care protocols you have encountered while working in ICU?
2	What barriers can you identify to initiating and delivering end-of-life care in ICU? Can you provide some examples of these barriers?
3	What enablers can you identify to initiating and delivering end-of-life care in ICU? Can you provide some examples of these enablers?
4	Who should be involved in making the decisions about end-of-life care in the Intensive Care Unit?
5	What challenges have you experienced when active treatment has been ceased and end-of-life care commenced?
6	What are the barriers to promoting effective commencement of end-of-life care in ICU?
7	What are the enablers to promoting effective commencement of end-of-life care in ICU?
8	What changes can be made in the ICU regarding communication about the patient's prognosis and commencement of end-of-life care?
9	Should education be provided to clinicians to enable them to provide end-of-life care in ICU?

3.3. Data collection

The study participants attended a one-hour focus group, which was conducted by the first-named author. Nine questions guided focus groups (Table 1) which was audio-recorded and transcribed verbatim. Focus groups were conducted in a quiet room, which ensured no interruptions. Focus groups for physicians and nurses were conducted independently to allow for comparisons between the two groups to be explored.

3.4. Data analysis

A total of 13 physicians and 24 nurses responded to participate in the focus group sessions. Participant confidentiality was upheld as no identifiable information was collected. Audio recordings and transcripts were reviewed repeatedly to ensure precise information was transcribed. The data were exposed to thematic analysis, which involved coding, and fracturing the data, or dividing the data into codes. Codes were categorised into temporary categories, with the final step linking the data into specific categories and sub-categories.[16] Any discrepancies were resolved by negotiation.

4. Results

Five focus groups were conducted, two involving physicians and three involving nurses. Eleven physicians and seventeen nurses participated in the study. Tables 2 and 3 present a summary of the demographic and qualification characteristics of participating physicians and nurses. Quotes from transcripts have been used to support the themes relating to barriers, enablers and challenges. These quotes have been coded using the nomenclature of PG and NG to indicate physician group and nursing group respectively, and P for participant number.

4.1. Barriers

Participants discussed the barriers that prevented them providing optimal EOL care including conflict, the availability of education and training, and environmental limitations.