HospiceFriendly HOSPITALS

Putting Hospice Principles into Hospital Practice.

National Audit of End-of-Life Care in Hospitals in Ireland

2008/9

The Culture of End-of-Life Care in Hospitals in Ireland

National Audit Report 4

May 2010

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

THE IRISH HOSPICE FOUNDATION

Research Team

Kieran McKeown	Social & Economic Research Consultant, 16 Hollybank Rd., Drumcondra, Dublin 9, Ireland. Email: kmckeown@iol.ie
Trutz Haase	Social & Economic Consultant, 17 Templeogue Rd., Terenure, Dublin 6W, Ireland. Email: thaase@iol.ie
Shelagh Twomey	National Audit Manager of HFH Programme Irish Hospice Foundation, Morrison Chambers, 32 Nassau St., Dublin 2, Ireland. Email: shelagh.twomey@hospice-foundation.ie

How to cite this report

McKeown, K., Haase, T., and Twomey, S., 2010. The Culture of End-of-Life Care in Hospitals in Ireland, Report 4, Dublin: Irish Hospice Foundation. Available at http://www.hospicefriendlyhospitals.net

Ownership & Confidentiality

This report is the joint property of the hospitals who contributed to the national audit of end-of-life care in 2008/9, and the Irish Hospice Foundation. Information about any individual hospital is confidential to that hospital.

List of National Audit Reports

Report One	Resources and Facilities for End-of-Life Care in Hospitals in Ireland
Report Two	Dying in Hospital in Ireland: Nurse and Doctor Perspectives
Report Three	Dying in Hospital in Ireland: Family Perspectives
Report Four	The Culture of End-of-Life Care in Hospitals in Ireland
Report Five	Dying in Hospital in Ireland: An Assessment of the Quality of Care in the Last Week of Life

Testament
by Wendell Berry [1]

1.
Dear relatives and friends, when my last breath
Grows large and free in air, don't call it death --
A word to enrich the undertaker and inspire
His surly art of imitating life; conspire
Against him. Say that my body cannot now
Be improved upon; it has no fault to show
To the sly cosmetician. Say that my flesh
Has a perfect compliance with the grass
Truer than any it could have striven for.
You will recognize the earth in me, as before
I wished to know it in myself: my earth
That has been my care and faithful charge from birth,
And toward which all my sorrows were surely bound,
And all my hopes. Say that I have found
A good solution, and am on my way
To the roots. And say I have left my native clay
At last, to be a traveler; that too will be so.
Traveler to where? Say you don't know.

2.
But do not let your ignorance
Of my spirit's whereabouts dismay
You, or overwhelm your thoughts.
Be careful not to say

Anything too final. Whatever
Is unsure is possible, and life is bigger
Than flesh. Beyond reach of thought
Let imagination figure

Your hope. That will be generous
To me and to yourselves. Why settle
For some know-it-all's despair
When the dead may dance to the fiddle

Hereafter, for all anybody knows?
And remember that the Heavenly soil
Need not be too rich to please
One who was happy in Port Royal.

I may be already heading back,
A new and better man, toward

1 Wendell Berry (1934 -), published at www.poetry-chaikhana.com. He is farmer, poet, novelist, essayist, and teacher, is the author of 32 books. He lives in Kentucky, USA.

That town. The thought's unreasonable,
But so is life, thank the Lord!

3.
So treat me, even dead,
As a man who has a place
To go, and something to do.
Don't muck up my face

With wax and powder and rouge
As one would prettify
An unalterable fact
To give bitterness the lie.

Admit the native earth
My body is and will be,
Admit its freedom and
Its changeability.

Dress me in the clothes
I wore in the day's round.
Lay me in a wooden box.
Put the box in the ground.

4.
Beneath this stone a Berry is planted
In his home land, as he wanted.

He has come to the gathering of his kin,
Among whom some were worthy men,

Farmers mostly, who lived by hand,
But one was a cobbler from Ireland,

Another played the eternal fool
By riding on a circus mule

To be remembered in grateful laughter
Longer than the rest. After

Doing that they had to do
They are at ease here. Let all of you

Who yet for pain find force and voice
Look on their peace, and rejoice.

Table of Contents

Figures and Tables

Acknowledgements

This audit is about hospitals and the quality of their care for patients at the end of life. Without the participation and support of these hospitals, the audit would not have been possible. We are thus enormously grateful to the 43 participating hospitals - 24 acute and 19 community – which had the vision to see this audit as an opportunity to examine and improve their end-of-life care. We would like to thank the management and staff of each hospital, and especially the hospital audit managers who were responsible for data collection. The acute and community hospitals which participated in the audit are:

Acute Hospitals	**Hospital Audit Managers**
Cork University Hospital	Fionuala O'Gorman
Mid-Western Regional Hospital Limerick	Catherine Hand
Cavan General Hospital	Bridget Clarke
Monaghan General Hospital	Josephine O'Hagan
Our Lady of Lourdes Hospital, Drogheda	Mary McCrane
Our Lady's Hospital, Navan	Concepta Tallon
Louth County Hospital, Dundalk	Kathriona Campbell
Kerry General Hospital, Tralee	Richard Walsh
Wexford General Hospital	Bernard Finnegan
St. James's Hospital, Dublin 8	Paul Gallagher & Lucy Kielty
Sligo General Hospital, Sligo	Kate Bree
Mater Misericordiae University Hospital	Breda Doyle
Connolly Hospital	Catriona Higgins
Letterkenny General Hospital	Pauline McManus
St. Luke's Hospital, Rathgar	Wendy Fair
Portlaoise, Midland Regional Hospital	Emer McEvoy & Ann Sheerin
Beaumont Hospital	Mary Baggot
Waterford Regional Hospital	Cliona Rafter
South Tipperary General Hospital	Maria Barry
St. Luke's Hospital, Kilkenny	Debbie Kavanagh
Tallaght Hospital	Kathleen Flynn
Nenagh, Mid-Western Regional Hospital	Mary Clifford
Naas General Hospital	Breda Murphy
Tullamore, Midlands Regional Hospital	Claire O'Dea & Lorna Griffith

Community Hospitals	**Hospital Audit Managers**
St. Joseph's Hospital, Trim	Frances Flynn
Royal Hospital Donnybrook	Anne Dooley
Bru Chaoimhin	Muthu Saba
Bellvilla	Niamh Curran
Meath Community Unit	Karen Rowlett
St. Mary's Hospital, Phoenix Park	Michelle Russell
St John's Hospital, Sligo	Fran Butler
St. Mary's Castleblayney	Susan McGoldrick
Oriel House	Geraldine Smyth
Leopardstown Park Hospital	Elaine Flanagan
Peamount Hospital, Newcastle	Elaine Keane
Breffni	Ann Gaffney
Virginia	Bernardine Lynch

Lisdaran	Bernie McManus
Sullivan Centre, Cavan	Martha Adams
Boyne View Drogheda	Lena Varghese
	Ciara Cullen
Cottage Hospital, Drogheda	Karen McElaine (Unit 1)
	Mary Gallagher (Unit 2)
St. Mary's Hospital, Drogheda	Myrna Guay (Unit 1)
	Ann Keane (Unit 2)
St. Joseph's Hospital, Ardee	Eileen Dullaghan
	Bernie Murphy & Patricia Barry

In addition to the audit managers, many hospital staff members contributed to the audit. Nurses and doctors completed detailed questionnaires on a sample of patients who died in their care. Nurses and healthcare assistants completed a questionnaire on the culture of care in their ward, while a similar questionnaire was completed by a sample of staff drawn from throughout the hospital.

The families of the aforementioned patients made a huge contribution to the audit, and this is gratefully acknowledged. Their perspective is irreplaceable in helping us to understand how patients and their relatives experience hospital care at the end of life.

At national level, HSE staff supplied us with data and datasets which were extremely useful. We particularly thank the following people:

Des Williams	HSE National Employment Monitoring Unit
Howard Johnson & Carmel Cullen	HSE Health Information Unit
Judy Cronin	HSE FactFile
Sean O’Cinnéide	HSE Consultant Appointments Unit
Mary Culliton and Deirdre McKeown	HSE Office of Consumer Affairs

Some hospitals participated in two pilot phases of the audit, one carried out by the HFH Programme itself and the other by the Royal College of Surgeons of Ireland (RCSI). We thank both groups of hospitals for helping us to break new ground by showing, through these pilot studies, that the audit was technically feasible and a potentially powerful instrument of change when embraced by the entire hospital community. The acute and community hospitals who participated in the pilot studies are:

HFH Pilot Study	**RCSI Pilot Study**
Cork University Hospital	Midland Regional, Mullingar
Mater M University Hospital	Naas General Hospital
St. Mary's Phoenix Park	St. John's Hospital, Sligo
Leopardstown Park Hospital	St. Columba’s, Co. Kilkenny
St. Mary's Castleblayney	
St. Columba’s, Co. Kilkenny	

Within the HFH programme, we acknowledge the contribution to the national audit of the staff team comprising:

Mervyn Taylor	Programme Manager

Shelagh Twomey	Deputy Programme Manager
Helen Donovan	Standards Development Coordinator
Mary Bowen	Operations Manager
Denise Connor	Project Development Coordinator
Róisín Clarke	Programme Administrator
Grace O'Sullivan	Programme Administrator & Development Support
Lorna Peelo-Kilroe	National Practice Development Coordinator End-of-Life Care
Paul Murray	Development Coordinator - Forum on End-of-Life Care
Joanne Carr	Development Coordinator
Amanda Manning	Development Coordinator
Fran McGovern	Development Coordinator
Bryan Nolan	Development Coordinator
Aoife O'Neil	Development Coordinator
Ruth Agar	Development Coordinator
Colette Cunningham	Development Coordinator
Mary Friel	Development Coordinator
Nuala Harmey	Development Support

The national audit was guided and supported by an Evaluation Sub-Committee and their contribution is gratefully acknowledged. The members of the Evaluation Sub-Committee are:

Prof. David Clark	Chair, Visiting Professor of Hospice Studies, TCD & UCD
Orla Keegan	Head of Education, Research & Bereavement Services, The Irish Hospice Foundation
Mervyn Taylor	Programme Manager, Hospice Friendly Hospitals Programme
Shelagh Twomey	Deputy Programme Manager, Hospice Friendly Hospitals Programme
Max Watson	Consultant in Palliative Medicine, Northern Ireland Hospice
Gail Birkbeck	The Atlantic Philanthropies (in attendance)

The HFH Programme is overseen by a National Steering Committee and its input to the audit is also acknowledged. Its membership currently comprises:

Prof. Cillian Twomey	Chair, Consultant Physician in geriatric medicine at Cork University Hospital and St. Finbarr's Hospital, Cork
Prof. David Clark	Visiting Professor of Hospice Studies, TCD & UCD
Denis Doherty	Chairman, The Irish Hospice Foundation Chairman, and Chairman, Nursing Homes Ireland
Eugene Murray	Chief Executive Officer, The Irish Hospice Foundation
Prof. Brendan McCormack	Director of Nursing Research & Practice Development, Royal Group of Hospitals, Belfast and University of Ulster at Jordanstown

Orla Keegan	Head of Education, Research & Bereavement Services, Irish Hospice Foundation
Richard Dooley	Network Manager, South Eastern Hospitals Group, HSE
Ann Ryan	Inspector Manager, Health Information & Quality Authority
Brenda Power	Broadcaster and journalist
Geraldine Fitzpatrick	Principal Officer, Services for Older People & Palliative Care, Department of Health & Children
Sheila Dickson,	First Vice-President, Irish Nurses Organisation
Margaret Murphy	Patient Representative on the Council of the Irish Society for Quality and Safety in Healthcare
Dr. Doiminic Ó Brannagáin	Consultant in Palliative Medicine, Health Services Executive, North East
Barbara Fitzgerald	Director of Nursing, Naas General Hospital
Dr. Peter Lawlor	Consultant in Palliative Medicine, St. James's Hospital and Our Lady's Hospice
Dr. Emer Longley	General Practitioner, Inchicore Medical Centre, D8.
Noel Mulvihill,	Health Service Executive, Local Health Manager, LHO - Dublin North Central (HSE)

The research design for the audit, including questionnaires, is published in a separate Manual (McKeown, 2008). In addition to those listed above, many people contributed to the Manual. Siobhán McCarthy and Professor Ciarán O'Boyle, at the Royal College of Surgeons of Ireland (RCSI), prepared a literature review on the instruments used in the survey of bereaved relatives. Dr. Karen Ryan, Consultant in Palliative Medicine at the Mater Hospital and St. Francis Hospice, made helpful comments on earlier drafts of some of the questionnaires. Similarly, Professor Phil Larkin, Chair of Palliative Care Studies at University College Dublin, made constructive suggestions on all the questionnaires. The Manual was reviewed by a number of external experts – including Dr. Patricia Ricker from Harvard University, Dr. Joanne Lynn from the US Office of Clinical Standards and Quality at the Centers for Medicare and Medicaid Services, and Dr. Mark Dynarski from Mathematica Policy Research, NY – and their comments are gratefully acknowledged.

All of the data were entered by Insight Statistical Consulting, under the direction of David Harmon. This work was carried out with meticulous attention to detail for which we are most grateful.

We express our thanks to the funding partners of the HFH programme without whom the audit would not have been possible: The Atlantic Philanthropies, the Health Service Executive, the Health Services National Partnership Forum and the Dormant Accounts Fund.

Finally, in acknowledging everyone's contribution to the national audit of end-of-life care, we wish to emphasise that responsibility for this report, and any errors it may contain, rests entirely with the Research Team.

Dr. Kieran McKeown, on behalf of the Research Team.
May 2010.

Executive Summary

This report describes the attitudes of hospital staff to a range of end-of-life issues. These attitudes manifest some aspects of the hospital's culture about end-of-life care because they touch on underlying beliefs and values about dying and the care of patients who die in hospital. The report is based on two datasets derived from a survey of: (i) 2,358 ward staff with a response rate of 83%; and (ii) 1,858 hospital staff with a response rate of 64%.

Respondent Characteristics

The vast majority of respondents are female (81%), consistent with the overall gender profile of HSE staff which is 80% female[2]. Nearly a quarter (23%) of all staff were brought up outside Ireland – especially the Philippines and India – which is much higher than in the Irish health services generally where 10% of staff are non-Irish[3]. As a result, English is not the first language for nearly a quarter (24%) of ward staff.

Feeling Comfortable Talking About Dying and Death

Nearly four out of ten staff, in both the ward (39%) and hospital (37%), are very or completely comfortable with talking about death and dying, similar to the proportion in the national population (38%)[4]. However staff are markedly less comfortable – by 10 percentage points - with talking to people who have been bereaved recently, just as in the national population. Within wards, nurse managers are the most comfortable and nurses are the least comfortable.

Preferred Place to Die

There is a much higher preference to die at home among both ward staff (81%) and hospital staff (77%) compared to the national population (67%)[5]. Correspondingly, the proportion preferring to die in hospital (6%) is smaller than in the national population (10%). This finding is consistent with other studies which show that doctors and nurses have a stronger preference to die at home compared to patients[6].

Quality of End-of-Life Care in Irish Hospitals

A majority of hospital staff (63%) rate the end-of-life care in Irish hospitals as good or excellent, but significantly lower compared to the general population who have had direct experience of end-of-life care in hospital in the past two years (75%)[7].

2 HSE and Department of Health 2009: Table B3, p.61.
3 HSE and Department of Health 2009:62.
4 Based on a survey of 1,000 adults aged 15+ in the Republic of Ireland, carried out in 2004 (Weafer and Associates Research, 2004).
5 Based on a survey of 1,000 adults aged 15+ in the Republic of Ireland, carried out in 2004 (Weafer and Associates Research, 2004).
6 Sprung, Carmel, Sjokvist, et, al., 2007.
7 Weafer & Associates Research, 2004: Figures 12 and 15, pages 16 and 19. This suggests that people's experience of hospitals tends to be quite positive and, perhaps more significantly, tends to be more positive among those who speak from direct experience of hospital services. This is consistent with a study in 2007 by HSE's Office of Consumer Affairs, comprising a random sample of 3,517 Irish people, on experiences of public health and social care services. A sub-sample of these (344, 10%) had experience of hospital services in the last year and reported high overall levels of satisfaction on dimensions such as: effective treatment by a trusted professional (78%), involvement in decisions and respect for own preferences (75%), clear and comprehensive information (80%), emotional support, empathy and respect (83%), easy to get around the hospital (74%). However there was a marked dip in satisfaction on dimensions such as cleanliness of hospital toilets (62%), contact with the hospital by phone (69%), and car-parking facilities (46%) (UCD and Lansdowne Market Research, 2007)

Most and Least Important Things About Dying
The two most important things about care when dying, according to staff, are: to be free from pain (86%) and to be surrounded by loved ones (87%). These are also the two most important things about care when dying in the national population. The three least important things for staff about care when dying are: spiritual support (13% compared to 19% in the general population), medical and nursing support (19% compared to 32% in general population), and a private space (25% compared to 11% in the general population).

Physical Environment of Ward
Ward staff rated their ward, on a 1-10 scale, at 4.7 in acute hospitals and 6.4 in community hospitals. These ratings were highest in oncology wards (6.1), and lowest in A&E (2.9). The two highest ratings are for dignity (6.6) and privacy (5.8) while the lowest are for environment (4.8) and control (3.7). This pattern of results is at variance with an independent observation of 15 acute and 5 community hospitals – all included in this audit - which gave an overall score of 3.6 out of 10 for the physical environment of these hospitals[8].

Bed Occupancy
The survey revealed that nearly eight out in ten ward staff (79%) believe that the bed occupancy rate in their ward is high or very high, and this perception is much stronger in acute than in community hospitals. This is consistent with the first audit report which indicated an overall bed occupancy rate of 93% for both the acute and community hospitals. Ireland has the fourth highest bed-occupancy rate in the OECD where the average is 75%[9].

Patient turnover
The survey revealed that nearly six in ten ward staff (58%) believe patient turnover is high or very high, and much higher in acute than community hospitals. Given that patient turnover is determined by the average length of stay, this needs to be seen in the context that average length of stay is slightly higher in Ireland's acute hospitals (6.7 days) compared to the OECD average (6.3 days)[10]; in addition, the average length of stay of patients who die in acute hospitals in Ireland (24 days) is high by comparison with the UK[11] and the US[12].

Patient Dependency
Nearly three quarters of ward staff (74%) believe that patient dependency in the ward is high or very high, with little difference between acute than community hospitals.

Patient Deaths
For a majority of ward staff (85%), deaths occur relatively infrequently at about every two weeks or less. Deaths are more frequent in acute than in community hospitals.

8 Tribal, 2007.
9 OECD, 2007.
10 OECD, 2007:73. In the HSE's 2009 National Service Plan, the target average length of stay in acute hospitals is 5.9 days (HSE National Service Plan 2009, 2008:71).
11 A study of 599 deaths in an acute hospital in the south west of England found that the average length of stay before death was 12 days (Abel, Rich, Griffin, and Purdy, 2009:3 and Table 6). A study of 314 cancer deaths in Boston Lincolnshire between September 2006 and March 2007 found that the average length of stay before death was 16.6 days (Addicott and Dewar, 2008:Tables 4 and 7).
12 The Institute for Healthcare Improvement has adopted 7.24 days as an indicator of an efficient length of stay during the last six months of life (Martin, Nelson, Lloyd, and Nolan, 2007:6; see also Wennberg, et al, 2004). This target was set following research published by Dartmouth Atlas which showed that length of stay in the last six months of life varied across the US from 4.87 to 19.67 days for the same diagnostic categories and independently of need and outcome albeit with significant variations in cost (Wennberg, Fisher, Stukel, Skinner, Sharp, and Bronner, 2004).

Staff Sufficiency
More than half the ward staff (56%), especially in acute hospitals, believe there is not sufficient staff on the ward.

Staff Turnover
Staff turnover is perceived to be low. This is consistent with the relatively low annual turnover of staff in acute (15%) and community (14%) hospitals[13] and in Ireland generally[14].

Working Environment
More than eight out of ten staff (81%) believe their workplace is good or very good. The highest rated aspects of the ward, on a scale from 1-10, are the standard of care (8.7), ward management (8.1), and staff relationships (7.9). End-of-life care was given a lower rating (7.3) along with ward facilities (7.9).

Work satisfaction
Overall work satisfaction is high, consistent with the results of a national survey on job satisfaction in Ireland which found 'over 90 per cent of respondents agreeing or strongly agreeing that 'in general' they are satisfied with their job'[15]. Hospital staff are twice as likely to be dissatisfied with their work (11%) compared to ward staff (5%). At the level of wards, the highest proportion of dissatisfied staff (16%) are to be found in A&E and the lowest in oncology (0%). Dissatisfaction with work is twice as high in acute hospitals (12%) as in community hospitals (6%). Doctors are the most dissatisfied group of hospital staff (15%) while the least dissatisfied are those involved in other patient care such as pastoral care, bereavement, and end-of-life care (4%).

Quality of End-of-Life Care
On a scale from 1-10, ward staff rate the quality of end-of-life care on their ward at 8.1, higher for community hospitals (8.7) than for acute hospitals (8.0). These scores are high and show relatively little variability.

Acceptability of Way Patients Die in Hospital
The vast majority of ward staff (90%) and hospital staff (87%) regard deaths in the ward and hospital as acceptable to them. Deaths are perceived to be more acceptable in community hospitals than in acute hospitals. Within wards, the highest rates of unacceptable deaths are to be found in A&E (26%) and the lowest in oncology (3%).

Education, Training and Preparedness for End-of-Life Care
The survey asked ward and hospital staff to rate 11 statements about the hospital's education, training and other supports for end-of-life care. Seven items were rated consistently below the mid-point (5) and can therefore be regarded as less than adequate while the other four statements scored are just above the mid-point and might be regarded as minimally adequate. Nevertheless, the vast majority of ward staff feel prepared for the death of a patient, both professionally (92%) and personally (90%).

13 McKeown, Haase and Twomey, 2010a.
14 Bergin, 2009:24
15 O'Connell and Russell, 2007:62. This study also found that job satisfaction tends to be higher among managers, professionals and technical staff and lower among sales staff and operatives while those in part-time work tend to be marginally more satisfied than those in full-time work.

Supports for Staff Very Upset After a patient's Death
Over half the ward staff (51%) felt very upset after a patient's death during the past year; this suggest a higher rate of upset compared to nurses who completed the audit on deceased patients where only 21% reported feeling very upset after a patient's death. The vast majority of ward and hospital staff can rely on the support of colleagues, their manager, and in-house counselling if they felt very upset at the death of a patient.

Hospital Priorities
Staff rated the priority given to 13 different activities in the hospital. Most activities received broadly similar priority, averaging 7 out of 10. The highest priority is for active treatment of the patient and the lowest is for carrying out innovative research. End-of-life care, though not the top priority, is perceived to receive a substantial amount of attention, according to ward staff (7.6) and hospital staff (7.4).

Religious Ethos
The majority of ward staff (65%) and hospital staff (72%) perceive their hospital to be fairly religious. Staff in community hospitals are twice as likely to perceive their hospital as very religious compared staff in acute hospitals. Very few staff describe their hospital as non-religious.

Conclusions and issues for consideration
The purpose of this report is to describe some aspects of hospital culture with a view to examining what impact it might have the outcomes of end-of-life care, bearing in mind that much of what is called 'culture' remains in the realm of the unconscious in the form of unspoken assumptions[16]. The ultimate test of the impact of these variables will depend on the statistical analysis in the fifth audit report. Nevertheless, the aspects of hospital culture described in this report are also of intrinsic interest, and we raise a number of issues in the final section of the report which merit further attention and reflection.

16 Scott, Mannion, Davies and Marshall, 2003:125.

1 Introduction

This report describes the attitudes of hospital staff to a range of end-of-life issues. These attitudes manifest some aspects of the hospital's culture about end-of-life care because they touch on underlying beliefs and values about dying and the care of patients who die in hospital. It is recognised that the culture of a hospital, as embodied in the attitudes and values of its staff, influences behaviour and the quality of care. At the same time, it is also recognised that much of what is called 'culture' remains in the realm of the unconscious as unspoken assumptions. As one review of studies on the influence of organisational culture in healthcare settings has observed: 'the essence of an organisation's culture lies in its unspoken assumptions. These assumptions may be conceived as an organisational unconscious, of which artefacts and values are conscious manifestations. However one views the psychoanalytic metaphor, it is generally acknowledged that organisational cultures are like icebergs in that only the peak is visible above the surface… . The basic technique for examining the submerged culture is to look for discrepancies between espoused values and actual practices (artefacts). By exploring these faults in the fabric of organisational life, … it is possible to bring an underlying pattern of assumptions to the surface'[17].

This understanding of culture has two implications. First, the description of end-of-life culture offered in this report is likely to represent the tip of the cultural iceberg, covering those aspects of hospital culture that are more amenable to measurement by survey techniques. This does not invalidate the results but it draws attention to their limitations, and the possibility that significant aspects of hospital culture, because they remain unconscious to the researcher as much as to hospital staff, are not included. Second, there are other methods for accessing hospital culture – such as critical incident analysis[18], focus groups[19], case studies[20], use of emotional touchpoints[21] – which may be more suited to unearthing the more shadowy side of hospital culture precisely because they use actual events in the life of the hospital as indicators of underlying and unspoken values and assumptions. As with individuals,

17 Scott, Mannion, Davies and Marshall, 2003:125.

18 Critical incident analysis was used effectively in a study by Keegan et al, 1999: Chapter Eight. This study, based on 155 relatives of patients who died in St. James's Hospital, Dublin between July 1996 and June 1997. Relatives were asked to describe 'specific events which were meaningful to them and signified either positive or negative features of the care received' (Ibid:53). This yielded nearly twice as many negative (568) as positive (297) incidents.

19 This method was used in a study at Our Lady of Lourdes Hospital in Drogheda (Browne, O'Mahony and MacEochaidh, 2005).

20 This method was used in a study of hospitals commissioned by the Hospice Friendly Hospitals Programme and involved collecting data on good and bad deaths in these hospitals using 102 written narratives, 57 interviews with hospital practitioners, and 14 focus 14 focus groups with 104 practitioners (Quinlan and O'Neill, 2009).

21 This method has been used in a number of care settings in Scotland as part of a Leadership in Compassionate Care Programme (Dewar, Mackay, Smith, Pullin and Tocher, 2009). The method involves asking the patient to speak about a number of different points, or touchpoints, in the patients journey. Emotional touchpoints might include: coming into the hospital, going for tests, mealtimes, visiting times, night-times, talking with doctors and nurses, etc. A range of emotional words are printed on cards – such as numb, powerless, bewildered, happy, curious, hopeful and encouraged - and the patient is asked to select the emotion that matches the touchpoint and then elaborate. These different elements of the method are integrated as follows: 'The patient or family member was invited to discuss their experiences of being in hospital. This was conducted in a private room on the ward. The touchpoints were laid out on a table and the patient was invited to select, from these touchpoints, those that they would like to talk about. They were also asked if there were other key moments that they would like to discuss. … . Taking each touchpoint in turn the storyteller was then asked to describe what happened and select from the emotional words those that best summed up for them how that experience felt. There were blank cards that could be used if the patient used an emotional word that is not in the pre-prepared collection of emotional words. They were then invited to say why they felt this way. If appropriate, they were also asked to discuss how things could have been different, particularly if the emotion identified was a negative one. Talking with patients about what they see as potential solutions to issues they have raised helps patients to co-design the service rather than being passive givers of information' (Ibid:32). Following the interview, the story is written up and the patient is given an opportunity to read and adapt as wished. Significantly, the authors emphasise that 'there needs to be a strong connection between the story and action. The stories need to be linked with other evidence and put into the context of the culture so that meaningful learning and action can be facilitated' (Ibid:34).

those aspects of hospital culture that are easiest to speak about are often those which are socially presentable and acceptable, while those aspects that are less socially acceptable, and even shameful, are typically more difficult to speak of - but they still manifest themselves in behaviour and practices that directly and indirectly influence the hospital's quality of care.

The ultimate test of the extent to which this report captures some key dimensions of the hospital's end-of-life culture will depend on whether these dimensions are shown to influence the main outcomes of end-of-life care. The results of that test, will involve detailed statistical analysis in the fifth and final audit report[22]. This underlines the exploratory nature of the study reflecting, in turn, the exploratory nature of much research in this area as one recent review has observed: 'Although the notion of organisational culture is now invoked frequently in the social science and popular management literature, it remains a contested concept, fraught with rival interpretations and eluding a consensual definition. This contestability, however, has not precluded culture change and management from becoming a familiar prescription in health system reform. Nowhere is this more apparent than in the UK health system… . There is a real need for more and better-tested bespoke instruments for assessing cultures in the NHS organisations. … Once we have established the characteristics of desirable cultures (maybe through further intensive qualitative work) we will then be in a position to build better instruments. Given the range and diversity of issues central to cultural assessment in healthcare, the building, testing and refining of a variety of culture instruments will be an ongoing task'[23].

This fourth audit report is based on two datasets. The first dataset is based on a survey of nurses and healthcare assistants in each of the wards where a patient died and whose death is included in the audit. Ten staff per ward were randomly selected to participate in this survey, and these were weighted to reflect the number of nurses and healthcare assistants in each ward. The response rate, based on both the number of wards (283 out of 347) and the number of ward staff (2,358 out of a maximum total of 2,830) was 83% (Tables 1.1a-b)

The second dataset is based on a survey of hospital staff outside of wards. A quota sample of 100 staff was drawn in each hospital with participation proportionate to five different staff categories:

(1) Management (including CEO / GM, Director and Assistant Directors of Nursing) and administration (including reception and ward clerks)
(2) Medical and dental (including consultant and non-consultant doctors)
(3) Nursing specialists (not specific to a ward)
(4) Health and social care (including allied health professionals such as radiographer, social worker, physiotherapist, occupational therapist, speech therapist)
(5) General support staff (including porters, catering, household, security, mortuary)

22 McKeown, Haase, Twomey, Pratschke and Engling, 2010e.
23 Mannion, Davies and Marshall, 2005:197 and 223. The exploratory nature of culture studies is also underlined by the difficulty in finding studies which demonstrate a robust link between organisational culture and organisational performance. One review of these studies has suggested that 'Notwithstanding the more or less rigorous investigations of academic researchers, an entire industry has been built on the idea that organisational culture and performance are indeed linked. We therefore need to know whether this industry is built on sand or solid rock, and whether to spend scarce public money on organisational development programmes based on that rationale. Secondly, the whole story about organisational culture and performance is a long way from being told. There have been few empirical studies, and most of them are methodologically weak. The potential cost of giving up the search at this relatively early stage is greater than the cost of taking it forward along a path, which both methodologically and thematically seems to be relatively clear.' (Scott, Mannion, Davies and Marshall, 2003:130).

(6) Other patient care (including pastoral care, bereavement coordinator, end-of-life care coordinator, complaints officer, patient advice and liaison officer).

This resulted in a sample of 1,858 hospital staff. The response rate was 64% in acute hospitals; many community hospitals in the audit do not have 100 staff and therefore could not meet the quota (Tables 1.2a-b).

The three main wards represented in the sample are medical (34%), surgical (20%) and ICU (20%) (Table 1.3). These are also the three wards where the vast majority of patients in the audit died (Table 2.18 in the second audit report[24]).

The sampling error associated with both samples, at the 95% level of probability, is in the 1-2% range for each statistic generated from the sample. In other words, each statistic is likely to be correct for the entire population of audited hospitals to within 1-2% percentage points[25].

The data analysis involves reporting the results for each variable by the following categories:

- type of hospital (major teaching, major regional, other acute, community)
- type of ward (A&E, ICU, surgical, medical, oncology, geriatric, other)
- ward position (nurse manager, nurse, healthcare assistant)
- staff category (management, medical, nursing specialist, health care professional, general support staff, other patient care).

It is acknowledged that more detailed analysis of the dataset is possible and desirable and this will be presented in the fifth and final audit report[26].

The results are now presented, broadly using the same format as the questionnaires, as follows:

Section 2: Staff Characteristics
Section 3: Attitudes to Dying and Death
Section 4: Ward Environment
Section 5: Working Environment
Section 6: Quality of End-of-Life Care
Section 7: Professional and Personal Preparation for End-of-Life Care
Section 8: Experiences after the Death of a Patient
Section 9: Education and Training for End-of-Life Care
Section 10: Hospital Priorities

In Section 11 of the report we present our conclusions and raise issues for further consideration. All of the statistical tables are in a Data Appendix at the end of the report.

24McKeown, Haase and Twomey, 2010b.
25 More specifically, frequencies of 10% or 90% have a sampling error in the +/-1% range while frequencies of 50% to 70% have a sampling error in the +/-2% range. This implies that the statistical significance of any relationship between variables can only be determined on a case-by-case basis.
26 McKeown, Haase, Twomey, Pratschke and Engling, 2010e.

2 Respondent Characteristics

The vast majority of respondents are female (81%), both those who completed Questionnaire 4 (90%) and Questionnaire 5 (70%) (Table 2.1). This is consistent with the overall gender profile of HSE staff where 80% are female, but nursing staff are 92% female[27].

The mean age of ward staff (37 years) is five years younger than other hospital staff (42 years) (Table 2.2). This is also consistent with the overall age profile of staff in the Irish health services generally where nurses and health care professionals tend to be younger than other staff[28].

Ward staff have been working for the hospital for an average of 7.7 years, compared to 10 years for other hospital staff (Table 2.3). Within the ward, staff have worked there for an average of 5 years (Table 2.4).

Nearly a quarter (23%) of all staff were brought up outside Ireland (Table 2.5), much higher than in the Irish health services generally where 10% of staff are non-Irish[29]. Ward staff (31%) are much more likely to be non-Irish compared to other hospital staff (13%). The two main countries from which non-Irish staff come are the Philippines and India, which is also the main source of non-Irish staff in the Irish health services generally[30]. Consistent with this, English is the first language for the vast majority of staff (84%) (Table 2.6). However English is not the first language for nearly a quarter (24%) of ward staff.

In summary, the two sets of respondents in the survey on end-of-life culture - one selected from wards, the other from across the hospital - are broadly similar to each other and to the staff profile in Irish health services generally[31]. However, there are also significant differences between ward and hospital staff: ward staff are younger (37 compared to 42 years), more likely to be female (70% compared to 90%), have worked for a shorter time in the hospital (8 years compared to 10 years), are more likely to be non-Irish (31% compared to 13%), and to have English as a second language (24% compared to 7%). In subsequent sections, we analyse if these respondent characteristics – and others such as type of hospital, type of ward, ward position, and staff category - are associated with differences in attitude to end-of-life care.

27 HSE and Department of Health 2009: Table B3, p.61.
28 HSE and Department of Health 2009:58.
29 HSE and Department of Health 2009:62.
30 HSE and Department of Health 2009:62.
31 See HSE and Department of Health 2009.

3 Attitudes to Dying and Death

This section describes four sets of attitudes to end-of-life issues among ward and hospital staff. The first set is whether staff feel comfortable with talking about dying and death; this may by seen as an indicator of what is more usually called the fear of dying and death (Section 3.1). The second set of attitudes is about their preferred place to die, particularly the importance attached to dying at home (Section 3.2). The third set is their perception of end-of-life care in Irish hospitals (Section 3.3) while the fourth is their rating of the most, and least, important things about care when dying (Section 3.4). The questions used to measure these attitude are taken from a national survey on dying and death in Ireland[32], and were also used in our survey of bereaved relatives as reported in the third audit report[33]. As a result, we are able to assess the position of staff on these issues relative to the national population.

3.1 Feeling Comfortable Talking About Dying and Death

The fear of dying and death is common, and most people experience it, at some stage and to some degree. It is widely recognised that this fear has an influence on how each person relates to, and is able to speak about, dying and death. Naturally, this fear affects healthcare professionals as much as other people, and this has been cited as one of the reasons why end-of-life care in hospitals is often less than satisfactory[34].

Against this background, ward and hospital staff were asked two questions:

- How comfortable are you personally with talking about death or dying?
- How comfortable are you personally with talking to people who have been recently bereaved?

32 Weafer & Associates Research, 2004.

33 McKeown, Haase and Twomey, 2010c.

34 The link between the fear of dying and death, and the quality of care offered to dying patients was articulated over 40 years ago by Elisabeth Kubler-Ross – herself a medical doctor - in her pioneering work on dying and death where she writes: 'When a patient is severely ill, he is often treated as a person with no right to an opinion. … He may cry out for rest, peace, dignity, but he will get infusions, transfusions, a heart machine, or a tracheostomy. He may want one single person to stop for one single moment so that he can ask one single question – but he will get a dozen people round the clock, all busily preoccupied with his heart rate, pulse, electrocardiogram or pulmonary functions, his secretions or excretions, but not with him as a human being. … Is the reason for this increasingly mechanical, depersonalised approach our own defensiveness? Is this approach our own way to cope with and repress the anxieties that a terminally or critically ill patient evokes in us? Is our concentration on equipment, on blood pressure, our desperate attempt to deny the impending end, which is so frightening and disquieting to us that we displace all our knowledge onto machines, since they are less close to us than the suffering face of another human being, which would remind us once more of our lack of omnipotence, our own limitations and fallibility and, last but not least perhaps, our own mortality?' (Kubler-Ross, 2009:7-8). There is a large body of literature on the fear of dying and death - by philosophers, poets, religious teachers, etc – of which a key theme is that a person's response to this fear determines their likelihood of a 'good death' as well as a 'good life'. The life and work of Socrates (469-399BC) is often cited as an example of this. When condemned to death for allegedly corrupting the youth of Athens, Socrates observed that he had no fear of dying since he had been practicing death all his life because he regarded death as no more than release and separation of the soul from the limitations of the body which is also the state of wisdom sought by the true philosopher; 'If a man has trained himself throughout his life to live in a state as close as possible to death, would it not be ridiculous for him to be distressed when death comes to him? … True philosophers make dying their profession' (Plato, 2003:129). In more recent times, under the influence of Kierkegaard (1983), the American cultural anthropologist, Ernest Becker, has argued that human conditioning and culture is shaped by the need to deny death but this can be transcended through a process of self-realisation where the person 'opens himself up to infinity … links his secret inner self, his authentic talent, his deepest feelings of uniqueness to the very ground of creation' (Becker, 1974:90). A core theme in these writings is the invitation provided by dying and death to reflect on the true nature of the self, and the reality of existence which is unaffected by dying and death. This is also a central theme in eastern philosophies, articulated in the life and work of Ramana Maharshi: 'If a man considers he is born he cannot avoid the fear of death. Let him find out if he has been born or if the Self has any birth. He will discover that the Self always exists, that the body which is born resolves itself into thought and that the emergence of thought is the root of all mischief. Find wherefrom thoughts emerge. Then you will abide in the ever-present inmost Self and be free from the idea of birth or the fear of death' (Ramana Maharshi, 1989:82).

The responses reveal that nearly four out of ten staff, in both the ward (39%) and hospital (37%), are very or completely comfortable with talking about death and dying (Tables 3.1a-b). This is identical to the proportion in the national population (38%) who are very or completely comfortable with talking about death and dying, when sampling error is taken into account.

Significantly, staff are markedly less comfortable with talking to people who have been bereaved recently, just as in the national population. Nearly three out of ten staff, in both the ward (28%) and hospital (28%), are very or completely comfortable with talking to people who have been bereaved recently similar to the proportion in the national population (25%) (Tables 3.2a-b).

The most significant influence on whether staff feel comfortable talking about dying and death is their role and position in the ward and hospital. Within wards, nurse managers are the most comfortable and nurses are the least comfortable while health care assistants are consistently 10 percentage points more comfortable compared to nurses. Within the hospital, the most comfortable roles for talking about dying and death are 'other patient care' (which includes pastoral care, bereavement coordinator, end-of-life care coordinator, complaints officer, patient advice and liaison officer). Doctors and nurse specialists are also much more comfortable than other staff categories in talking about dying and death. Generally, being comfortable talking about dying and death does not vary by ward - except for intensive care which is consistently more comfortable than other wards – or by size of hospital.

3.2 Preferred Place to Die

In a national survey carried out in 2004, a clear majority of Irish people (67%) indicated that they would like to die at home with only a tenth preferring to die in a hospital (10%) or a hospice (10%)[35]. We also asked this question in our survey of ward and hospital staff and the results show a much higher preference to die at home among both ward staff (81%) and hospital staff (77%) (Table 2.3a-b). Correspondingly, the proportion preferring to die in hospital (6%) is even smaller than in the national population (10%). This finding is consistent with other studies which show that doctors and nurses have a stronger preference to die at home compared to patients[36]. The preference to die at home is higher in acute than in community hospitals and highest among medical and nursing staff.

3.3 Quality of End-of-Life Care in Irish Hospitals

Hospital staff were asked to give their perception of end-of-life care in Irish hospitals generally, and not just their own specific hospital. In the national population survey, nearly six out of ten (57%) rated end-of-life care as good or excellent but this rose to three quarters (75%) among those who had someone close who died in an Irish hospital in the past two years[37]. By contrast, 63% of staff rated the end-of-life care in

35 Based on a survey of 1,000 adults aged 15+ in the Republic of Ireland, carried out in 2004 (Weafer and Associates Research, 2004).

36 This is based on a survey of 1,899 ICU doctors, nurses and patients in six European countries, who were asked where they would rather be if they had a terminal illness with only a short time to live; the results showed that more doctors and nurses would prefer to be at home or in a hospice and more patients and families preferred to be in an ICU (Sprung, Carmel, Sjokvist, et al., 2007). The same study also revealed that physicians provide more extensive treatment to seriously ill patients than they would choose for themselves, possibly indicating a public demand for life-prolonging interventions that may have little prospect of success.

37 Weafer & Associates Research, 2004: Figures 12 and 15, pages 16 and 19. This suggests that people's experience of hospitals tends to be quite positive and, perhaps more significantly, tends to be more positive among those who speak from direct experience of hospital services. This is consistent with a study in 2007 by HSE's Office of Consumer Affairs, comprising a random sample of 3,517 Irish people, on experiences of public health and social

Irish hospitals as good or excellent (Table 2.4a-b). This is significantly lower compared to the general population who have had direct experience of the hospital's end-of-life care in the past two years.

3.4 The Most Important Things About Dying

Staff were asked to list the most important things about care when dying. The two most important things, by a wide margin, are: to be free from pain (86%) and to be surrounded by loved ones (87%) (Table 2.5a-b). These are also the two most important things about care when dying in the national population and among relatives in the audit, respectively: (i) to be free from pain (55% and 57%) and (ii) to be surrounded by loved ones (68% and 20%).

Similarly, there is broad agreement between staff and the general population in their rating of the least important aspects of care when dying. The three least important things for staff are: spiritual support (13% compared to 19% in the general population), medical and nursing support (19% compared to 32% in general population), and a private space (25% compared to 11% in the general population).

These results suggest that staff share the same broad priorities as the general public on the things that are most, and least, important about end-of-life care. However staff place lesser value on medical and nursing support compared to the general public, possibly reflecting their awareness of its limitations. They also give a lower rating for the quality of end-of-life care in Irish hospitals compared to the general population. Conversely, hospital staff place much greater importance on a private space compared to the general public, which may also be informed by their day-to-day experience of the difference that a single room can make to a dying patient.

3.5 Summary

This section described four sets of attitudes to end-of-life issues among ward and hospital staff. The first set is about the fear of dying and death, and shows that staff are no different to the national population in that nearly four out of ten (39%) are 'very or completely comfortable' with talking about death and dying. However, they are markedly less comfortable with talking to people who have been bereaved recently (28%), as in the national population. Doctors, nurse managers, nurse specialists, and pastoral care staff are the most comfortable talking about dying and death, but nurses are the least comfortable and are 10 percentage points less comfortable compared to health care assistants. The second set of attitudes is about the preferred place to die, and the preference to die at home is much stronger among staff (79%) compared to the national population (67%). This finding is consistent with other studies which show that doctors and nurses have a stronger preference to die at home compared to patients[38], and may be related to the third set of attitudes which are about the quality of end-of-life care in Irish hospitals. Staff rate the quality of end-

care services. A sub-sample of these (344, 10%) had experience of hospital services in the last year and reported high overall levels of satisfaction on dimensions such as: effective treatment by a trusted professional (78%), involvement in decisions and respect for own preferences (75%), clear and comprehensive information (80%), emotional support, empathy and respect (83%), easy to get around the hospital (74%). However there was a marked dip in satisfaction on dimensions such as cleanliness of hospital toilets (62%), contact with the hospital by phone (69%), and car-parking facilities (46%) (UCD and Lansdowne Market Research, 2007)

38 This is based on a survey of 1,899 ICU doctors, nurses and patients in six European countries, who were asked where they would rather be if they had a terminal illness with only a short time to live; the results showed that more doctors and nurses would prefer to be at home or in a hospice and more patients and families preferred to be in an ICU (Sprung, Carmel, Sjokvist, et al., 2007). The same study also revealed that physicians provide more extensive treatment to seriously ill patients than they would choose for themselves, possibly indicating a public demand for life-prolonging interventions that may have little prospect of success.

of-life care in Irish hospitals as lower (63% rate it as good or excellent) compared to those in the national population who have had someone close die in an Irish hospital in the past two years (75% rated it as good or excellent). Finally, the fourth set of attitudes concern the most, and least, important things about care when dying. The two most important things for staff, as for the general public, are to be surrounded by loved ones and to be free from pain. There is also broad agreement between staff and the general population in their rating of the least important aspects of care when dying: spiritual support (13% compared to 19% in the general population), medical and nursing support (19% compared to 32% in general population), and a private space (25% compared to 11% in the general population).

These findings suggest that the attitudes and values of staff and the general public are broadly similar on end-of-life issues. It is true that staff have a more negative perception of end-of-life care in hospital, and of medical and nursing support generally and, perhaps because of this, have a greater preference to die at home compared to the general population. However they share the same fears about dying and death as the general population and this is an area which would merit from further reflection and attention by staff in hospitals, since it may interfere with the overall quality of end-of-life care.

It is clear that talking about dying and death, but especially talking to someone who has been bereaved recently, is not something about which the majority of staff feel very or completely comfortable. If one infers from this that talking to a patient who is dying is just as uncomfortable as talking to someone who has been bereaved recently, then it follows that many staff may feel uncomfortable around communicating with patients as well as relatives about end-of-life issues. This inference is consistent with the findings in the second[39] and third[40] audit reports which showed that communication with patients is assessed by relatives, nurses and doctors as the weakest aspect of care, and there is least agreement (10%) in their assessments on this aspect of care. It is also be consistent with another Irish study which found that hospital practitioners have difficulty talking openly, simply, and sensitively about dying and death[41].

A particularly striking aspect of the findings is that nurses who provide the day-to-day care for patients at the end of life are much less comfortable talking about dying and death compared to the health care assistants who work alongside them, but are also less comfortable than the general public. This clearly suggests that any intervention to improve end-of-life communication with patients and relatives must also address the fears that nurses have about dying and death including ultimately, their own fear of dying and death. This implies that communication skills, particularly in the context of end of life, have a personal and not just a professional dimension, thereby inviting staff into some deeper reflection on how they empathise[42] and interact[43] with

39 McKeown, Haase and Twomey, 2010b.
40 McKeown, Haase and Twomey, 2010c.
41 Quinlan and O'Neill, 2009:5, in their study of hospital practitioners, report that: 'The practice, in general, among clinicians in terms of communication around dying and death is to follow the patient's lead, to answer any direct questions. This means that clinicians seldom volunteer information. Also highlighted as problematic were euphemisms that are used by clinicians when talking to patients about dying and death. Consultants were said to be very cautions and deliberately oblique with the language they use with patients'.
42 Empathy has been described as 'the key to a caring patient-doctor relationship – the art of medicine' (Janssen, Macleod and Walker, 2008:390). Empathy has an affective component which, like sympathy, has the capacity to feel as the other person is thought to feel. However, unlike sympathy, empathy also has a cognitive component which is the capacity to reflect and understand why the other person feels as they do. The importance of empathy is underlined by the fact that it is associated with reduced symptoms and improved satisfaction for patients (Reynolds and Scott, 2000), and is a good predictor of clinical competence (Hojat, Gonnella, Nessa, et al, 2002), diagnostic accuracy and patient compliance (Roter, Stewart, Putnam, et al, 1997; Coulehan, Platt, Egener, et al, 2001).

patients, including the extent to which their relationships with patients are informed by – and infused with – compassion[44]. Inescapably, this caring relationship has a personal as well as a professional dimension and, in their practical manifestation, these dimensions are inseparable[45].

There is a strong consensus between staff and the general public that the two most important things about care when dying is to be surrounded by loved ones and to be free from pain. As regards the first of these priorities - to be surrounded by loved ones - it is clear from our analysis in the second[46] and third reports[47] that patients who die in hospital enjoy a high level of relationship well-being, while most hospitals support the patient to spend as much time as they wish with family and friends in their last days. As regards the second priority – to be free from pain – the evidence on the performance of hospitals is less than conclusive, essentially because there is a wide discrepancy in the perceptions of relatives (34%), nurses (16%) and doctors (10%) on the percent of patients who are in pain all or most of the time during the last week of life. These discrepancies raise questions about the diagnosis and treatment

43 There are numerous ways of characterising styles of interaction depending on the underlying psychological theory. One of the most respected – and which underpins most behavioural and cognitive approaches – is attachment theory which explains a person's style of interaction by the way they 'attach' or connect with people, itself influenced by their early life experience of significant others, especially parents (Bowlby, 1979; Ainsworth, 1991). Depending on those formative experiences in early life, three main types of attachment and interaction style emerge: secure attachment, insecure-avoidant attachment, and insecure-anxious attachment. A secure style is where others are regarded as reliable and available and is associated with a warm, positive and reassuring style of interaction. An insecure-avoidant style is where others are regarded as uninterested or unavailable and is associated with an interaction style that is cold, competitive and controlled. An insecure-anxious style is where others are seen as unreliable or difficult and leads to an interaction style characterised by anxiety, stress and lack of confidence. The significance of this for doctors – but which applies equally to all health professionals - has been explored in a recent article on medical education: 'Attachment theory can provide valuable insight into situations where caring is paramount. In an institutional setting, patients are typically vulnerable and searching for security. Stresses to heighten a patient's vulnerability and need for attachment include their role as an ill person, the uncertainty of their well-being, the requirement placed upon them to trust strangers, their separation from loved and reliable people, and the novel context. …… Clinicians need far more than a diagnosis in order to understand the perceptions, experiences, and resulting behavior of the person who is ill . …. . A doctor's experiences of care, his or her resulting attachment style, and the levels of support that colleagues and senior figures provide the doctor can make an important difference to the experiences and outcomes of a person under that doctor's care. …. A secure clinician is unlikely to become overwhelmed or controlling when faced with the clingy or anxious behavior typical of insecure-anxious patients.' (Janssen, Macleod and Walker, 2008:391-392).

44 It is recognised that compassionate care involves more than attending to the patient's physical needs; it also involves a dialogue between patient and caregiver where communication is 'human to human rather than clinician to patient. … In short, for healthcare professionals, compassion means seeing the person in the patient at all times and at all points of care' (Cornwell and Goodrich, 2009). According to Macleod and McPherson (2007:1591): 'The virtue of compassion is a trait combining an attitude of active regard for another's welfare with an imaginative awareness and emotional response of deep understanding, tenderness and discomfort at the other person's misfortune or suffering. It is expressed in acts of beneficence that attempt to prevent and alleviate the suffering of the other person'.

45 This is consistent with a recent review of the factors that shape the patient's experience in hospital: 'For patients in hospital, every detail of every interaction shapes the unique quality of the experience. From listening to patients, it is apparent that contact with the hospital as an organisation and with hospital personnel is shaped to a large degree by the actions, attitudes and behaviours of individual members of staff. In turn, these are shaped by their own personal experience, attitudes and values (including professional values), and by relationships between colleagues. The quality of the patient experience is also subtly shaped by the dynamics of the wider healthcare system and the political and social climate. … Moreover, because providing care exposes nurses to patients' distress, to human suffering, disability, pain, terminal illness and death, their natural human defences against psychological and emotional disturbance will, if the feelings do not receive attention, gradually and inevitably create ways of delivering care that protect nurses but are insensitive to patients. … While patients are perhaps less at risk of insensitive treatment when they are outpatients or day patients, all institutional clinical and care settings have the potential to depersonalise and dehumanise patients and caregivers. If we are concerned about the quality of patients' experience in hospital, then we need to find out how, practically, we can:

- Protect patients who are particularly at risk of insensitive treatment;
- Foster and promote compassion and empathy;
- Select staff who have the capacity to see the person in the patient;
- Support staff;
- Define behaviours that are and are not admissible;
- Give staff the courage to speak up on patients' behalf when and if the quality of care declines.' (Cornwell, 2009:1).

46 McKeown, Haase and Twomey, 2010b.

47 McKeown, Haase and Twomey, 2010c.

of pain among patients who die in Irish hospitals, and suggest the need for more robust evidence to show that hospitals have the procedures and protocols in place to make sure that pain is properly assessed and treated, and that all patients are kept free from pain, as both staff and the general public expect.

4 Ward Environment

The audit measured three aspects of the ward environment: the physical aspect, the patient aspect, and the staff aspect. The physical aspect was measured by asking staff to evaluate the ward in terms of its privacy, dignity, environment and control (Section 4.1). The patient aspect was measured by asking staff to rate the ward in terms of bed-occupancy, patient turnover, patient dependency, and patient deaths (Sections 4.2-4.5). The staff aspect was measured by staff rating the ward in terms of staff sufficiency, staff turnover, and as a workplace (Sections 4.6-4.8).

4.1 Physical Environment

There is substantial evidence that the physical characteristics of a hospital, especially its wards and rooms, influence the quality of care and the quality of life of patients. This was highlighted in a recent review of research on the use of evidence-based design in health care settings: 'Compared to 2004, the body of evidence has grown rapidly and substantially … It is now widely recognised that well designed physical settings play an important role in making hospitals less risky and stressful, promoting more healing for patients, and providing better places for staff to work'[48]. In the first audit report[49] we found that 15% of beds in hospitals are in single rooms. Despite this, the second audit report[50] found that a third of patients (33%) spent most of the last week of life in a single room, and more than four in ten (44%) died in a single room. This suggests that hospital staff try to allocate single rooms to patients in order to facilitate a more dignified death, itself indicating an awareness of the importance of single rooms at the end of life.

The survey asked ward staff to rate the physical characteristics of the ward where they work, on a scale from 1 (very poor) to 10 (excellent). This involved rating 15 aspects of the ward covering privacy (such as allowing conversations with family and staff), dignity (such as facilitating personal care and access to toilet), environment (such as experiencing nature, daylight and quiet), and control (such as altering the temperature, light or air in the room or turn on/off the TV).

The overall rating is 5.0, and is higher in community hospitals (6.4) compared to acute hospitals (4.7) (Tables 4.1a-b). It is also significantly higher in geriatric wards (6.2) and oncology wards (6.1), and lowest in A&E (2.9). The two highest ratings are for dignity (6.6) and privacy (5.8) while the lowest is for environment (4.8) and control (3.7). Health care assistants gave consistently higher ratings on all physical aspects of the ward compared to nurses and nurse managers.

This pattern of results is at variance with an independent observation of 15 acute and 5 community hospitals – all included in this audit - carried out for the HFH programme in 2007 by Tribal healthcare consultants[51]. That study gave an overall score of 3.6 out of 10 for the physical environment of these hospitals, well below the self-assessed score of ward staff (5.0). This suggests that healthcare consultants, possibly because they are more aware of what is possible, achievable and desirable in terms of evidence-based design in hospitals, are considerably more critical of hospital facilities compared to management, staff and relatives. This in turn

48 Ulrich, Zimring, Zhu, et al, 2008; Keller and Kronick, 2008; Sadler, Keller and Rostenberg, 2009. The practical implications of this research for improving the design of existing and new hospital facilities are spelt out in Sadler, Keller and Rostenberg, 2009.
49 McKeown, Haase and Twomey, 2010a.
50 McKeown, Haase and Twomey, 2010b.
51 Tribal, 2007.

underlines the vagaries of self-assessment as a method of auditing a hospital's physical environment and, as the authors of the Tribal study who pointed out, there is 'no recognised structured approach which can be used to assess these conditions [the physical conditions of hospitals] and to compare one hospital with another'[52].

4.2 Bed Occupancy

Returns in the first audit report indicate an overall bed occupancy rate of 93% for both acute and community hospitals, ranging from 75% to 100.5%[53]. Larger hospitals tend to have higher occupancy rates, at 95% and upwards and, overall, Ireland has the fourth highest bed-occupancy rate in the OECD where the average is 75%[54].

The survey revealed that nearly eight out in ten (79%) believe that the bed occupancy rate in the ward is high or very high, and this perception is much stronger in acute than in community hospitals (Table 4.2). Staff in surgical wards (87%) and A&E wards (84%) are particularly likely perceive their bed occupancy levels as high or very high. Nurse managers are much more likely to regard the bed occupancy rate as high or very high (90%) compared to nurses (78%) and health care assistants (70%).

It is true that there is no single desirable level of bed-occupancy but the rate in Ireland is generally regarded as too high because, in conjunction with existing admission and discharge policies[55], it has the effect of causing overcrowding, reducing access for new patients, increasing the risk of infection, and threatening the quality of care of patients. A recent survey on the control of infection in 49 acute hospitals in Ireland found that 'a high rate of bed occupancy compromised their ability to implement the [MRSA] guidelines'[56]. In addition, high bed occupancy has been identified as a factor which can threaten the overall quality of care[57].

4.3 Patient Turnover

Patient turnover is determined by the average length of stay and this tends to be slightly higher in acute hospitals in Ireland (6.7 days) compared to the OECD average (6.3 days)[58] In the second audit report we found that the average length of stay for patients who died in acute hospitals was 24 days; this is much higher than the national average (6.7 days) for all acute hospital in-patients, and higher

52 Tribal, 2007:iii.
53 McKeown, Haase and Twomey, 2010a.
54 OECD, 2007. The HSE bed-occupancy target for 2009 of 86% (HSE Supplementary PR Data March 2009, 2009:18; HSE National Service Plan 2009, 2008:71).
55 A random sample of 3,035 medical and surgical in-patients across 37 acute hospitals were reviewed between November 2006 and February 2007 by PA Consulting Group and Balance of Care Group (2007). The results showed that 13% could have been treated outside an acute setting, 75% of elective survey patients were admitted earlier than necessary, 39% of day patients could have been treated in an alternative setting, and discharge planning was in evidence from the notes of 40% of patients. In response to this, the HSE introduced a Code of Practice for Integrated Discharge Planning in December 2008 with the overall purpose of reducing the average length of stay in hospitals to the OECD average. This code of practice provides a framework for care and case management and comprises a suite of national standards, recommended practices, forms, toolkits, key metrics and audit tools.
56 Cited in Fitzpatrick, Roche, Cunney and Humphreys, 2009:278
57 A recent study of the factors enabling compassionate care in acute hospital settings noted that: 'The factor that has arisen again and again in terms of producing stress and reducing compassion is the heightened bed occupancy within hospitals. As hospitals cope with increasing patient demand and higher levels of throughput, it becomes even more important to address humanity within the process, dealing compassionately with staff so that they in turn can do the same for patients. There is of course nothing wrong per se with technically focused, rapid treatment, high-turnover, and short lengths of hospital stay – only a minority of patients would willingly prolong their stay in hospital – but it is important for compassion to be seen and valued as essential to the delivery of care, not an option or add-on' (Firth-Cozens and Cornwell, 2009:12).
58 OECD, 2007:73. In the HSE's 2009 National Service Plan, the target average length of stay in acute hospitals is 5.9 days (HSE National Service Plan 2009, 2008:71).

compared to those aged 65 and over (11.5 days)[59]. It is also clear that the average length of stay of patients who die in acute hospitals in Ireland is high by comparison with the UK[60] and the US[61].

The survey revealed that nearly six in ten ward staff (58%) believe that patient turnover in the ward is high or very high, and much higher in acute than community hospitals (Table 4.3). Understandably, A&E wards (82%) and surgical wards (78%) are particularly likely to be perceived as having high or very high turnover levels. Nurse managers are much more likely to regard patient turnover as high or very high (68%) compared to nurses (59%) and health care assistants (50%).

It has been observed that patient turnover combined with high occupancy levels can put pressure on the quality of care. A recent study of the factors enabling compassionate care in acute hospital settings noted that: 'The factor that has arisen again and again in terms of producing stress and reducing compassion is the heightened bed occupancy within hospitals. As hospitals cope with increasing patient demand and higher levels of throughput, it becomes even more important to address humanity within the process, dealing compassionately with staff so that they in turn can do the same for patients. There is of course nothing wrong per se with technically focused, rapid treatment, high-turnover, and short lengths of hospital stay – only a minority of patients would willingly prolong their stay in hospital – but it is important for compassion to be seen and valued as essential to the delivery of care, not an option or add-on'[62].

4.4 Patient Dependency

The survey revealed that nearly three quarters of ward staff (74%) believe that patient dependency in the ward is high or very high, with little difference between acute and community hospitals when sampling error is taken into account (Table 4.4). Dependency levels are highest in geriatric wards (83%) and intensive care (80%). Nurse managers are more likely to report high or very high dependency levels in the ward (83%) compared to nurses (74%) and health care assistants (69%).

4.5 Patient Deaths

In the first audit report, we estimated the death rate in each hospital as the number of deaths divided by the number of in-patients multiplied by 100. This reveals that the annual death rate in the acute sector is 2.8% of all in-patients (ranging from 1.3% to 4.7%) compared to a death rate of 8.4% in the community sector (ranging from 0.0% to 24.0%). The higher death rate in community hospitals is due to the much smaller number of inpatients in these hospitals relative to their number of deaths, and relative to the number of inpatients in acute hospitals. About a third of acute hospital deaths take place in either intensive care (20%) or A&E (12%), but the majority of deaths (68%) occur in other wards. The survey revealed that, for a majority of ward staff

59 Hospital In-Patient Enquiry, 2006:Table 3.9.

60 A study of 599 deaths in an acute hospital in the south west of England found that the average length of stay before death was 12 days (Abel, Rich, Griffin and Purdy, 2009:3 and Table 6). A study of 314 cancer deaths in Boston Lincolnshire between September 2006 and March 2007 found that the average length of stay before death was 16.6 days (Addicott and Dewar, 2008:Tables 4 and 7).

61 The Institute for Healthcare Improvement has adopted 7.24 days as an indicator of an efficient length of stay during the last six months of life (Martin, Nelson, Lloyd, and Nolan, 2007:6; see also Wennberg, et al, 2004). This target was set following research published by Dartmouth Atlas which showed that length of stay in the last six months of life varied across the US from 4.87 to 19.67 days for the same diagnostic categories and independently of need and outcome albeit with significant variations in cost (Wennberg, Fisher, Stukel, Skinner, Sharp, and Bronner, 2004).

62 Firth-Cozens and Cornwell, 2009:12.

(85%), deaths occur relatively infrequently at about once every two weeks or less (Table 4.5). Deaths are more frequent in acute than community hospitals, and are least frequent in geriatric and surgical wards.

4.6 Staff Sufficiency

The survey revealed that more than half the ward staff (56%) believe there is not sufficient staff on the ward (Table 4.6). The perception of insufficient staff is more likely to be found in acute hospitals (58%) than community hospitals (46%), and in A&E (74%), surgical (66%) and medical wards (65%).

4.7 Staff Turnover

In the first audit report, we estimated staff turnover - as measured by the proportion of staff employed for less than one year - at 15% in acute hospitals and 14% in community hospitals, with considerable variation around this average in both sectors. This compares to a national turnover rate of approximately 10%, with lower turnover rates among workers who are older, more skilled, and employed in the public sector[63]. The survey revealed that just over a tenth of ward staff (13%) rated turnover as high or very high (Table 4.7). Turnover rates do not vary significantly by hospital, ward or staff category. These perceptions seem to be consistent with the more objective data in the first audit report.

4.8 Workplace

The survey invited ward staff to rate their working environment, on a scale from 1 (very poor) to 10 (excellent), along six dimensions covering staff relationships, ward management, standard of care, end-of-life care, ward facilities, and as a place to work. The results yielded an overall rating 7.7 which means that more than eight out of ten staff (81%) believe their workplace is good or very good (Tables 4.8a-b).

The highest rated aspects of the ward are the standard of care (8.7), ward management (8.1) and staff relationships (7.9). Significantly, end-of-life care is rated as one of the lower aspects (7.3) along with ward facilities (6.6). The overall ratings do not vary between hospitals or between ward staff. However staff in A&E wards gave a lower overall rating compared to other wards (6.6).

4.9 Summary

This section measured three aspects of the ward environment: the physical aspect, the patient aspect, and the staff aspect. On the physical aspect, staff rated their ward at 5.0 out of 10, higher in community hospitals (6.4) and in oncology wards (6.1). The highest ratings are for dignity (6.6) and privacy (5.8), the lowest are for environment (4.8) and control (3.7). These results are higher than an independent observation of 15 acute and 5 community hospitals – all included in this audit - which gave an overall score of 3.6 out of 10 for the physical environment of these hospitals[64].

The key findings on the patient aspect of wards are that bed occupancy rates and dependency levels are perceived to be high or very high by 79% and 74% of ward staff respectively, while patient turnover, reflecting longer lengths of stay, is

63 Bergin, 2009:24
64 Tribal, 2007.

perceived by 58% of ward staff to be high or very high. Patient deaths are relatively infrequent with nearly three quarters (85%) of ward staff reporting that they occur every two weeks or less, and are even less frequent in community hospitals.

Turning to the staff aspect of wards, more than half (56%) believe there is not sufficient staff on the ward, especially in acute hospitals (58%), and in wards such as A&E (74%), surgical (66%), and medical (65%). Staff turnover is perceived to be low. The overall staff rating of the ward is relatively high (7.7 out of 10), especially its standard of care (8.7), its ward management (8.1) and its staff relationships (7.9), while lower ratings were reserved for end-of-life care (7.3) and ward facilities (6.6).

These findings suggest that while wards are busy environments, with facilities that are about average, they are nevertheless good places to work in terms of the quality of care provided and the quality of management and staff relations. However it is significant that, in the opinion of ward staff, deaths occur relatively infrequently on wards, and are rarely more frequent than once every two weeks or less. We do not know if the volume-outcome relationship – whereby a higher volume of hospital activity is associated with better outcomes[65] – applies to end-of-life care but it is noteworthy that ward staff rate the standard of end-of-life care as markedly lower than the standard of care generally. In the fifth and final audit report we will analyse if the frequency of deaths in a ward is related to the standard of end-of-life care, as the volume-outcome hypothesis would predict.

65 Numerous studies have established a direct and positive relationship between volume and outcome, particularly in the area of cancer services, whereby a higher volume of cancer operations is associated with higher outcomes in terms of survival rates. It is generally assumed that the causal sequence is from volume to outcome based on the principle that 'practice makes perfect'; the reverse causal sequence from outcome to volume – whereby better outcomes lead to a higher volume of referrals and cases – is generally discounted. The volume-outcome relationship is stated as a core principle in A Strategy for Cancer Control in Ireland (National Cancer Forum, 2006:44-45): 'There is clear evidence that people who have surgical treatment for many common cancers in centres with higher throughput, experience better quality of care and better survival rates. Services that take place in such centres are generally characterised by the following features:
• care is more specialised, thus increasing the likelihood of better survival
• there are higher caseloads of patients, increasing the experience and ability to sub-specialise of individual clinicians and clinical teams
• diagnosis and treatment planning is conducted by multidisciplinary teams
• care delivery is informed by evidence-based guidelines
• audit and other quality assurance programmes are in place
• there is participation in clinical trials and other forms of cancer research
• undergraduate and postgraduate teaching takes place'.

5 Work Satisfaction

The survey measured work satisfaction by asking ward and hospital staff: 'Overall, how satisfied are you with your current work situation?'. The response options range from 1 (very dissatisfied) to 10 (very satisfied). The results reveal significant differences between and within ward and hospital staff.

In general work satisfaction is higher among ward staff (7.3) compared to hospital staff (6.5) (Tables 5.1a-b). If work dissatisfaction is defined as scores in the 1-3 range, then twice as many hospital staff (11%) are dissatisfied with their work compared to ward staff (5%).

Work satisfaction among ward staff varies considerably between wards and hospitals. At the level of wards, the highest proportion of dissatisfied staff are to be found in A&E (16%) and the lowest in oncology (0%). At the level of hospitals, major regional hospitals have the highest levels of dissatisfaction (11%) while major teaching hospitals have the lowest levels of dissatisfaction (4%).

Work satisfaction among hospital staff varies with category of hospital and category of staff. In acute hospitals, dissatisfaction with work is twice as high (12%) as in community hospitals (6%). Doctors are the most dissatisfied group of hospital staff (15%) while the least dissatisfied are those involved in other patient care such as pastoral care, bereavement and end-of-life care (4%).

The relatively high levels of work satisfaction among ward staff (95%) and hospital staff (89%) are consistent with the results of a national survey on job satisfaction in Ireland which found 'over 90 per cent of respondents agreeing or strongly agreeing that 'in general' they are satisfied with their job'[66]. This is not unexpected given that job satisfaction tends to be higher among managers, professionals and technical staff, which constitute the majority of ward and hospital staff. Nevertheless, it is significant that dissatisfaction among ward staff in A&E (16%), and among doctors across the hospitals (15%), is much higher compared to both other staff and the national picture.

66 O'Connell and Russell, 2007:62. This study also found that job satisfaction tends to be higher among managers, professionals and technical staff and lower among sales staff and operatives while those in part-time work tend to be marginally more satisfied than those in full-time work.

6 Quality of End-of-Life Care

Ward staff were asked to rate 16 aspects on end-of-life care on their ward on a scale from 1 (very poor) to 10 (very good). The 16 aspects on end-of-life care are:

- Recognising when a patient needs palliative care rather than curative care
- Communicating with patients and relatives in a sensitive, truthful and reassuring way
- Communicating and sharing information effectively among hospital staff
- Making sure that the patient's end-of-life care is coordinated
- Giving patients an opportunity to talk about their worries and wishes
- Giving relatives or friends an opportunity to talk about their worries and wishes
- Making sure the patient's preferences are respected
- Making sure the patient is comfortable, and the ward is properly managing their pain and other symptoms
- Comforting a patient who is afraid of dying
- Supporting relatives or friends to spend time with the dying patient
- Creating a sense of dignity and respect around the moment of the patient's death
- Respecting the spiritual needs of people from different religious traditions around death
- Removing the person who has died respectfully from the ward
- Providing a mortuary that respects the dead
- Supporting bereaved relatives with information, advice and counselling as they need it
- Having clear policies and procedures for end-of-life care

The results indicate a mean score of 8.1 for all items combined, ranging from 7.7 to 8.7 (Tables 6.1a-b). The results are higher for community hospitals (8.7) than for acute hospitals (8.0). They are also higher in oncology (8.7) and geriatric wards (8.7) than in A&E (7.3). Health care assistants gave higher ratings (8.6) compared to nurses (8.0), or nurse managers (7.9).

These scores are high and show relatively little variability. By their nature, the scores reflect the 'objective' qualities of end-of-life care but also the 'subjective' qualities of how ward staff perceive it, bearing in mind that these two aspects are not easy to separate. In order to test the correspondence between objective reality and subjective perception, we examined data from other parts of the audit on different aspects of end-of-life care in each hospital. As a result, we found that although ward staff rate hospital policies and procedures on end-of-life care at 7.6, the first audit report[67] found that a third of acute hospitals had no such policies. Similarly, ward staff rated the mortuary facilities at 8.5 even though the first audit report found that, of the 21 mortuary facilities audited, each had less than half the facilities required by the Design and Dignity Guidelines[68]. Similarly, the high scores accorded by ward staff for communication with patients, managing pain and other symptoms, and supporting relatives with information and advice, are scarcely borne out by the results in the second[69] and third reports[70] where the lack of agreement on these aspects of care between relatives, nurses and doctors suggests a much less positive picture. This is an important finding and underlines the danger, for audit purposes, of asking general questions about end-of-life care – whether to ward or hospital staff - since these tend to generate general answers and, as we see, even misleading answers.

67 McKeown, Haase and Twomey, 2010a.
68 Hospice Friendly Hospitals Programme, 2008:18.
69 McKeown, Haase and Twomey, 2010b.
70 McKeown, Haase and Twomey, 2010c.

7 Acceptability of Way Patients Die

The audit borrowed a question from a study of dying in French hospitals[71] which asked nurses to rate the acceptability to them and their family or friends, of how the patient died in hospital. We used this question to assess how nurses, doctors and relatives rate the acceptability of each patient's death on a 10-point scale, from 1 (definitely not acceptable) to 10 (very acceptable), with unacceptable being defined as a score of 1-3. The results in the third audit report indicated that a fifth (21%) of relatives found the patient's death to be unacceptable, compared to nurses (13%) and doctors (3%).

Ward and hospital staff were also asked this question, albeit in more general terms: Generally, based on your experience of working in this ward [or hospital], do you feel the way patients die in this ward [or hospital] would be acceptable to you, or your family or friends?

The results indicate that the vast majority of ward staff (90%) and hospital staff (87%) regard the deaths as acceptable to them (Tables 7.1a-c). When sampling error is taken into account, these differences are probably not statistically significant.

Deaths in acute hospitals are perceived by ward and hospital staff to be more unacceptable than deaths in community hospitals. For example, 12% of ward staff in acute hospitals rate deaths as unacceptable compared to only 5% in community hospitals. Within wards, the highest rates of unacceptable deaths are to be found in A&E (26%) and the lowest in oncology (3%). Among hospital staff, health care professionals (which include radiographers, social workers, physiotherapists, etc) are more likely to rate deaths as unacceptable (18%) compared to nursing management (7%).

It is difficult to draw definitive conclusions from these findings. However, the finding that deaths are more unacceptable in acute hospitals (15%) compared to community hospitals (5%) is not borne out by the patient-level assessments of deaths reported in the second and third audit reports which showed no difference in the unacceptability of deaths between acute and community hospitals in the opinion of relatives, nurses and doctors. As in the previous section, this suggests that general questions about the acceptability of how patients die in a ward or hospital may be less reliable than more specific questions about how specific patients died.

71 Ferrand, Jabre, Vincent-Genod, et al, 2008.

8 Education, Training and Preparedness for End-of-Life Care

The survey asked ward and hospital staff to rate different types of education, training and other supports for end-of-life care. This involved rating the following statements on a scale was from 1 (not good enough) to 10 (good enough):

1. Hospital offers training on the care of patient and family at the patient's end-of-life
2. Hospital offers training in communication skills on dying, death, and bereavement, including breaking bad news to people
3. Hospital offers training in what people from different cultures expect at death
4. Hospital offers courses on understanding the effects of loss, grief and bereavement on people
5. Hospital offers courses on understanding the legal and ethical issues around end-of-life care
6. Hospital offers opportunities for debriefing, reflection and counseling
7. Hospital holds post-death reviews
8. Managers show leadership in improving end-of-life care
9. Hospital has clear policies and procedures on dying, death and bereavement
10. Hospital offers specialist knowledge and support through its palliative care service
11. Hospital encourages positive inter-disciplinary team working

The results indicate that the first seven items are rated consistently below the mid-point (5) and can therefore be regarded as less than adequate (Tables 8.1a-b). The final four statements score marginally above the mid-point and might be regarded as minimally adequate. These perceptions do not vary by type of hospital or ward, or by category of staff and, as such, represent a substantial consensus across the hospital system.

The survey also asked ward and hospital staff the following question: Since qualifying, have you gone on a formal training course on end-of-life care or palliative care? The results indicate that a fifth of ward staff (21%) received formal training post-qualification compared to just over a tenth (12%) of hospital staff (Tables 8.2a-b). Participation in training is higher in community than in acute hospitals although, in the first audit report, acute hospitals provided more in-service training than community hospitals. Among ward staff, training in end-of-life care is more likely to happen in oncology wards (32%) and be undertaken by nurse managers (35%). Among hospital staff, training is more likely to be undertaken by nursing management (35%) and those involved in other patient care such as pastoral care and bereavement counselling (46%). Nearly half the training for ward staff is provided in-house (46%) compared to just over a quarter of the training for hospital staff (28%).

The vast majority of ward staff feel prepared for the death of a patient, both professionally (92%) and personally (90%) (Tables 8.3a-b). This does not vary by type of hospital but nursing and medical are the most prepared although a significant minority of staff in surgical wards (17%) feel unprepared professionally. Hospital staff in community hospitals feel more professionally prepared (71%) compared to those in acute hospitals (62%). The categories of hospital staff who feel least prepared for dealing with the death of a patient are management and administration (58%), health care professionals such as radiographers, social workers and physiotherapist (46%), and general support staff such as porters, catering and household (37%).

These findings are in line with the expectation that those staff who are most directly involved with patients – nursing and medical staff – are most prepared professionally and personally for the death of a patient. However it is significant that the vast majority of all staff – including nursing and medical staff – have not undertaken any formal training, post qualification, in end-of-life care. The reasons for this seem to lie within the hospital itself which is consistently regarded as inadequate on many aspects of education, training and other supports for end-of-life care.

9 Supports for Staff Very Upset After a Patient's Death

It is recognised that staff need to be supported, particularly those involved in end-of-life services who may experience particular upset. These supports can be practical or emotional, and may include opportunities for debriefing, a quiet space in the hospital to reflect after a death, or access to counselling, psychological, psychiatric or bereavement support services, either inside or outside the hospital.

Ward and hospital staff were asked: In the past year, have you been very upset after a patient's death? The results reveal that just over half the ward staff (51%) felt very upset after a patient's death; of these over half (54%) needed to talk to someone, and over half of these (55%), in turn, actually talked to someone, usually inside the hospital (Tables 9.1a-b). Nurse managers are more likely to be very upset (59%) than health care assistants (44%), while staff in oncology (68%) and A&E (65%) are more likely to be very upset compared to staff in other wards (51%). Ward staff in acute hospitals are more likely to be very upset after a patient's death (55%) compared to ward staff in community hospitals (32%).

Turning to hospital staff, the survey revealed that just over a third (36%) felt very upset after a patient's death in the past year. Doctors (48%) and those involved in other patient care such as pastoral and bereavement services (43%) were more likely to feel very upset. However doctors are significantly less likely to need to talk to someone (44%) – and less likely to actually talk to someone - compared to those involved in other patient care (71%). The rate of upset among hospital staff (36%) is broadly similar across the different types of hospital and lower than the rate of upset among ward staff (51%).

Ward and hospital staff were also asked: In the future, if you were very upset after the death of a patient, what supports could you get? The results reveal that the vast majority of ward staff could rely on the support of colleagues (94%), their manager (86%), and in-house counselling (Tables 9.2a-b). Similarly for hospital staff, the vast majority could rely on the support of colleagues (94%), in-house counselling (77%), and their manager (74%). This pattern is consistent across hospitals, wards and staff positions.

These results suggest a higher rate of upset among ward staff (51%) compared to the nurses who completed Questionnaire 1 on deceased patients since only 21% of these reported feeling very upset after the death of a patient[72]. Equally, the proportion of staff who talked to someone about their upset is higher in this survey than among the nurses who completed Questionnaire 1[73]. The results of this survey suggest that the overall level of support for staff is high – in terms of supports from colleagues, managers and in-house counselling - despite the fact that, as revealed in the first audit report, many hospitals do not have a document outlining the supports that are available to staff who are involved in end-of-life services or in traumatic incidents. It is difficult to reconcile these different sets of results although the sample sizes in the survey of ward staff (n=2,358) and hospital staff (n=1,858) are sufficiently large to give them credibility.

72 McKeown, Haase and Twomey, 2010b.
73 McKeown, Haase and Twomey, 2010a.

10 Hospital Priorities

There are many aspects to the work of a hospital and, faced with competing demands and limited resources, it is inevitable that some aspects will receive greater attention than others. In view of this – and with a particular interest in the priority accorded to end-of-life care – the survey asked ward and hospital staff to rate the attention which the hospital gives to 13 different aspects of its work. This involved rating 13 aspects on a scale was from 1 (very little attention) to 10 (a lot of attention):

- Active treatment of patient's illness
- Optimising the quality of life for each patient
- Ensuring the quality of its end-of-life care
- Controlling infection
- Developing a person-centred approach to patients
- Developing a person-centred approach to staff
- Increasing patient independence and decision-making
- Making sure that all patients are treated equally
- Giving staff opportunities to develop their career
- Supporting staff who give end-of-life care
- Making sure the hospital's beliefs and principles are respected
- Avoiding legal risks and being open to legal claims
- Carrying out innovative research

The results reveal that most activities receive broadly similar attention. Among ward staff, the average level of attention is 7.1 and the range is 5.8 to 8.0, Similarly, among hospital staff, the average level of attention is 7.0 and the range is 5.3 to 8.2 (Tables 10.1a-b).

The one activity that receives the most attention, as perceived by ward staff (8.0) and hospital staff (8.2), is active treatment of the patient. Similarly, the one activity that receives the least attention, as perceived by ward staff (5.8) and hospital staff (5.3) is carrying out innovative research.

End-of-life care, though not perceived as a top priority, is perceived to receive a substantial amount of attention, according to ward staff (7.6) and hospital staff (7.4). It is significant that both ward and hospital staff perceive that different aspects of staff care – developing a person-centred approach to staff, giving staff opportunities to develop their career, supporting staff who give end-of-life care - receive less attention than all other aspects of hospital activity, apart from research.

These perceptions do not vary significantly by ward or by category of staff. However, compared to acute hospitals, community hospitals give consistently higher ratings for every single activity. For example, in the case of 'active treatment of patient's illness', acute hospitals rate this from 7.9 (according to ward staff) to 8.1 (according to hospital staff), but community hospitals rate it from 8.5 (according to ward staff) to 8.3 (according to hospital staff). Similarly, in the case of 'carrying out innovative research', acute hospitals rate this from 5.3 (according to hospital staff) to 5.7 (according to ward staff) but community hospitals rate it from 5.7 (according to hospital staff) to 6.3 (according to ward staff). By any objective standards, acute hospitals give more attention than community hospitals to both the active treatment of illness and to carrying out innovative research. This suggests that staff in community hospitals have a perception of their activities that is relatively isolated from the boarder hospital sector. Given that the sample of staff from community hospitals is substantial (n=382) and geographically dispersed, this suggests that they may have

internalised a set of self-referential standards that are out of touch with the broader hospital sector and, in the cognitive sense, could be regarded as ‘distorted perceptions’.

It is clear from the survey that while end-of-life care is not perceived by staff as a top priority for the hospital, it is far from being regarded as a neglected activity. Indeed, ward and hospital staff in both the acute and community sectors regards various aspects of care for staff – developing a person-centred approach to staff, giving staff opportunities to develop their career, supporting staff who give end-of-life care - as a much lower priority for the hospital compared to end-of-life care. While these priorities are not incompatible, the results suggest that staff-care is perceived to be more neglected than end-of-life care and, correspondingly, in need of more attention within hospitals. In other words, these findings do not suggest a demand for more attention to be given to end-of-life care within hospitals.

11 Religious Ethos

One aspect of the ethos of a hospital is the extent to which religious beliefs inform some or all of its work. As with other parts of the survey, our interest is in whether the intensity of a hospital's religious ethos has any influence on the outcomes of end-of-life care. We measured religious ethos on a three-point scale: non-religious, fairly religious, very religious.

The results show that hospitals tend to be perceived as either fairly religious or very religious. Very few staff, at either ward-level (6%) or hospital-level (12%), perceive hospitals to be non-religious (Table 11).

The majority of ward staff (65%) and hospital staff (72%) perceive their hospital to be fairly religious. However ward staff are more likely to regard their hospital as very religious (29%) compared to hospital staff (16%), possibly because its religious ethos is more visible on wards, especially in the context of end-of-life care. Staff in community hospitals are twice as likely to perceive their hospital as very religious compared staff in acute hospitals.

These results suggest that all hospitals have a religious ethos. While ward staff are more conscious of this, it is clear that all hospital staff are also aware of it. It is possible that the degree of variation in religious ethos may be understated by the use of a thee-point scale which, in turn, may make it more difficult to identify a connection between it and end-of-life outcomes, if there is one. We report on this in the fifth audit report[74].

74 McKeown, Haase, Twomey, Pratschke and Engling, 2010e.

12 Conclusions and Issues for Consideration

Every organisation has a 'culture' of underlying beliefs and values which manifest in its behaviour and performance. The culture of an organisation is often described as like an iceberg because it mainly comprises unspoken, and often unconscious, assumptions which lie beneath the surface[75]. Given that actual behaviour is often a surer indicator of organisational culture than stated beliefs and values, there are some risks attached to the data in this report because it is based on a survey of staff attitudes to various aspects of the hospital, including its end-of-life care. Throughout the report we checked, wherever possible, the subjective perceptions of staff against other data sources and this indeed revealed substantial and consistent discrepancies between the two, and led us to the view that acute and community hospitals, while part of the same hospital sector, seem to have somewhat different sub-cultures and different ways of evaluating their hospital and its standard of service. This illustrates both the strength as well as the weakness of our approach, and also underlines why other methods for accessing hospital culture – such as critical incident analysis[76], focus groups[77], case studies[78], use of emotional touchpoints[79] – have a role to play in revealing the contents of hospital culture.

Our interest in hospital culture is primarily from the perspective of understanding how it may influence the hospital's end-of-life care. For that reason, the ultimate test of the extent to which this report captures something important about hospital culture will depend on whether any aspect of culture, as we have documented it, can be shown to influence the patient's quality of care at the end of life. The results of that test, will involve detailed statistical analysis, and are in the fifth audit report.

The study is based on two datasets derived from a survey of: (i) 2,358 ward staff equivalent to a response rate of 83%; and (ii) 1,858 hospital staff equivalent to a response rate of 64%. The vast majority of these staff are female (81%), much like the gender profile of HSE staff in general[80]. Nearly a quarter (23%) of all staff were

75 Scott, Mannion, Davies and Marshall, 2003:125.

76 Critical incident analysis was used effectively in a study by Keegan et al, 1999: Chapter Eight. This study, based on 155 relatives of patients who died in St. James's Hospital, Dublin between July 1996 and June 1997. Relatives were asked to describe 'specific events which were meaningful to them and signified either positive or negative features of the care received' (Ibid:53). This yielded nearly twice as many negative (568) as positive (297) incidents.

77 This method was used in a study at Our Lady of Lourdes Hospital in Drogheda (Browne, O'Mahony and MacEochaidh, 2005).

78 This method was used in a study commissioned of hospitals in the Hospice Friendly Hospitals Programme and involved collecting data on good and bad deaths in these hospitals using 102 written narratives, 57 interviews with hospital practitioners, and 14 focus 14 focus groups with 104 practitioners (Quinlan and O'Neill, 2009).

79 This method has been used in a number of care settings in Scotland as part of a Leadership in Compassionate Care Programme (Dewar, Mackay, Smith, Pullin and Tocher, 2009). The method involves asking the patient to speak about a number of different points, or touchpoints, in the patients journey. Emotional touchpoints might include: coming into the hospital, going for tests, mealtimes, visiting times, night-times, talking with doctors and nurses, etc. A range of emotional words are printed on cards – such as numb, powerless, bewildered, happy, curious, hopeful and encouraged - and the patient is asked to select the emotion that matches the touchpoint and then elaborate. These different elements of the method are integrated as follows: 'The patient or family member was invited to discuss their experiences of being in hospital. This was conducted in a private room on the ward. The touchpoints were laid out on a table and the patient was invited to select, from these touchpoints, those that they would like to talk about. They were also asked if there were other key moments that they would like to discuss. … . Taking each touchpoint in turn the storyteller was then asked to describe what happened and select from the emotional words those that best summed up for them how that experience felt. There were blank cards that could be used if the patient used an emotional word that is not in the pre-prepared collection of emotional words. They were then invited to say why they felt this way. If appropriate, they were also asked to discuss how things could have been different, particularly if the emotion identified was a negative one. Talking with patients about what they see as potential solutions to issues they have raised helps patients to co-design the service rather than being passive givers of information' (Ibid:32). Following the interview, the story is written up and the patient is given an opportunity to read and adapt as wished. Significantly, the authors emphasise that 'there needs to be a strong connection between the story and action. The stories need to be linked with other evidence and put into the context of the culture so that meaningful learning and action can be facilitated' (Ibid:34).

80 HSE and Department of Health 2009: Table B3, p.61.

brought up outside Ireland and, as a result, English is not the first language for nearly a quarter of ward staff.

It might be expected that staff in hospital, especially those who work in wards, would be more comfortable talking about dying and death compared to the general population, but this is not the case. The survey showed that while four in ten staff are 'very or completely comfortable' with talking about death and dying, they are markedly less comfortable, by 10 percentage points, with talking to people who have been bereaved recently, as in the national population. It is true that doctors, nurse managers, nurse specialists, and pastoral care staff are the most comfortable talking about dying and death, but nurses are among the least comfortable and are 10 percentage points less comfortable compared to health care assistants.

It might also be expected that hospital staff would have a greater preference to die in hospital compared to the general population, but that is not the case either. Hospital staff much prefer to die at home compared to the national population[81], a finding consistent with other studies which show that doctors and nurses have a stronger preference to die at home compared to patients[82]. Similarly, hospital staff rate the end-of-life care in Irish hospitals as significantly lower compared to those in the general population who have had direct experience of end-of-life care in hospital in the past two years (75%)[83]. There is however consensus between hospital staff and the general public that the two most important things about care when dying are: to be free from pain and to be surrounded by loved ones.

Wards, as described by their staff, are busy but good places to work in terms of the quality of care provided and the quality of management and staff relations, and the overall quality of facilities. The vast majority of ward staff (90%) and hospital staff (87%) regard deaths in the ward and hospital as acceptable to them. However, deaths occur relatively infrequently on wards, and are rarely more frequent than once every two weeks or less. This raises the question of whether the volume-outcome relationship – whereby a higher volume of hospital activity is associated with better outcomes[84] – applies to end-of-life care as to many other hospital activities. End-of-

81 Based on a survey of 1,000 adults aged 15+ in the Republic of Ireland carried out in 2004 (Weafer and Associates Research, 2004).

82 Sprung, Carmel, Sjokvist, et al., 2007.

83 Weafer & Associates Research, 2004: Figures 12 and 15, pages 16 and 19. This suggests that people's experience of hospitals tends to be quite positive and, perhaps more significantly, tends to be more positive among those who speak from direct experience of hospital services. This is consistent with a study in 2007 by HSE's Office of Consumer Affairs, comprising a random sample of 3,517 Irish people, on experiences of public health and social care services. A sub-sample of these (344, 10%) had experience of hospital services in the last year and reported high overall levels of satisfaction on dimensions such as: effective treatment by a trusted professional (78%), involvement in decisions and respect for own preferences (75%), clear and comprehensive information (80%), emotional support, empathy and respect (83%), easy to get around the hospital (74%). However there was a marked dip in satisfaction on dimensions such as cleanliness of hospital toilets (62%), contact with the hospital by phone (69%), and car-parking facilities (46%) (UCD and Lansdowne Market Research, 2007)

84 Numerous studies have established a direct and positive relationship between volume and outcome, particularly in the area of cancer services, whereby a higher volume of cancer operations is associated with higher outcomes in terms of survival rates. It is generally assumed that the causal sequence is from volume to outcome based on the principle that 'practice makes perfect'; the reverse causal sequence from outcome to volume – whereby better outcomes lead to a higher volume of referrals and cases – is generally discounted. The volume-outcome relationship is stated as a core principle in A Strategy for Cancer Control in Ireland (National Cancer Forum, 2006:44-45): 'There is clear evidence that people who have surgical treatment for many common cancers in centres with higher throughput, experience better quality of care and better survival rates. Services that take place in such centres are generally characterised by the following features:

- care is more specialised, thus increasing the likelihood of better survival
- there are higher caseloads of patients, increasing the experience and ability to sub-specialise of individual clinicians and clinical teams
- diagnosis and treatment planning is conducted by multidisciplinary teams
- care delivery is informed by evidence-based guidelines
- audit and other quality assurance programmes are in place
- there is participation in clinical trials and other forms of cancer research

life care, though not the top priority for the hospital, is perceived to receive a substantial amount of attention, according to ward and hospital staff.

Over half the ward staff (51%) felt very upset after a patient's death during the past year; this is high compared to nurses who completed the audit on deceased patients where only 21% reported feeling very upset after a patient's death. However the vast majority of ward and hospital staff can rely on the support of colleagues, their manager, and in-house counselling if they feel very upset at the death of a patient. The majority of ward staff (65%) and hospital staff (72%) perceive their hospital to be fairly religious and very few staff describe their hospital as non-religious.

These findings offer some insight into the nature of hospital culture, including some of the challenges involved in describing that culture accurately. While further analysis will be undertaken in the fifth audit report on the influence of hospital culture on end-of-life outcomes, the findings presented here raise a number of issues about the context and challenge of end-of-life care in Irish hospitals. We now outline seven separate issues which arise from this part of the audit.

12.1 Fear of Dying and Death

Hospital staff, especially those who work in wards, are no more, or less, comfortable talking about dying and death compared to the general population. This may come as a surprise given that they encounter dying and death much more frequently in their work. Given their key role in end-of-life care, the fears of staff about dying and death merits further reflection and attention by hospitals. It is clear that talking about dying and death, but especially talking to someone who has been bereaved recently, is not something about which the majority of staff feel very or completely comfortable. If one infers from this that talking to a patient who is dying is just as uncomfortable as talking to someone who has been bereaved recently, then it follows that many staff may feel uncomfortable around communicating with patients as well as relatives about end-of-life issues. This inference is consistent with the findings in the second[85] and third[86] audit reports which showed that communication with patients was assessed by relatives, nurses and doctors as the weakest aspect of care, and there was least agreement (just 10%) in their assessments on this aspect of care. It is also consistent with another Irish study which found that hospital practitioners have difficulty talking openly, simply, and sensitively about dying and death[87].

A particularly striking aspect of the findings is that nurses who provide the day-to-day care for patients at the end of life are much less comfortable talking about dying and death compared to the health care assistants who work alongside them, but are also less comfortable than the general public. This clearly suggests that any intervention to improve end-of-life communication with patients and relatives must also address the fears that nurses have about dying and death including ultimately, their own fear of fear of dying and death[88]. This implies that communication skills, particularly in the

• undergraduate and postgraduate teaching takes place'.

85 McKeown, Haase and Twomey, 2010b.

86 McKeown, Haase and Twomey, 2010c.

87 Quinlan and O'Neill, 2009:5, in their study of hospital practitioners, report that: 'The practice, in general, among clinicians in terms of communication around dying and death is to follow the patient's lead, to answer any direct questions. This means that clinicians seldom volunteer information. Also highlighted as problematic were euphemisms that are used by clinicians when talking to patients about dying and death. Consultants were said to be very cautions and deliberately oblique with the language they use with patients'.

88 The link between the fear of dying and death, and the quality of care offered to dying patients was articulated over 40 years ago by Elisabeth Kubler-Ross – herself a medical doctor - in her pioneering work on dying and death where she writes: 'When a patient is severely ill, he is often treated as a person with no right to an opinion. … He may cry out for rest, peace, dignity, but he will get infusions, transfusions, a heart machine, or a tracheostomy. He may want

context of end of life, have a personal and not just a professional dimension, thereby inviting staff into some deeper reflection on how they empathise[89] and interact[90] with patients, including the extent to which their relationships with patients are informed by – and infused with – compassion[91]. Inescapably, this caring relationship has a personal as well as a professional dimension and, in their practical manifestation, these dimensions are inseparable[92].

---

one single person to stop for one single moment so that he can ask one single question – but he will get a dozen people round the clock, all busily preoccupied with his heart rate, pulse, electrocardiogram or pulmonary functions, his secretions or excretions, but not with him as a human being. … Is the reason for this increasingly mechanical, depersonalised approach our own defensiveness? Is this approach our own way to cope with and repress the anxieties that a terminally or critically ill patient evokes in us? Is our concentration on equipment, on blood pressure, our desperate attempt to deny the impending end, which is so frightening and disquieting to us that we displace all our knowledge onto machines, since they are less close to us than the suffering face of another human being, which would remind us once more of our lack of omnipotence, our own limitations and fallibility and, last but not least perhaps, our own mortality?' (Kubler-Ross, 2009:7-8). There is a large body of literature on the fear of dying and death - by philosophers, poets, religious teachers, etc – of which a key theme is that a person's response to this fear determines their likelihood of a 'good death' as well as a 'good life'. The life and work of Socrates (469-399BC) is often cited as an example of this. When condemned to death for allegedly corrupting the youth of Athens, Socrates observed that he had no fear of dying since he had been practicing death all his life because he regarded death as no more than release and separation of the soul from the limitations of the body which is also the state of wisdom sought by the true philosopher; 'If a man has trained himself throughout his life to live in a state as close as possible to death, would it not be ridiculous for him to be distressed when death comes to him? … True philosophers make dying their profession' (Plato, 2003:129). In more recent times, under the influence of Kierkegaard (1983), the American cultural anthropologist, Ernest Becker, has argued that human conditioning and culture is shaped by the need to deny death but this can be transcended through a process of self-realisation where the person 'opens himself up to infinity … links his secret inner self, his authentic talent, his deepest feelings of uniqueness to the very ground of creation' (Becker, 1974:90). A core theme in these writings is the invitation provided by dying and death to reflect on the true nature of the self, and the reality of existence which is unaffected by dying and death. This is also a central theme in eastern philosophies, articulated in the life and work of Ramana Maharshi: 'If a man considers he is born he cannot avoid the fear of death. Let him find out if he has been born or if the Self has any birth. He will discover that the Self always exists, that the body which is born resolves itself into thought and that the emergence of thought is the root of all mischief. Find wherefrom thoughts emerge. Then you will abide in the ever-present inmost Self and be free from the idea of birth or the fear of death' (Ramana Maharshi, 1989:82).

89 Empathy has been described as 'the key to a caring patient-doctor relationship – the art of medicine' (Janssen, Macleod and Walker, 2008:390). Empathy has an affective component which, like sympathy, has the capacity to feel as the other person is thought to feel. However, unlike sympathy, empathy also has a cognitive component which is the capacity to reflect and understand why the other person feels as they do. The importance of empathy is underlined by the fact that it is associated with reduced symptoms and improved satisfaction for patients (Reynolds and Scott, 2000), and is a good predictor of clinical competence (Hojat, Gonnella, Nessa, et al, 2002), diagnostic accuracy and patient compliance (Roter, Stewart, Putnam, et al, 1997; Coulehan, Platt, Egener, et al, 2001).

90 There are numerous ways of characterising styles of interaction depending on the underlying psychological theory. One of the most respected – and which underpins most behavioural and cognitive approaches – is attachment theory which explains a person's style of interaction by the way they 'attach' or connect with people, itself influenced by their early life experience of significant others, especially parents (Bowlby, 1979; Ainsworth, 1991). Depending on those formative experiences in early life, three main types of attachment and interaction style emerge: secure attachment, insecure-avoidant attachment, and insecure-anxious attachment. A secure style is where others are regarded as reliable and available and is associated with a warm, positive and reassuring style of interaction. An insecure-avoidant style is where others are regarded as uninterested or unavailable and is associated with an interaction style that is cold, competitive and controlled. An insecure-anxious style is where others are seen as unreliable or difficult and leads to an interaction style characterised by anxiety, stress and lack of confidence. The significance of this for doctors has been explored in a recent article on medical education: 'Attachment theory can provide valuable insight into situations where caring is paramount. In an institutional setting, patients are typically vulnerable and searching for security. Stresses to heighten a patient's vulnerability and need for attachment include their role as an ill person, the uncertainty of their well-being, the requirement placed upon them to trust strangers, their separation from loved and reliable people, and the novel context. …… Clinicians need far more than a diagnosis in order to understand the perceptions, experiences, and resulting behavior of the person who is ill . …. . A doctor's experiences of care, his or her resulting attachment style, and the levels of support that colleagues and senior figures provide the doctor can make an important difference to the experiences and outcomes of a person under that doctor's care. …. A secure clinician is unlikely to become overwhelmed or controlling when faced with the clingy or anxious behavior typical of insecure-anxious patients.' (Janssen, Macleod and Walker, 2008:391-392).

91 It is recognised that compassionate care involves more than attending to the patient's physical needs; it also involves a dialogue between patient and caregiver where communication is 'human to human rather than clinician to patient. … In short, for healthcare professionals, compassion means seeing the person in the patient at all times and at all points of care' (Cornwell and Goodrich, 2009). According to Macleod and McPherson (2007:1591): 'The virtue of compassion is a trait combining an attitude of active regard for another's welfare with an imaginative awareness and emotional response of deep understanding, tenderness and discomfort at the other person's misfortune or suffering. It is expressed in acts of beneficence that attempt to prevent and alleviate the suffering of the other person'.

92 This is consistent with a recent review of the factors that shape the patient's experience in hospital: 'For patients in hospital, every detail of every interaction shapes the unique quality of the experience. From listening to patients, it is apparent that contact with the hospital as an organisation and with hospital personnel is shaped to a large degree

12.2 Understanding Negative Attitudes to Dying in Hospital

Most people die in a hospital or similar setting outside the home[93]. In view of this, and the long-term trend towards 'the hospitalisation of dying and death', it is somewhat paradoxical that the preference to die at home – and not to die in a hospital - remains so strong. Among the general population, for example, there is a strong preference to die at home (67%) but this preference is even stronger among hospital staff (79%). Other studies have also shown that doctors and nurses have a stronger preference to die at home compared to patients[94]. This may be related to the fact, established by the survey, that hospital staff rate the quality of end-of-life care in Irish hospitals as lower (63% rate it as good or excellent) compared to those in the national population who have had someone close die in an Irish hospital in the past two years (75% rated it as good or excellent). It may also be related to the fact, also established by the survey, which shows that hospital staff give much less importance to the value of medical and nursing support in end-of-life care (19%) compared to the general population (32%).

Without further analysis, it is difficult to interpret the full significance of this set of attitudes. On the one hand, it may simply indicate that hospital staff have a more realistic understanding of what 'actually' happens in hospital compared to the general public. On the other hand, this attitude may be an impediment to continuous quality improvement, unless counter-balanced by a commitment to excellence by management and staff alike. However neither of these options would seem to be fully consistent with the fact that staff regard their ward as a good place to work because of the quality of care provided and the quality of management and staff relations. Similarly, job satisfaction is generally high across all categories of hospital, with the possible exception of doctors and A&E staff. As with other findings in this report, the attitudes of staff merit further reflection within the context of the hospital to determine whether they reflect no more than personal preferences of where to die, or whether they are a more symptomatic indicator of how staff perceive the quality of the hospital's end-of-life care.

---

by the actions, attitudes and behaviours of individual members of staff. In turn, these are shaped by their own personal experience, attitudes and values (including professional values), and by relationships between colleagues. The quality of the patient experience is also subtly shaped by the dynamics of the wider healthcare system and the political and social climate. … Moreover, because providing care exposes nurses to patients' distress, to human suffering, disability, pain, terminal illness and death, their natural human defences against psychological and emotional disturbance will, if the feelings do not receive attention, gradually and inevitably create ways of delivering care that protect nurses but are insensitive to patients. … While patients are perhaps less at risk of insensitive treatment when they are outpatients or day patients, all institutional clinical and care settings have the potential to depersonalise and dehumanise patients and caregivers. If we are concerned about the quality of patients' experience in hospital, then we need to find out how, practically, we can:

- Protect patients who are particularly at risk of insensitive treatment;
- Foster and promote compassion and empathy;
- Select staff who have the capacity to see the person in the patient;
- Support staff;
- Define behaviours that are and are not admissible;
- Give staff the courage to speak up on patients' behalf when and if the quality of care declines.' (Cornwell, 2009:1).

93 In Ireland, at least half of all deaths occur in acute hospitals (48%) or hospices (4%); deaths at home still constitute a quarter of the total (25%), and a fifth die in long-stay facilities (20%); the remainder are deaths from suicide and traffic accidents (3%).

94 This is based on a survey of 1,899 ICU doctors, nurses and patients in six European countries, who were asked where they would rather be if they had a terminal illness with only a short time to live; the results showed that more doctors and nurses would prefer to be at home or in a hospice and more patients and families preferred to be in an ICU (Sprung, Carmel, Sjokvist, et al., 2007). The same study also revealed that physicians provide more extensive treatment to seriously ill patients than they would choose for themselves, possibly indicating a public demand for life-prolonging interventions that may have little prospect of success.

12.3 Most Important Things About Care When Dying

The two most important things about care when dying, for staff as for the general public, are: to be surrounded by loved ones and to be free from pain. This is an important consensus between service providers and service users, and offers an important signal on the priorities which hospitals could adopt in order to improve its end-of-life care. As regards the first of these priorities - to be surrounded by loved ones - it is clear from our analysis in the second[95] and third reports[96] that patients who die in hospital enjoy a high level of relationship well-being, while most hospitals support the patient to spend as much time as they wish with family and friends in their last days. As regards the second priority – to be free from pain – the evidence on the performance of hospitals is less than conclusive essentially because, in assessing the number of patients who are in pain all or most of the time during the last week of life, there is a wide discrepancy in the perceptions of relatives (34%), nurses (16%) and doctors (10%). These discrepancies raise questions about the diagnosis and treatment of pain among patients who die in Irish hospitals, and suggest the need for more robust evidence to show that hospitals have the procedures and protocols in place to make sure that pain is properly assessed and treated, and that all patients are kept free from pain, as both staff and the general public expect. This does not negate the case for single rooms – which are also required in order to control the spread of hospital-based infection[97] – but helps to place this priority in the broader context of the things that are most important in terms of end-of-life care.

12.4 Rating the Physical Environment of Hospitals

There is substantial evidence that the physical characteristics of a hospital, especially its wards and rooms, influence the quality of care and the quality of life of patients. This was highlighted in a recent review of research on the use of evidence-based design in health care settings: 'Compared to 2004, the body of evidence has grown rapidly and substantially … It is now widely recognised that well designed physical settings play an important role in making hospitals less risky and stressful, promoting more healing for patients, and providing better places for staff to work'[98]. Throughout the audit, we found that staff give relatively high ratings for the quality of the hospital's physical environment, despite the relative scarcity of single rooms (15%). Although just under half of all patients (48%) died in a single room, this is lower than the 70% of patients who die in single rooms in hospitals in Northern Ireland[99]. Moreover, nearly half of all patients who died in a shared room would have preferred a single room (45%). In previous audit reports we suggested that the tendency by staff to over-rate the physical environment of hospitals may be due to a lack of awareness about what is possible and desirable in terms of evidence-based design in hospitals. However the results of this survey offer an additional explanation which is that, among the things that are important about care when dying, privacy is close to the bottom of the list for both hospital staff as for the general public.

95 McKeown, Haase and Twomey, 2010b.
96 McKeown, Haase and Twomey, 2010c.
97 Cited in Fitzpatrick, Roche, Cunney and Humphreys, 2009; see also Dowdeswell, Erskine and Heasman, 2004.
98 Ulrich, Zimring, Zhu, et al, 2008; Keller and Kronick, 2008; Sadler, Keller and Rostenberg, 2009. The practical implications of this research for improving the design of existing and new hospital facilities are spelt out in Sadler, Keller and Rostenberg, 2009.
99 This estimate is taken from the audit of dying, death and bereavement in Northern Ireland. Most deaths were in the three areas of general medicine (40%), elderly care (20%) and general surgery (10%) where the proportion 'cared for in a single room on more than 75% of occasions' is 65%, 75% and 80% respectively (Northern Ireland Health and Social Care Bereavement Network, 2009:6 and 28). From this it is a reasonable inference that around 70% of deaths are in single rooms.

12.5 Is There a Separate Sub-Culture in Community Hospitals?

There is no official definition of a 'community hospital' in Ireland but the convention is to differentiate it from an 'acute hospital' if it does not have an accident and emergency department. Community hospitals are effectively long-stay facilities but offer a higher level of medical support compared to the average nursing home. Our analysis in the first audit report indicated that there are some similarities between community hospitals and acute hospital in terms of the age of the buildings (about 60% are pre-1960), the standard of mortuaries (both have about 40% of the recommended facilities), the proportion of single rooms (15%), and bed occupancy levels (93%). However, community hospitals tend to have a less developed infrastructure for end-of-life care than acute hospitals; for example, most do not have palliative care staff, they provide less induction and in-service training in end-of-life issues, and most do not have a bereavement service.

In view of these objective differences between the two sectors, it is striking that staff ratings for various aspects of their hospital activity – and not just end-of-life care - are consistently higher in community hospitals than in acute hospitals. For example, staff were asked to rate the attention given by their hospital to 13 separate activities and the results show that, compared to acute hospitals, community hospitals give consistently higher ratings for every single activity. For example, in the case of 'active treatment of patient's illness', acute hospitals rate this from 7.9 (according to ward staff) to 8.1 (according to hospital staff) but community hospitals rate it from 8.3 (according to hospital staff) to 8.5 (according to ward staff). Similarly, in the case of 'carrying out innovative research', acute hospitals rate this from 5.3 (according to hospital staff) to 5.7 (according to ward staff) but community hospitals rate it from 5.7 (according to hospital staff) to 6.3 (according to ward staff). By any objective standards, acute hospitals give more attention than community hospitals to both the active treatment of illness and to carrying out innovative research, and this suggests that staff in community hospitals have a perception of their activities that is relatively isolated from the boarder hospital sector.

As regards end-of-life care, ward staff were asked to rate, on a 1-10 scale, 16 aspects of this care. The results show that the ratings of staff in community hospitals are consistently higher, for every item, compared to acute hospitals. It is true that all of the ratings are high when compared to more objective evidence in the audit; for example, mortuary facilities are rated 8.7 in community hospitals and 8.5 in acute hospitals even though most mortuaries have only 40% of the recommended facilities. Similarly, many hospitals do not have clear policies and procedures on end-of-life care but this item is rated 8.6 in community hospitals and 7.3 in acute hospitals. Nevertheless, it appears that staff in community hospitals have a different and less demanding set of standards compared to acute hospitals. Other examples include the physical environment of the ward which is rated by staff in community hospitals at 6.4 out of 10 compared to 4.7 out of 10 in acute hospitals, although it is doubtful if these reflect objective differences. Similarly, ward staff in community hospitals rate 5% of deaths in the hospital as unacceptable compared to 12% in acute hospitals.

These examples suggest that there are systematic differences in how staff in acute and community hospitals rate the standard of their service. The consistently higher scores found in community hospitals, often not supported by objective evidence, suggests that staff in these hospitals may be applying, albeit implicitly, a more lenient standard of judgement to that found in acute hospitals. Given the substantial sample size involved (382 staff in 19 community hospitals) and its wide geographical dispersal, this suggests that staff in community hospitals may have internalised a set

of self-referential standards that are out of touch with the broader acute hospital sector and these standards could be regarded, in a cognitive sense, as 'distorted perceptions'. For these reasons, it seems justified to refer to community hospitals as having a specific sub-culture within the hospital sector. This highlights the need for national standards for end-of-life care but it also draws attention to the need for community hospitals to become a more integral part of the hospital sector.

12.6 Perceptions of Need to Improve End-of-Life Care

A core premise of the HFH programme is that there is a need to improve end-of-life care in Irish hospitals. However most hospital staff do not seem to feel such a need. Although the vast majority of ward staff (79%) and hospital staff (88%) have not undertaken any formal post-qualification training in end-of-life care, the vast majority of ward staff feel prepared for the death of a patient, both professionally (92%) and personally (90%). This is despite the fact that less than three in ten (28%) feel 'very or completely comfortable' talking to people who have been recently bereaved. It is true that some staff do not feel prepared for dealing with the death of a patient - such as management and administration (58%), health care professionals such as radiographers, social workers and physiotherapist (46%), and general support staff such as porters, catering and household (37%) – but this is understandable since they do not work full-time on wards.

The perception of many staff is that end-of-life care is not a significantly neglected aspect of the hospital's activities. It is clear from the survey that end-of-life care still receives a substantial amount of attention as reflected and in an average score of 7.5 out of 10. Indeed, ward and hospital staff in both the acute and community sectors regard various aspects of care for staff – such as developing a person-centred approach to staff, giving staff opportunities to develop their career, supporting staff who give end-of-life care - as a much lower priority for the hospital compared to end-of-life care. While these priorities are not incompatible, the results suggest that care for staff is perceived as a more neglected activity compared to end-of-life care and, correspondingly, in need of more attention within hospitals. These findings suggest that a strategy to improve the standard of end-of-life care will require a range of initiatives to raise awareness about the need for improvement as well as linking improvements to greater personal and professional support for staff.

12.7 Limitations of Survey Data for Audit Purposes

The usefulness of the data collected in this survey, as already indicated, has still to be determined by analysing how these 'cultural variables' impact on selected end-of-life outcomes in the fifth audit report[100]. However it is already clear that the pattern of responses to certain questions, when investigated against more objective data, reveals that general questions about end-of-life care – whether to ward or hospital staff – may simply generate correspondingly general, and possibly misleading, answers. For example, we found that although ward staff rate hospital policies and procedures on end-of-life care at 7.6 out of 10, the first audit report[101] found that a third of acute hospitals had no such policies. Similarly, the high scores (ranging from 7.6 to 8.7 out of 10) were given by ward staff for various aspects of care - communication with patients, managing pain and other symptoms, and supporting relatives with information and advice – are not borne out by the results in the

100 McKeown, Haase, Twomey, Pratschke and Engling, 2010e.
101 McKeown, Haase and Twomey, 2010a.

second[102] and third reports[103] where the lack of agreement on these aspects of care between relatives, nurses and doctors suggests a much less positive picture. We also found that over half the ward staff (51%) felt very upset after a patient's death but only a fifth of nurses (21%) who completed the audit on patient deaths reported feeling very upset after the death of a patient. These inconsistencies may reflect the quality of the questions, and this draws attention to limitations of the data in this report. Pending the results of the statistical analysis in the fifth audit report, this is an important lesson for the re-design of the second phase of the audit.

12.8 Concluding Comment

This report has highlighted some of the attitudes found in Irish hospitals, particularly those which we believe may be relevant to end-of-life care. As with all studies of organisational culture, we acknowledge that these attitudes may represent no more than the tip of a much larger iceberg that shapes the behaviour and performance of hospital staff. This report is part of a much larger audit and, as such, its findings contribute to the broader agenda of finding key influences on the quality of end-of-life care. The fact that issues have been identified in the report which are not normally raised in the context of quality improvement – such as the attitudes of staff to the fear of dying and death, their negative attitudes to dying in hospital, their rating of the most and least important things about care when dying, the separate staff sub-cultures in acute and community hospitals, and whether staff perceive a need to improve end-of-life care - may help broaden and deepen the process of reflection within hospitals. As with other reports in the audit, this report is an invitation to hospitals to engage with these issues and to respond appropriately.

102 McKeown, Haase and Twomey, 2010b.
103 McKeown, Haase and Twomey, 2010c.

13 Bibliography

Abel, J., Rich, A., Griffin, T., and Purdy, S.,2009. 'End-of-life care in hospital: a descriptive study of all inpatient deaths in 1 year', Palliative Medicine, 28 May.

Achterberg, WP., Gambassi, G., Finne-Soveri, H, Liperoti, R., Noro, A., Frijters, DHM., Cherubine, A., Dell'Aquila, G., and Ribbe, MW., 2009. 'Pain in European long-term care facilities: Cross-national study in Finland, Italy and the Netherlands', Pain, doi:10.1016/j.pain.2009.10.008.

Addicott, R., and Dewar, S., 2008. Improving choice at end of life: A descriptive analysis of the impact and costs of The Marie Curie Delivering Choice Programme in Lincolnshire, London: King's Fund. Available at www.kingsfund.org.ul/publications. Accessed on 14 October 2009.

Addington-Hall, JM., et al, 1992. 'Randomised Control Trial of effects of coordinating care for terminally ill caner patients', BMJ, Vol 305, pp.1317-1322.

Addington-Hall, J., and O'Callaghan, AC., 2009. 'A comparison of the quality of care provided to cancer patients in the UK in the last three months of life in in-patient hospices compared to hospitals, from the perspective of bereaved relatives: results from a survey using the VOICES questionnaire', Palliative Medicine, 23, pp.190-197.

Ainsworth, MDS., 1991. 'Attachments and other Affectional Bonds Across the Life Cycle', in Parkes, CM., Stevenson-Hindle, J., and Marris, P., (Editors), Attachment Across the Life Cycle, pp.33-51, New York: Tavistock/Routledge.

Angus, DC., Barnato, AE., Linde-Zwirble, WT., et al., 2004. 'Use of intensive care at the end of life in the United States: an epidemiologic study'. Crit Care Med, 32: 638-43.

Baker, R., Wu, A.W., Teno, J.M., Kreling, B., Damiano, A.M., Rubin, H.R., Roach, M.J., Wenger, N.S., Phillips, R.S., Desbiens, N.A., Connors, A.F., Jr., Knaus, W., & Lynn, J., 2000. 'Family satisfaction with end-of-life care in seriously ill hospitalized adults'. Journal of the American Geriatrics Society, 48(5 Suppl), S61-9.

Bate, P., Mendel, P., and Robert, G., 2008. Organizing for Quality: The Improvement Journeys of Leading Hospitals in Europe and the United States: Oxford: Radcliffe Publishing.

Bjornberg, A., Cebolla Garrofe, B., and Lindblad,A., 2009. European Healthcare Consumer Survey Index 2009: Report, Health Consumer Powerhouse. Available at www. healthpowerhouse.se. Accessed on 26 March 2010.

Bondestam, E., Hovgren, K., Gaston Johansson, F., Jern, S., Herlitz, J., and Holmberg, S., 1987. 'Pain assessment by patients and nurses in the early phase of acute myocardial infarction'. J Adv Nurs, Nov, 12(6):677-82.

Bowlby, J., 1979. The Making and Breaking of Affectional Bonds, London: Tavistock.

Bruera, E., Willey, JS., Ewert-Flannagan, PA., Cline, MK., Kaur, G, Shen, L., Zhang, T., and Palmer, JL., 2005. 'Pain intensity assessment by bedside nurses and palliative care consultants: a retrospective study'. Support Care Cancer, Apr, 13(4):228-31.

Budischewski, KM., de la Fuente, F., Nierhoff, CE., Mose, S., 2006. 'The burden of pain of inpatients undergoing radiotherapy – discrepancies in the ratings of physicians and nurses'. Onkologie, Oct, 29(10):431-5.

Casarett, D., Pickard, A., Bailey, FA., et al., 2008. 'Do palliative consultations improve patient outcomes?' Journal of American Geriatric Society, 56(4), 593-599.

Census 2006, 2007. Principal Demographic Results, March, Dublin: Stationery Office.

Chanvej, L., Petpichetchian, W., Kovitwanawong, N, Chaibandit, C., Vorakul, C., Khunthong, T., 2004. 'A chart audit of postoperative pain assessment and documentation: the first step to implement pain assessment as the fifth vital sign in a University Hospital in Thailand', J Med Assoc Thai, Dec, 87(12):1447-53.

Cohen, SR., Boston, P., and Mount, BM., 2001. 'Changes in quality of life following admission to palliative care units', Palliative Medicine, 15(5), 363-371.

Collins, N., Phelan, D., Marsh, B., and Sprung, CL., 2006. 'End-of-life care in the intensive care unit: the Irish Ethicus data', Critical Care and Resuscitation, Volume 8, Number 4, December, pp.315-320.

Commission on Patient Safety and Quality Assurance, 2008. Building a Culture of Patient Safety, July, Dublin: Stationery Office. Available at www.doh.ie

Connor, S. R., Teno, J., Spence, C., & Smith, N., 2005. 'Family evaluation of hospice care: results from voluntary submission of data via website'. Journal of Pain and Symptom Management, 30(1), 9-17.

Copeland, G., 2005. A Practical Handbook for Clinical Audit, March, Published at: http://www.evidence.nhs.uk

Cornwell, J., and Goodrich, J., 2009. 'Exploring how to enable compassionate care in hospital to improve patient experience', 21 April, www.nursing times.net.

Cornwell, J., 2009. 'Exploring how to improve patients' experience in hospital at both national and local levels', 6 July, www.nursing times.net.

Coulehan, J.L., Platt, F.W., Egener, B., et al., 2001. 'Words that help build empathy'. Annals of Internal Medicine, 135, 221–227.

Curtis, J. R., Patrick, D. L., Engelberg, R. A., Norris, K., Asp, C., & Byock, I., 2002. 'A measure of the quality of dying and death. Initial validation using after-death interviews with family members'. J Pain Symptom Manage, 24(1), 17-31.

Davoudi, N., Afsharzadeh, P., Mohammadalizadeh, S., and Haghdoost, AA., 2008. 'A comparison of patients' and nurses' assessment of pain intensity in patients with coronary artery disease', Int J Nurs Pract. October 14(5):347-56.

Department of Health, 2008. End of Life Care Strategy: Promoting high quality care for all adults at the end of life, July, January, London: Department of Health. Available at: **http://www.dh.gov.uk/en/Publicationsandstatistics/index.htm.** Accessed 30 May 2009.

Department of Health, 2009. End of Life Care Strategy: Quality Markers and measures for end of life care, June, January, London: Department of Health. Available at: **http://www.dh.gov.uk/en/Publicationsandstatistics/index.htm.** Accessed 30 May 2009.

Facility Guidelines Institute and the AIA Academy of Architecture for Health, 2006. Available at: http://www.fgiguidelines.org/guidelines.html. Accessed 20 March 2009.

Ferrand, E., Jabre, P., Vincent-Genod, C., et al, 2008. 'Circumstances of Death in Hospitalized Patients and Nurses' Perceptions', Arch Intern Med, 168(8), 28 April, 867-875.

Finne-Soveri, UH., Ljunggren, G., Schroll, M., Jonsson, P.V., Hjaltadottir, I., El Kholy, K., and Tilvis, RS., 2000. 'Pain and its association with disability in the institutional long-term care in four Nordic countries', Can J Aging 19, pp. S38–S49.

Firth-Cozens, J., and Cornwell, J., 2009. The Point of Care: Enabling compassionate care in acute hospital settings, April, London: The King's Fund. Available at: www.kingsfund.org.uk/publications.

Fries, BE., Simon, SE., Morris, JN., Flodstrom, C., and Bookstein, FL., 2001. 'Pain in U.S. nursing homes: validating a pain scale for the minimum data set', Gerontologist 41, pp. 73–179.

Edmonds, P., & Rogers, A., 2003. 'If only someone had told me . . .' A review of the care of patients dying in hospital'. Clinical Medicine, 3(2), 149-52.

Gilbert, D., 2006. Stumbling on Happiness, New York: Knopf.

Goodrich, J., and Cornwell, J., 2008. Seeing the Person in the Patient: The Point of Care review paper, November, London: The King's Fund. Available from: www.kingsfund.org.uk/publications Accessed on 8 September 2009.

Goodrich, J., 2009. 'Exploring the wide range of terminology used to describe care that is patient-centred'. Nursing Times.net, 19 May. Available at: http://www.nursingtimes.net/nursing-practice-clinical-research/acute-care/exploring-the-wide-range-of-terminology-used-to-describe-care-that-is-patient-centred/5001746.article. Accessed 24 August 2009.

Grossman, SA., Sheidler, VR., Swedeen, K., Mucenski, J., Piantadosi, S., 1991. 'Correlation of patient and caregiver ratings of cancer pain', J Pain Symptom Manage, Feb, 6(2):53-7.

Harvey, S., Liddell, A., and McMahon, L., 2009. Windmill 2009: NHS response to the financial storm, London: The King's Fund. Available from: www.kingsfund.org.uk/publications Accessed on 18 December 2009.

Health Service Executive and Irish Hospice Foundation, 2008. Palliative Care for All: Integrating Palliative Care into Disease Management Frameworks, June, . Available at: http://www.hospice-foundation.ie and http://www.hse.ie Accessed on 8 June 2009.

HSE Audit of Palliative Care Service Provision, 2007, Dublin: Health Service Executive. Available at: http://www.hse.ie/eng/services/Publications/corporate/palframework.html Accessed on 5 October 2009.

HSE National Service Plan 2009, 2008. November. Dublin: Health Services Executive. Available at: http://www.hse.ie/eng/Publications/corporate/National_Service_Plan_2009.pdf Accessed on 5 October 2009.

HSE Palliative Care Services – Five Year Development Framework 2009-2013, 2009. Dublin: Health Service Executive. Available at: http://www.hse.ie/eng/services/Publications/corporate/palframework.html Accessed on 5 October 2009.

Hearn, J., and Higginson, IJ., - Palliative Care Audit Project Group, 1999. 'Development and validation of a core outcome measure for palliative care: The palliative care outcome scale', Quality in Health Care, Vol 8, pp.219-227.

Heyland, D.K., Groll, D., Rocker, G., Dodek, P., Gafni, A., Tranmer, J., Pichora, D., Lazar, N., Kutsogiannis, J., Shortt, S., & Lam, M., 2005. 'End-of-life care in acute care hospitals in Canada: a quality finish?' Journal of Palliative Care, 21(3), 142-50.

Hodges, M., London, M.R., & Lundstedt, J., 2006. 'Family-driven quality improvement in inpatient end-of-life care'. Journal for Healthcare Quality, 28(2), 20-6, 31.

Hodde, N. M., Engelberg, R. A., Treece, P. D., Steinberg, K. P., & Curtis, J. R., 2004. 'Factors associated with nurse assessment of the quality of dying and death in the intensive care unit'. Crit Care Med, 32(8), 1648-1653.

Hojat, M., Gonnella, J.S., Nasca, T.J., et al. 2002. 'Physician empathy: Definition, components, measurement, and relationship to gender and specialty'. American Journal of Psychiatry, 159, 1563–1569.

Horton, R., 2002. 'Differences in assessment of symptoms and quality of life between patients with advanced cancer and their specialist palliative care nurses in a home care setting', Palliative Medicine, Nov, 16(6):488-94.

Hospice Friendly Hospitals Programme, 2010. Quality Standards for End-of-Life Care in Hospitals, May, Dublin: Irish Hospice Foundation. Available at http://www.hospicefriendlyhospitals.net.

Hospice Friendly Hospitals Programme, 2008. Design and Dignity Guidelines for Physical Environments of Hospitals Supporting End-of-Life Care, June, Dublin: Irish Hospice Foundation. Available at http://www.hospicefriendlyhospitals.net.

Hospice Friendly Hospitals Programme, 2007. Design and Dignity Baseline Review, November, Dublin: Irish Hospice Foundation. Available at http://www.hospicefriendlyhospitals.net.

Hospital In-Patient Enquiry, 2006. December, Dublin: Economic and Social Research Institute.

HSE National Hospitals Office, 2008. Code of Practice for Healthcare Records Management, October, Available at www.hse.ie Accessed on 16 October 2009.

Irish Life Tables No. 15, 2009. 29 January, Dublin: Central Statistics Office. Available at: http://www.cso.ie/releasespublications/documents/births_d_m/current/irishlife.pdf. Accessed 24 August 2009.

Irish Medical Council, 2004. A Guide to Ethical Conduct and Behaviour, Dublin: Irish Medical Council.

Irvine, B., 1993. 'Developments in palliative nursing in and out of the hospital setting'. British Journal of Nursing, 2(4), 218-20, 222-4.

Janssen, AL., Macleod, RD., and Walker, ST., 2008. 'Recognition, reflection, and role models: Critical elements in education about care in medicine', Palliative and Supportive Care (), 6, 389–395.

Keegan, O., McGee, H., Brady, T., Kunin, H., Hogan, M., O'Brien, S., and O'Siorain, 1999. Care for the Dying – Experiences and Challenges. A study of quality of health service care during the last year of life of patients at Saint James's Hospital, Dublin, from their relatives' perspective, February, Dublin: Royal College of Surgeons of Ireland and the Irish Hospital Foundation, and St. James's Hospital.

Keegan, O., McGee, H., Hogan, M., Kunin, H., O'Brien, S., & O'Siorain, L. 2001. 'Relatives views of health care in the last year of life'. International Journal of Palliative Nursing, 7(9), 449-456.

Keller, JA., and Kronick, K., 2008. 'Transforming care in children's hospitals through environmental design: Literature Review', in Evidence for Innovation: Transforming Children's Health Through the Physical Environment, Alexandra VA: National Association of Children's Hospitals and Associated Institutions, pp.18-47. Available at http://www.childrenshospitals.net Accessed on 26 May 2009.

Kendall, M., Harris, F., Boyd, K., Sheik, A., Murray, S., Brown, D., Mallinson, I., Kearney, N., and Woth, A., 2007. 'Key challenges and ways forward in researching the 'good death': qualitative in-depth interview and focus group study', BMJ, 334:521 (10 March).

Klinkenberg, M., Willems, DL., van del Wal, G., Degg, DJ., 2004. 'Symptom burden in the last week of life', Journal of Pain and Symptom Management, 27(1):5-13.

Kubler-Ross, E., 2009. On Death and Dying. What the Dying have to Teach Doctors, Nurses, Clergy, and their own Families. Fortieth Anniversary Edition, Oxon: Routledge.

Law Reform Commission, 2009. Bioethics: Advance Care Directives, Report, September, Dublin: Law Reform Commission,

Levy, CR., Ely, EW., Payne, K., Engelberg, RA., Patrick, DL., and Curtis, JR., 2005. 'Quality of Dying and Death in Two Medical ICUs', Chest, 127, 5, May, pp.1775-1783. Available from www.chestjournal.org

Lorenz K., Lynn, J., Morton, SC., Dy S., Mularski, R., Shugarman, L., Sun, V., Wilkinson, A., Maglione, M., Shekelle, PG., 2004. End-of-Life Care and Outcomes. Evidence Report/Technology Assessment No. 110. (Prepared by the Southern California Evidence-based Practice Center, under Contract No. 290-02-0003.) AHRQ Publication No. 05-E004-2. Rockville, MD: Agency for Healthcare Research and Quality. December 2004. Available at www.ncbi.nlm.nih.gov

Lunney JR, Lynn J, Hogan C., 2002. 'Profiles of Older Medicare Decedents', J Am Geriatr Soc, Vol. 50, No. 6, pp. 1108-1112.

Lynn J., Schuster JL., Kabcenell A., 2000. Improving Care for the End of Life: A Sourcebook for Health Care Managers and Clinicians, RAND , 2000.

Lynn J., Schall M. W., Milne C., Nolan K. M., Kabcenell A., 2000. 'Quality improvements in end-of-life care: Insights from two collaboratives'. Journal of Quality Improvement 26: (5) 254-267.

Lynn J., 2004. Sick to Death and Not Going to Take it Anymore! Reforming Health Care for the Last Years of Life, California/Milbank Books on Health and the Public, University of California Press, Berkeley, CA: 2004.

Macleod, R., and McPherson, KM., 2007. 'Care and compassion: Part of person-centred rehabilitation, inappropriate response or a forgotten art?', Disability and Rehabilitation, Ocotber-November, 29(20-21):1589-1595.

Marie Curie Palliative Care Institute Liverpool, 2007. National Care of the Dying Audit – Hospitals (NCDAH): Generic Report, 2006/2007, December, Liverpool: Marie Curie Palliative Care Institute. Available from www.mcpcil.org.uk

Marie Curie Palliative Care Institute Liverpool, 2009. National Care of the Dying Audit – Hospitals (NCDAH): Round 2, Generic Report, 2008/2009, September, Liverpool: Marie Curie Palliative Care Institute. Available from www.mcpcil.org.uk

McCormack, B., and Wright, J., 2009. The Implementation of a Model of Person Centred Practice in Older Person Settings: Interim Report, July, Newtownabbey Co. Antrim: University of Ulster.

McCarthy, S., and O'Boyle, C., 2010. Family Views of End-of-Life Care in Acute and Community Hospitals, Dublin: Royal College of Surgeons of Ireland and the Irish Hospice Foundation.

McGlone, E., and Fitzgerald, F., 2005. Perceptions on Ageism in Health and Social Services in Ireland, Report No. 85, Dublin: National Council on Ageing and Older People.

McKeown, K., 2008. National Audit of End-of-Life Care in Hospitals in Ireland, The Manual, October, Dublin: Irish Hospice Foundation. Available at http://www.hospicefriendlyhospitals.net

McKeown, K., Haase, T., and Twomey, S., 2010a. Resources and Facilities for End-of-Life Care in Irish Hospitals, National Audit Report 1, May, Dublin: Irish Hospice Foundation. Available at http://www.hospicefriendlyhospitals.net

McKeown, K., Haase, T., and Twomey, S., 2010b. Dying in Hospital in Ireland: Nurse and Doctor Perspectives, National Audit Report 2, May, Dublin: Irish Hospice Foundation. Available at http://www.hospicefriendlyhospitals.net

McKeown, K., Haase, T., and Twomey, S., 2010c. Dying in Hospital in Ireland: Family Perspectives, National Audit Report 3, May, Dublin: Irish Hospice Foundation. Available at http://www.hospicefriendlyhospitals.net

McKeown, K., Haase, T., and Twomey, S., 2010d. The Culture of End-of-Life Care in Hospital in Ireland, National Audit Report 4, May, Dublin: Irish Hospice Foundation. Available at http://www.hospicefriendlyhospitals.net

McKeown, K., Haase, T., Pratschke, J., Twomey, S., Donovan, H., and Engling, F., 2010. Dying in Hospital in Ireland: An Assessment of the Quality of Care in the Last Week of Life, May, National Audit Report 5, Dublin: Irish Hospice Foundation. Available at: http://www.hospicefriendlyhospitals.net

McPherson, GJ., and Addington-Hall, JM., 2003. 'Judging the quality of care at the end of life: can proxies provide reliable information?', Social Science and Medicine, 56, pp.95-109.

Martin-Moreno, J., Harris, M., Gorgojo, L., Clark, D., Normand, C., Centeno, C., 2008. Palliative Care in the European Union, Strasburg: European Parliament.

Martin, LA., Nelson, EC., Lloyd, RC., and Nolan, TW., 2007. Whole System Measures, Innovation Series 2007, Cambridge Massachusetts: Institute for Healthcare Improvement. Available at www.ihi.org.

Morris, JN., Murphy K., and Nonemaker, S., 1995. Long term care facility Resident Assessment Instrument (RAI) user's manual version 2.0, HCFA, Baltimore.

Morrison, RS., Penrod, JD., Cassel, JB., Caust-Ellenbogen, M., Litke, A., Spragens, L., Meier, DE., 2008. 'Cost Savings Associated with US Hospital Palliative Care Consultation Programs', Arch Intern Med, Volume 168, Number 16, 8 September.

Mularski, RA., Heine, CE., Osborne, ML., Ganzini, L., & Curtis, JR., 2005. 'Quality of dying in the ICU: ratings by family members'. Chest, 128(1), 280-287.

Mularski, RA., Curtis, JR., Osborne, ML.,, Engleberg, RA., and Ganzini, L., 2004. 'Agreement among family members in their assessment of the Quality of Dying and Death', Journal of Pain and Symptom Management, Vol 28, No 4, October, pp.3.6-315.

Mularski, RA., et al., 2007. 'A Systematic Review of Measures of End-of-Life Care and Its Outcomes', HSE: Health Services Research 42:5, October, 1848-1870.

Murphy, P., Kreling, B., Kathryn, E., Stevens, M., Lynn, J., & Dulac, J., 2000. 'Description of the SUPPORT intervention. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments'. Journal of the American Geriatrics Society, 48(5 Suppl), S154-61.

National Advisory Committee on Palliative Care, 2001. Report, Dublin: Department of Health & Children.

Nolan, A., 2007. 'Productive Ward: releasing time to care', Health Service Journal, 117, 6052, S1-S19.

National Audit Office, 2008. End of Life Care, Report by the Comptroller and Auditor General, November, London: The Stationery Office.

Northern Ireland Health and Social Care Bereavement Network, 2009. Northern Ireland Audit: Dying, Death and Bereavement, Policies, procedures and practices in hospital and hospice settings, Belfast: Department of Health, Social Services and Public Safety.

OECD, 2007. Health at a Glance 2007, November. Paris: OECD.

O'Keeffe, S. T., Noone, I., & Pillay, I., 2000. 'Telling the truth about cancer: views of elderly patients and their relatives'. Irish Medical Journal, 93(4), 104-105.

O'Mahony, S., McHenry, J., Blank, AE., Snow, D., Karakas, SE., Santoro, G., Selwyn, P. and Kvetan, V., 2009. 'Preliminary report on the integration of a palliative care team into an intensive care unit', Palliat Med OnlineFirst, 13 October, 0(00) 1-12.

PA Consulting Group, 2007. Acute Hospital Bed Capacity Review: A Preferred Health System in Ireland to 2020: Detailed Report, September, Dublin: Health Services Executive. Available at: http://www.hse.ie/eng/Publications/Hospitals/PA_Consulting_Acute_Hospital_Bed_Capacity_Review_2008.html. Accessed 20 March 2009

PA Consulting Group and Balance of Care Group, 2007. Acute Hospital Bed Review: A review of acute hospital bed use in hospitals in the Republic of Ireland with an Emergency Department, June, Dublin: Health Services Executive.

Palliative Care Australia, 2008. Standards for Providing Quality Palliative Care for all Australians, http://pallcare.org.au

Parsley, K., and Corrigan, P., 1999. Quality Improvement in Healthcare: Putting Evidence into Practice, Cheltenham, UK: Nelson Thornes Ltd.

Patrick, D. L., Engelberg, R. A., & Curtis, J. R., 2001. 'Evaluating the quality of dying and death'. J Pain Symptom Manage, 22(3), 717-726.

Picker Institute, 2005. A guide to the NHS patient survey programme, Oxford: Picker Institute. Available at: http://www.pickerinstitute.org/publications.html Accessed 3 August 2009.

Pincombe, J., Brown, M., & McCutcheon, H., 2003. 'No time for dying: a study of the care of dying patients in two acute care Australian hospitals'. Journal of Palliative Care, 19(2), 77-86.

Proctor, WR., and Hirdes, JP., 2001. 'Pain and cognitive status among nursing home residents in Canada', Pain Res Manage 6, pp. 119–125.

Puntillo, K., Miaskowski, C., Kehrle, K., Stannard, D., Gleeson, S., and Nye, P., 1997. 'Relationship between behavioural and physiological indicators of pain, critical care patients' self-reports of pain, and opioid administration', Crit Care Med. Jul, 25(7):1159-66.

Puntillo, K., Neighbor, M, O'Neill, N., and Nixon, R., 2003. 'Accuracy of emergency nurses in assessment of patients' pain', Pain Manag Nurs. Dec, 4(4):171-5.

Puntillo, K., Neighbor, M, Chan, GK., and Garbez, R., 2006. 'The influence of chief complaint on opioid use in the emergency department', J Opioid Manag. Jul-Aug, 2(4):228-35.

Quinlan, C., and O'Neill, C., 2009. Practitioners' Perspectives on patient Autonomy at End of Life, November, Dublin: Hospice Friendly Hospitals Programme.

Rhodes, RL., Mitchell, SL., Miller, SC., Connor, SR., and Teno, JM., 2008. 'Bereaved Family Members' Evaluation of Hospice Care: What Factors Influence Overall Satisfaciton with Services?', Journal of Pain and Symptom Management, Vol. 35, No. 4, April, pp.365-371.

Reinertsen,JL., Bisognano, M., Pugh, MD., 2008. Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition). IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement. Available on www.IHI.org.

Reynolds,W.J. & Scott, B., 2000. 'Do nurses and other professional helpers normally display much empathy?' Journal of Advanced Nursing, 31, 226–234.

Roter, D.L., Stewart, M., Putnam, S.M., et al., 1997. 'Communication patterns of primary care physicians', JAMA, 277, 350–356.

Sadler, BL., Keller, JA., and Rostenberg, B., 2009. Using Evidence-Based Environmental Design to Enhance Safety and Quality. Institute for Healthcare Improvement Innovation Series White Paper, Cambridge, Massachusetts: Institute for Healthcare Improvement. Available at www.IHI.org Accessed on 26 May 2009.

Sawyer, P., Lillis, P., Bodner, BS., and Allman, RM., 2007. 'Substantial daily pain among nursing home residents', J Am Med Dir Assoc 8, pp. 158–165.

Scally, G., and Donaldson, L., 1998. 'Clinical governance and the drive for quality improvement in the new NHS in England', *British Medical Journal,* 4 July, 317(7150): 61-65.

Seland, M., Kaasa, S., and Klepstad, P., 2005. 'Symptoms assessment in cancer patients on admission to hospital', Tidsskr Nor Laegeforen, Sep 22, 125(18):2500-3. [Article in Norwegian].

Sprung, CL., Cohen, SL., Sjokvist, P., et al., 2003. 'End-of-life practices in European intensive care units. The Ethicus study'. JAMA, 290: 790-7.

Sprung, CL., Carmel, S., Sjokvist, P., et al., 2007. 'Attitudes of European doctors, nurses, patients and families regarding end of life decisions'. The ETHICATT Study. Intensive Care Medicine, 33:104-110.

Stromgren, AS., Sjogren, P., Goldschmidt, D., et al., 2005. 'A longitudinal study of palliative care: patient-evaluated outcome and impact of attrition', Cancer, 103(8), 1747-1755.

Tang, ST., and Corkle, R., 2002. 'Use of family proxies in quality of life research for cancer patients at the end of life: A literature review', Cancer Invest, 20, pp.1086-1104.

Teno, JM., 2005. 'Measuring End-of-Life Outcomes retrospectively?', Journal of Palliative Medicine, Volume 8, Supplement 1, pp.S42-S49.

Teno, J. M., Clarridge, B., Casey, V., Edgman-Levitan, S., & Fowler, J., 2001. 'Validation of Toolkit After-Death Bereaved Family Member Interview', Journal of Pain & Symptom Management, 22(3), 752-758.

Tiernan, E., Connor, MO., Kearney, PM., and Siorain, L., 2002. 'A Prospective Study of Preferred Versus Actual Place of Death Among Patients Referred to a Palliative Care Home-care Service', Irish Medical Journal, Vol 95, Issue 8, September, pp.232-235.

Turner, M., 2009. 'HealthStat: measuring the performance of the Irish public health service', Journal of the Statistical and Social Inquiry Society of Ireland, Vol.38, 2008/09, pp.178-204.

UCD and Lansdowne Market Research, 2007. Insight 07: Health and Social Serivces in Ireland – A Survey of Consumer Satisfaction, Dublin: Health Services Executive. Available at http://www.hse.ie/eng/Publications/Your_Service,_Your_Say_Consumer_Affairs/Reports/Insight_07.pdf Accessed on 27 May 2009.

Ulrich, R., 2008. 'Design and Dignity: The Case for Renewing our Hospitals', Public Lecture in St. Ann's Church, Dawson St. Dublin, June. Available at http://www.hospicefriendlyhospitals.net

Ulrich, R., Zimring, C., Zhu X, et al, 2008. 'A review of the research literature on evidence-based health-care design', Health Environments Research and Design Journal, 1(3):61-125.

Vital Statistics, 2009. Annual Report for 2006, July, Dublin: Stationery Office.

Walters, G., 2004. 'Is there such a thing as a good death?', Palliative Medicine, 18:404-408.

Weafer & Associates Research with TNS MRBI, 2004. A nationwide survey of public attitudes and experiences regarding death and dying, November, Dublin: Hospice Friendly Hospitals Programme.

Weafer, J., McCarthy, J., and Loughrey, M, 2009. Exploring Death and Dying: The views of the Irish public, November, Dublin: Hospice Friendly Hospitals Programme.

Weafer, J., 2009. A Qualitative Study of Public Perceptions of End-of-Life Issues, September, Dublin: Hospice Friendly Hospitals Programme.

Wennberg, JE., Fisher, ES., Stukel, TA, Skinner, JS., Sharp, SM., and Bronner, KK., 2004. 'Use of hospitals, physician visits, and hospice care during last six months of life among cohorts loyal to highly respected hospitals in the United States', British Medical Journal, Volume 328, 13 March, pp.607-610.

Zyczkowska, J., Szczerbinska, K., Jantzi, MR., and Hirdes, JP., 2007. Pain among the oldest old in community and institutional settings, Pain 129, pp. 167–176.

14 Data Appendix

Explanatory Note:

Each table in this appendix contains a reference to one of the six questionnaires on which the data is based (Q1, Q2, Q3, Q4, Q5, or Q6). It also contains a reference to the question number within each questionnaire (A1, B2, C3, etc). Thus, Q4A1 refers to Question A1 in Questionnaire 4, Q5B2 refers to Question B2 in Questionnaire 5, etc.

1 Data Coverage and Background (Q4A, Q5A)

Table 1.1a: Sample of Respondents on Ward Data (Q4) (N)

Q4A1	Ward Data	Nurse Manager	Nurse	Health Care Assist.	Total	Total Wards
ID	**Hospital**	**n**	**n**	**n**	**n**	**n**
A01	Cork University	16	92	15	123	14
A02	Limerick Mid-Western	20	95	13	128	14
A03	Cavan General	7	31	4	42	6
A04	Monaghan General	1	16	13	30	3
A05	Lourdes Drogheda	17	65	15	97	10
A06	Our Lady's Navan	7	35	1	43	5
A07	Louth County Dundalk	6	21	4	31	6
A08	Kerry General Tralee	8	54	2	64	10
A09	Wexford General	0	28	0	28	7
A10	St James's Dublin	25	145	33	203	21
A11	Sligo General	10	43	6	59	9
A12	Mater University	21	124	26	171	18
A13	Connolly Hospital	16	83	12	111	14
A14	Letterkenny General	12	61	14	87	9
A15	St Luke's Rathgar	6	22	0	28	4
A16	Portlaoise Regional	8	23	3	34	4
A17	Beaumont	20	156	26	202	20
A18	Waterford Regional	5	114	9	128	13
A19	South Tipp General	10	31	4	45	6
A20	St Luke's Kilkenny	9	60	6	75	8
A21	Tallaght Hospital	12	69	16	97	12
A22	Nenagh Mid-Western	5	15	0	20	5
A23	Naas General	5	49	15	69	6
A24	Tullamore Regional	7	37	8	52	10
C55	St. Mary's Phoenix Park	12	54	32	98	10
C56	St John's Hospital, Sligo	5	29	13	47	5
C70	Dublin Group**	10	62	61	133	18
C80	North East Group**	12	51	50	113	16
H87	**Acute Hospitals**	**253**	**1,469**	**245**	**1,967**	**234**
H88	**Community Hospitals**	**39**	**196**	**156**	**391**	**49**
H89	**All HfH Hospitals**	**292**	**1,665**	**401**	**2,358**	**283**

Table 1.1b: Sample of Respondents on Ward Data (Q4) (%)

Q4A1	Ward Data	Nurse Manager	Nurse	Health Care Assist.	Total	Quota achieved
ID	**Hospital**	**%**	**%**	**%**	**%**	**%**
A01	Cork University	13.0	74.8	12.2	100	87.9
A02	Limerick Mid-Western	15.6	74.2	10.2	100	91.4
A03	Cavan General	16.7	73.8	9.5	100	70.0
A04	Monaghan General	3.3	53.3	43.3	100	100.0
A05	Lourdes Drogheda	17.5	67.0	15.5	100	97.0
A06	Our Lady's Navan	16.3	81.4	2.3	100	86.0
A07	Louth County Dundalk	19.4	67.7	12.9	100	51.7
A08	Kerry General Tralee	12.5	84.4	3.1	100	64.0
A09	Wexford General		100.0		100	40.0
A10	St James's Dublin	12.3	71.4	16.3	100	96.7
A11	Sligo General	16.9	72.9	10.2	100	65.6
A12	Mater University	12.3	72.5	15.2	100	95.0
A13	Connolly Hospital	14.4	74.8	10.8	100	79.3
A14	Letterkenny General	13.8	70.1	16.1	100	96.7
A15	St Luke's Rathgar	21.4	78.6		100	70.0
A16	Portlaoise Regional	23.5	67.6	8.8	100	85.0
A17	Beaumont	9.9	77.2	12.9	100	101.0
A18	Waterford Regional	3.9	89.1	7.0	100	98.5
A19	South Tipp General	22.2	68.9	8.9	100	75.0
A20	St Luke's Kilkenny	12.0	80.0	8.0	100	93.8
A21	Tallaght Hospital	12.4	71.1	16.5	100	80.8
A22	Nenagh Mid-Western	25.0	75.0		100	40.0
A23	Naas General	7.2	71.0	21.7	100	115.0
A24	Tullamore Regional	13.5	71.2	15.4	100	52.0
C55	St. Mary's Phoenix Park	12.2	55.1	32.7	100	98.0
C56	St John's Hospital, Sligo	10.6	61.7	27.7	100	94.0
C70	Dublin Group**	7.5	46.6	45.9	100	73.9
C80	North East Group**	10.6	45.1	44.2	100	70.6
H87	**Acute Hospitals**	12.9	74.7	12.5	100	**84.1**
H88	**Community Hospitals**	10.0	50.1	39.9	100	**79.8**
H89	**All HfH Hospitals**	12.4	70.6	17.0	100	**83.3**

* For each ward where a death is recorded in the audit, a quota of 10 completed questionnaires per ward was set. The % of quota is set by dividing the number of questionnaires completed (Questionnaire 4) by the number of wards, and then multiplying by 100. NA (Not Applicable) refers to hospitals with no deaths in the audit.

** *See endnotes.*

Table 1.2a: Sample of Respondents on Hospital Data (Q5) (N)

Q5A1	Hospital Data	Mgmt. Admin	Med. Dental	Nursing	Health Care Prof.	Gen. Support	Other Patient care	Total
ID	**Hospital**	**n**	**n**	**n**	**n**	**n**	**n**	**n**
A01	Cork University	27	17	2	17	23	0	86
A02	Limerick Mid-Western	23	16	2	22	22	4	89
A03	Cavan General	25	9	4	12	11	2	63
A04	Monaghan General	1	0	0	0	0	1	2
A05	Lourdes Drogheda	28	19	4	19	19	1	90
A06	Our Lady's Navan	10	6	7	5	5	2	35
A07	Louth County Dundalk	18	0	6	7	3	0	34
A08	Kerry General Tralee	14	11	3	7	15	2	52
A09	Wexford General	4	6	10	14	23	2	59
A10	St James's Dublin	27	22	7	18	21	3	98
A11	Sligo General	20	13	5	15	10	2	65
A12	Mater University	7	7	2	16	13	2	47
A13	Connolly Hospital	22	12	4	14	16	0	68
A14	Letterkenny General	11	7	1	14	14	1	48
A15	St Luke's Rathgar	28	4	5	14	4	2	57
A16	Portlaoise Regional	27	8	3	9	25	1	73
A17	Beaumont	29	22	2	20	25	2	100
A18	Waterford Regional	33	19	2	17	18	3	92
A19	South Tipp General	19	3	2	17	16	1	58
A20	St Luke's Kilkenny	17	9	1	19	11	2	59
A21	Tallaght Hospital	15	9	2	13	10	1	50
A22	Nenagh Mid-Western	12	0	15	18	16	1	62
A23	Naas General	28	19	2	20	26	3	98
A24	Tullamore Regional	14	5	1	11	7	2	40
C55	St. Mary's Phoenix Park	12	2	7	7	21	1	50
C56	St John's Hospital, Sligo	11	0	1	3	18	2	35
C70	Dublin Group**	61	8	24	29	59	5	186
C80	North East Group**	17	0	13	5	23	4	62
H87	**Acute Hospitals**	**459**	**243**	**92**	**338**	**353**	**40**	**1,525**
H88	**Community Hospitals**	**101**	**10**	**45**	**44**	**121**	**12**	**333**
H89	**All HfH Hospitals**	**560**	**253**	**137**	**382**	**474**	**52**	**1,858**

Table 1.2b: Sample of Respondents on Hospital Data (Q5) (%)

Q5A1	Hospital Data	Mgmt. Admin	Med. Dental	Nursing	Health Care Prof.	Gen. Supp.	Other Patient care	Total	Quota achiev-ed
ID	**Hospital**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
A01	Cork University	31.4	19.8	2.3	19.8	26.7		100	86.0
A02	Limerick Mid-Western	25.8	18.0	2.2	24.7	24.7	4.5	100	89.0
A03	Cavan General	39.7	14.3	6.3	19.0	17.5	3.2	100	63.0
A04	Monaghan General	50.0					50.0	100	2.0
A05	Lourdes Drogheda	31.1	21.1	4.4	21.1	21.1	1.1	100	90.0
A06	Our Lady's Navan	28.6	17.1	20.0	14.3	14.3	5.7	100	35.0
A07	Louth County Dundalk	52.9		17.6	20.6	8.8		100	34.0
A08	Kerry General Tralee	26.9	21.2	5.8	13.5	28.8	3.8	100	52.0
A09	Wexford General	6.8	10.2	16.9	23.7	39.0	3.4	100	59.0
A10	St James's Dublin	27.6	22.4	7.1	18.4	21.4	3.1	100	98.0
A11	Sligo General	30.8	20.0	7.7	23.1	15.4	3.1	100	65.0
A12	Mater University	14.9	14.9	4.3	34.0	27.7	4.3	100	47.0
A13	Connolly Hospital	32.4	17.6	5.9	20.6	23.5		100	68.0
A14	Letterkenny General	22.9	14.6	2.1	29.2	29.2	2.1	100	48.0
A15	St Luke's Rathgar	49.1	7.0	8.8	24.6	7.0	3.5	100	57.0
A16	Portlaoise Regional	37.0	11.0	4.1	12.3	34.2	1.4	100	73.0
A17	Beaumont	29.0	22.0	2.0	20.0	25.0	2.0	100	100.0
A18	Waterford Regional	35.9	20.7	2.2	18.5	19.6	3.3	100	92.0
A19	South Tipp General	32.8	5.2	3.4	29.3	27.6	1.7	100	58.0
A20	St Luke's Kilkenny	28.8	15.3	1.7	32.2	18.6	3.4	100	59.0
A21	Tallaght Hospital	30.0	18.0	4.0	26.0	20.0	2.0	100	50.0
A22	Nenagh Mid-Western	19.4		24.2	29.0	25.8	1.6	100	62.0
A23	Naas General	28.6	19.4	2.0	20.4	26.5	3.1	100	98.0
A24	Tullamore Regional	35.0	12.5	2.5	27.5	17.5	5.0	100	40.0
C55	St. Mary's Phoenix Park	24.0	4.0	14.0	14.0	42.0	2.0	100	50.0
C56	St John's Hospital, Sligo	31.4		2.9	8.6	51.4	5.7	100	35.0
C70	Dublin Group**	32.8	4.3	12.9	15.6	31.7	2.7	100	31.0
C80	North East Group**	27.4		21.0	8.1	37.1	6.5	100	15.5
H87	**Acute Hospitals**	**30.1**	**15.9**	**6.0**	**22.2**	**23.1**	**2.6**	**100**	**63.5**
H88	**Community Hospitals**	**30.3**	**3.0**	**13.5**	**13.2**	**36.3**	**3.6**	**100**	**27.8**
H89	**All HfH Hospitals**	**30.1**	**13.6**	**7.4**	**20.6**	**25.5**	**2.8**	**100**	**51.6**

*A quota of 100 completed questionnaires was set for hospitals with 100 or more staff. The % of quota is set by dividing the number of questionnaires completed (Questionnaire 5) by 100, and then multiplying by 100. NA (Not Applicable) refers to hospitals with less than 100 staff.

Table 1.3: Type of Wards in Sample of Ward Staff (Q4) and Patient Deaths (Q1&2)

Q5	Ward Data	n	% Wards	% Wards with Deaths in Audit
H97	**Acute Hospitals**	**1,967**	**100**	**100**
	A & E	134	6.8	4.7
	ICU	393	20.0	20.5
	Surgical	390	19.8	14.0
	Medical	672	34.2	47.0
	Oncology	108	5.5	4.8
	Geriatric	115	5.8	3.3
	Other	155	7.9	5.8
H98	**Comm. Hospitals**	**391**	**100**	**100**
	Geriatric	354	90.5	88.2
	Other	37	9.5	11.8
H99	**Total**	**2,358**	**100**	**100**

2 Respondent Characteristics

Table 2.1: Gender of Respondents

	Ward and Hospital Data	Male %	Female %	Total %	n
Q4A5	All HfH Hospitals (Q4)	9.9	90.1	100	2,334
Q5A4	All HfH Hospitals (Q5)	29.6	70.4	100	1,849

Table 2.2: Age of Respondents

	Ward and Hospital Data	Under 25 %	25-34 %	35-44 %	45-54 %	55+ %	Total %	Mean	n
Q4A5	All HfH Hospitals (Q4)	6.8	39.6	32.0	16.4	5.1	100	36.7	2,234
Q5A4	All HfH Hospitals (Q5)	2.7	25.4	29.6	28.2	14.1	100	42.0	1,793

Table 2.3: Years Respondent Has Worked in Hospital

	Ward and Hospital Data	Under 1 year %	1-3 years %	4-9 years %	10-20 years %	over 20 years %	Total %	Mean	n
Q4A5	All HfH Hospitals (Q4)	1.5	27.0	47.0	16.5	8.0	100	7.7	2,349
Q5A4	All HfH Hospitals (Q5)	2.5	22.0	36.7	22.4	16.3	100	10.0	1,746

Table 2.4: Years Respondent Has Worked in Ward

	Ward and Hospital Data	Under 1 year %	1-3 years %	4-9 years %	10-20 years %	over 20 years %	Total %	Mean	n
Q4A5	All HfH Hospitals (Q4)	7.9	37.2	42.0	10.0	2.9	100	5.2	2,349

Table 2.5: Where Respondent Was Brought Up

	Ward and Hospital Data	Ireland %	UK, US, Aus, NZ %	Philip p-ines %	India %	Africa %	Other %	Total %	n
Q4A5	All HfH Hospitals (Q4)	69.4	2.9	12.0	11.9	1.7	2.1	100	2,333
Q5A4	All HfH Hospitals (Q5)	86.5	4.6	0.9	1.4	1.0	5.8	100	1,841

Table 2.6: First Language of Respondent

	Ward and Hospital Data	English is first language %	English is not first language %	Total %	n
Q4A5	All HfH Hospitals (Q4)	76.0	24.0	100	2,327
Q5A4	All HfH Hospitals (Q5)	92.6	7.4	100	1,849

3 General Attitudes to Dying and Death (Q4B, Q5B)

Table 3.1a: Comfortable Personally Talking About Death and Dying

Q4 B1	Ward Data	Not at all %	Not very %	Relat-ively %	Very %	Comp-letely %	Total %	n
	Major Teaching Hospitals	2.0	19.6	40.5	24.4	13.5	100	786
	Major Regional Hospitals	2.1	13.1	43.3	30.4	11.1	100	289
	Other Acute Hospitals	1.3	9.9	49.7	25.3	13.8	100	876
	Acute Hospitals	**1.7**	**14.3**	**45.0**	**25.7**	**13.3**	**100**	**1,951**
	Community Hospitals	**2.1**	**16.9**	**43.3**	**23.8**	**13.8**	**100**	**390**
	All HfH Hospitals	**1.8**	**14.7**	**44.7**	**25.4**	**13.4**	**100**	**2,341**
Q5 B1	**Hospital Data**							
	Major Teaching Hospitals	1.0	12.3	44.1	23.9	18.6	100	381
	Major Regional Hospitals	2.4	15.8	48.2	20.2	13.4	100	253
	Other Acute Hospitals	1.8	15.6	45.8	20.5	16.3	100	879
	Acute Hospitals	**1.7**	**14.8**	**45.8**	**21.3**	**16.4**	**100**	**1,513**
	Community Hospitals	**2.4**	**14.0**	**51.8**	**19.8**	**11.9**	**100**	**328**
	All HfH Hospitals	**1.8**	**14.7**	**46.9**	**21.0**	**15.6**	**100**	**1,841**
	Ireland*	***8***	***12***	***41***	***15***	***23***	***100***	***1,000***

**Source: Weafer & Associates Research, 2004*

Table 3.1b: Comfortable Personally Talking About Death and Dying

Q4 B1	Ward Data	Not at all %	Not very %	Relat-ively %	Very %	Comp-letely %	Total %	n
	A & E	0.0	15.0	48.1	24.1	12.8	100	133
	Intensive Care	2.1	10.3	41.9	29.8	15.9	100	389
	Surgical	2.3	17.3	48.7	21.4	10.3	100	388
	Medical	1.5	13.5	44.3	25.3	15.4	100	668
	Oncology	0.0	9.4	52.8	28.3	9.4	100	106
	Geriatric	2.4	18.6	39.7	25.2	14.1	100	468
	Other	1.6	16.4	49.2	24.9	7.9	100	189
	Nurse Manager	0.0	4.5	39.5	34.0	22.0	100	291
	Nurse	2.1	17.1	46.2	23.9	10.7	100	1,651
	Health Care Assistant	1.5	12.3	42.4	25.6	18.3	100	399
	Total	**1.8**	**14.7**	**44.7**	**25.4**	**13.4**	**100**	**2,341**
Q5 B1	**Hospital Data**							
	Management / Admin	1.6	17.7	50.8	16.9	13.0	100	555
	Medical / Dental	0.0	7.3	37.9	32.3	22.6	100	248
	Nursing Management	0.0	11.0	45.6	24.3	19.1	100	136
	Health Care Professionals	1.1	17.9	48.9	21.3	10.8	100	380
	General Support Staff	4.5	14.7	46.4	18.1	16.4	100	470
	Other Patient Care	0.0	3.8	40.4	26.9	28.8	100	52
	Total	**1.8**	**14.7**	**46.9**	**21.0**	**15.6**	**100**	**1,841**

Table 3.2a: Comfortable Talking to Recently Bereaved About Death and Dying

Q4 B2	Ward Data	Not at all %	Not very %	Relat-ively %	Very %	Comp-letely %	Total %	n
	Major Teaching Hospitals	2.0	25.8	45.2	20.1	6.9	100	787
	Major Regional Hospitals	1.7	17.8	51.7	22.4	6.3	100	286
	Other Acute Hospitals	2.1	17.1	52.0	20.8	7.9	100	869
	Acute Hospitals	**2.0**	**20.8**	**49.2**	**20.8**	**7.3**	**100**	**1,942**
	Community Hospitals	**2.8**	**21.4**	**45.6**	**22.4**	**7.7**	**100**	**388**
	All HfH Hospitals	**2.1**	**20.9**	**48.6**	**21.0**	**7.3**	**100**	**2,330**
Q5 B2	**Hospital Data**							
	Major Teaching Hospitals	1.9	14.4	51.6	18.2	13.9	100	374
	Major Regional Hospitals	3.2	25.1	49.0	14.2	8.5	100	247
	Other Acute Hospitals	2.8	22.1	48.3	16.0	10.8	100	855
	Acute Hospitals	**2.6**	**20.7**	**49.3**	**16.3**	**11.2**	**100**	**1,476**
	Community Hospitals	**2.2**	**22.5**	**45.3**	**24.1**	**6.0**	**100**	**316**
	All HfH Hospitals	**2.6**	**21.0**	**48.5**	**17.6**	**10.3**	**100**	**1,792**
	Ireland*	***11***	***23***	***41***	***13***	***12***	***100***	***1,000***

**Source: Weafer & Associates Research, 2004*

Table 3.2b: Comfortable Talking to Recently Bereaved About Death and Dying

Q4 B2	Ward Data	Not at all %	Not very %	Relat-ively %	Very %	Comp-letely %	Total %	n
	A & E	1.5	28.6	46.6	19.5	3.8	100	133
	Intensive Care	1.0	20.0	46.5	24.9	7.5	100	385
	Surgical	3.1	22.6	53.8	13.9	6.6	100	381
	Medical	1.9	18.1	48.4	22.6	9.0	100	668
	Oncology	1.9	14.0	53.3	26.2	4.7	100	107
	Geriatric	2.8	23.0	44.4	21.5	8.4	100	466
	Other	2.1	22.1	52.6	18.9	4.2	100	190
	Nurse Manager	0.3	7.6	46.4	30.9	14.8	100	291
	Nurse	2.3	23.3	50.5	19.0	4.9	100	1,641
	Health Care Assistant	2.8	20.4	42.5	22.4	12.1	100	398
	Total	**2.1**	**20.9**	**48.6**	**21.0**	**7.3**	**100**	**2,330**
Q5 B2	**Hospital Data**							
	Management / Admin	2.8	26.8	49.7	14.0	6.7	100	541
	Medical / Dental	0.4	13.1	45.5	25.0	16.0	100	244
	Nursing Management	0.8	12.1	41.7	34.1	11.4	100	132
	Health Care Professionals	2.9	23.5	51.9	15.1	6.6	100	378
	General Support Staff	4.0	20.8	49.2	13.4	12.5	100	447
	Other Patient Care	0.0	2.0	38.0	34.0	26.0	100	50
	Total	**2.6**	**21.0**	**48.5**	**17.6**	**10.3**	**100**	**1,792**

Table 3.3a: Where Staff Member would Prefer to be Cared for if Dying

Q4 B3	Ward Data	Hosp-ital %	Home %	Hospice %	Nurs-ing Home %	Other %	Total %	n
	Major Teaching Hospitals	8.4	77.0	14.0	0.3	0.3	100	770
	Major Regional Hospitals	3.6	82.7	12.6	0.0	1.1	100	278
	Other Acute Hospitals	4.1	86.2	9.1	0.1	0.5	100	831
	Acute Hospitals	**5.8**	**81.9**	**11.7**	**0.2**	**0.5**	**100**	**1,879**
	Community Hospitals	**10.0**	**76.2**	**10.6**	**1.6**	**1.6**	**100**	**369**
	All HfH Hospitals	**6.5**	**81.0**	**11.5**	**0.4**	**0.7**	**100**	**2,248**
Q5 B3	**Hospital Data**							
	Major Teaching Hospitals	6.9	69.3	22.1	.9	.9	100	348
	Major Regional Hospitals	6.0	76.2	16.6	.9	.4	100	235
	Other Acute Hospitals	5.6	79.1	13.5	1.1	.7	100	828
	Acute Hospitals	**6.0**	**76.2**	**16.2**	**1.0**	**.7**	**100**	**1,411**
	Community Hospitals	**5.6**	**79.1**	**12.0**	**3.0**	**.3**	**100**	**301**
	All HfH Hospitals	**5.9**	**76.7**	**15.4**	**1.3**	**.6**	**100**	**1,712**
	Ireland*	***10***	***67***	***10***	***5***	***8***	***100***	***1,000***

**Source: Weafer & Associates Research, 2004*

Table 3.3b: Where Staff Member would Prefer to be Cared for if Dying

Q4 B3	Ward Data	Hosp-ital %	Home %	Hospice %	Nurs-ing Home %	Other %	Total %	n
	A & E	3.2	84.1	11.1	0.0	1.6	100	126
	Intensive Care	4.9	81.1	13.5	0.0	0.5	100	371
	Surgical	4.6	84.8	10.1	0.0	0.5	100	368
	Medical	6.2	82.4	11.0	0.2	0.3	100	648
	Oncology	5.8	79.8	13.5	1.0	0.0	100	104
	Geriatric	11.3	76.3	9.7	1.6	1.1	100	443
	Other	5.9	77.7	15.4	0.0	1.1	100	188
	Nurse Manager	1.8	82.9	14.2	0.0	1.1	100	275
	Nurse	6.9	81.3	11.1	0.3	0.4	100	1,585
	Health Care Assistant	8.2	78.1	11.1	1.0	1.5	100	388
	Total	**6.5**	**81.0**	**11.5**	**0.4**	**0.7**	**100**	**2,248**
Q5 B3	**Hospital Data**							
	Management / Admin	8.0	75.4	13.8	2.1	0.6	100	513
	Medical / Dental	3.6	82.7	13.2	0.0	0.5	100	220
	Nursing Management	2.4	82.5	12.7	1.6	0.8	100	126
	Health Care Professionals	3.7	73.6	21.1	0.8	0.8	100	356
	General Support Staff	8.0	76.9	12.9	1.6	0.7	100	451
	Other Patient Care	0.0	67.4	32.6	0.0	0.0	100	46
	Total	**5.9**	**76.7**	**15.4**	**1.3**	**0.6**	**100**	**1,712**

Table 3.4a: Overall Care of People who Die in Irish Hospitals

Q4 B4	Ward Data	Very poor %	Poor %	Fair %	Good %	Excell-ent %	Total %	n
	Major Teaching Hospitals	1.9	5.1	20.6	51.1	21.3	100	785
	Major Regional Hospitals	1.8	10.2	33.3	45.3	9.5	100	285
	Other Acute Hospitals	2.0	6.0	26.8	48.4	16.7	100	861
	Acute Hospitals	**1.9**	**6.3**	**25.3**	**49.0**	**17.5**	**100**	**1,931**
	Community Hospitals	**0.8**	**4.0**	**20.3**	**51.1**	**23.8**	**100**	**374**
	All HfH Hospitals	**1.7**	**5.9**	**24.5**	**49.4**	**18.5**	**100**	**2,305**
Q5 B4	**Hospital Data**							
	Major Teaching Hospitals	3.7	9.3	30.3	44.7	12.1	100	356
	Major Regional Hospitals	2.7	8.9	32.9	40.4	15.1	100	225
	Other Acute Hospitals	1.6	7.2	32.2	45.9	13.2	100	811
	Acute Hospitals	**2.3**	**8.0**	**31.8**	**44.7**	**13.2**	**100**	**1,392**
	Community Hospitals	**3.0**	**7.3**	**33.8**	**42.7**	**13.2**	**100**	**302**
	All HfH Hospitals	**2.4**	**7.9**	**32.2**	**44.3**	**13.2**	**100**	**1,694**
	Ireland*	***2***	***9***	***14***	***34***	***41***	***100***	***1,000***

**Source: Weafer & Associates Research, 2004*

Table 3.4b: Overall Care of People who Die in Irish Hospitals

Q4 B4	Ward Data	Very poor %	Poor %	Fair %	Good %	Excell-ent %	Total %	n
	A & E	5.4	10.1	35.7	34.1	14.7	100	129
	Intensive Care	2.1	7.0	29.5	44.8	16.6	100	386
	Surgical	1.6	7.0	25.8	47.3	18.3	100	387
	Medical	1.8	5.8	22.4	53.8	16.2	100	656
	Oncology	0.0	3.8	26.7	49.5	20.0	100	105
	Geriatric	1.1	4.2	19.4	50.4	24.9	100	454
	Other	1.1	4.3	21.8	55.3	17.6	100	188
	Nurse Manager	2.8	6.4	27.3	52.5	11.0	100	282
	Nurse	1.4	6.3	25.1	49.0	18.1	100	1,631
	Health Care Assistant	2.3	3.8	19.9	48.5	25.5	100	392
	Total	**1.7**	**5.9**	**24.5**	**49.4**	**18.5**	**100**	**2,305**
Q5 B4	**Hospital Data**							
	Management / Admin	2.9	7.6	28.0	46.2	15.3	100	489
	Medical / Dental	2.5	7.5	35.1	41.4	13.4	100	239
	Nursing Management	0.0	9.1	40.9	49.2	0.8	100	132
	Health Care Professionals	1.5	10.3	44.2	37.8	6.2	100	339
	General Support Staff	3.6	5.6	23.9	47.1	19.8	100	444
	Other Patient Care	0.0	11.8	27.5	47.1	13.7	100	51
	Total	**2.4**	**7.9**	**32.2**	**44.3**	**13.2**	**100**	**1,694**

Table 3.5: Most Important Things when Dying (Ward & Hospital)

Q4K1 Q5J1	Aspect	Ward Staff %	Hospital Staff %	Total Staff %	Relatives %	Ireland* %
3	to be surrounded by loved ones	91	83	**87**	**20**	**68**
1	being free from pain	92	80	**86**	**57**	**55**
4	to be at home	60	39	**50**	**6**	**34**
2	being able to communicate	35	32	**34**	**6**	**35**
7	to be in private space	16	34	**25**	**6**	**11**
5	having medical support	14	24	**19**	**7**	**32**
6	having spiritual support	13	13	**13**	**6**	**19**

Note: Scores are based on the sum of first, second and third preferences for each aspect. For this reason, the columns do not add to 100%.

**Source: Weafer & Associates Research, 2004*

4 Ward Environment (C)

Table 4.1a: Nurses Perceptions of Ward (5 categories)

Q1B7	Ward Data	very poor %	poor %	middle %	good %	very good %	n
	Acute Hospitals						
7. 1- 3	Privacy	10.0	25.1	29.1	23.8	11.9	1,967
7. 4- 6	Dignity	5.8	16.5	29.8	28.6	19.2	1,967
7. 7-10	Environment	22.1	32.1	24.9	14.6	6.2	1,967
7.11-15	Control	41.3	31.6	16.1	8.4	2.5	1,967
	Comm. Hospitals						
7. 1- 3	Privacy	1.8	12.5	28.9	30.7	26.1	391
7. 4- 6	Dignity	1.3	6.4	19.4	27.4	45.5	391
7. 7-10	Environment	2.0	13.8	26.1	28.1	29.9	391
7.11-15	Control	21.7	26.9	27.6	16.1	7.7	391
	All HFH Hospitals						
7. 1- 3	Privacy	8.7	23.0	29.1	25.0	14.2	2,358
7. 4- 6	Dignity	5.1	14.8	28.1	28.4	23.6	2,358
7. 7-10	Environment	18.8	29.1	25.1	16.9	10.1	2,358
7.11-15	Control	38.1	30.8	18.0	9.7	3.4	2,358

Scores 1 or 2 = very poor; 3 or 4 = poor; 5 or 6 = middle; 7 or 8 = good; 9 or 10 = very good.

Table 4.1b: Nurses Perceptions of Ward

Q4 C6	Ward Data	Privacy	Dignity	Environ	Control	Total	n
		mean	mean	mean	mean	mean	
	Major Teaching Hospitals	5.9	6.6	4.5	3.9	5.0	796
	Major Regional Hospitals	4.9	5.8	3.4	2.8	4.0	290
	Other Acute Hospitals	5.5	6.2	4.6	3.3	4.7	881
	Acute Hospitals	**5.6**	**6.3**	**4.4**	**3.5**	**4.7**	**1,967**
	Community Hospitals	**6.9**	**7.8**	**6.8**	**4.8**	**6.4**	**391**
	A & E	4.3	4.4	2.3	1.6	2.9	134
	Intensive Care	5.6	6.0	3.8	2.8	4.3	393
	Surgical	5.4	6.4	4.5	3.7	4.8	390
	Medical	5.5	6.3	4.4	3.4	4.7	672
	Oncology	6.9	7.7	5.7	5.1	6.1	108
	Geriatric	6.7	7.7	6.6	4.7	6.2	469
	Other	6.1	6.9	5.3	4.6	5.6	192
	Nurse Manager	5.8	6.1	4.2	3.1	4.5	292
	Nurse	5.7	6.5	4.7	3.7	4.9	1,665
	Health Care Assistant	6.1	7.3	5.6	4.2	5.6	401
	Total	**5.8**	**6.6**	**4.8**	**3.7**	**5.0**	**2,358**

Table 4.2: Bed Occupancy

Q4 C1	Ward Data	Very low %	Low %	Medium %	High %	Very High %	Total %	n
	Major Teaching Hospitals	0.9	2.9	15.2	24.4	56.6	100	788
	Major Regional Hospitals	1.4	1.4	14.0	26.0	57.2	100	285
	Other Acute Hospitals	0.7	2.4	17.0	34.9	45.0	100	867
	Acute Hospitals	**0.9**	**2.5**	**15.8**	**29.3**	**51.5**	**100**	**1,940**
	Community Hospitals	**0.8**	**2.6**	**30.1**	**36.8**	**29.8**	**100**	**386**
	A & E	4.7	5.5	5.5	15.6	68.8	100	128
	Intensive Care	0.3	2.3	17.0	34.5	45.9	100	388
	Surgical	0.3	2.6	10.2	28.6	58.3	100	384
	Medical	1.1	1.7	15.9	28.7	52.6	100	665
	Oncology	0.0	2.8	29.9	36.4	30.8	100	107
	Geriatric	1.1	3.0	29.4	35.4	31.1	100	463
	Other	0.0	2.1	19.4	27.7	50.8	100	191
	Nurse Manager	0.0	1.0	9.1	23.3	66.6	100	287
	Nurse	0.8	2.6	18.2	30.9	47.5	100	1,645
	Health Care Assistant	1.8	3.3	24.9	34.3	35.8	100	394
	Total	**0.9**	**2.5**	**18.2**	**30.6**	**47.9**	**100**	**2,326**

Table 4.3: Patient Turnover

Q4 C2	Ward Data	Very low %	Low %	Medium %	High %	Very High %	Total %	n
	Major Teaching Hospitals	3.3	11.5	25.7	29.8	29.7	100	791
	Major Regional Hospitals	0.4	4.6	23.9	33.3	37.9	100	285
	Other Acute Hospitals	1.6	6.6	24.6	38.5	28.7	100	870
	Acute Hospitals	**2.1**	**8.3**	**24.9**	**34.2**	**30.5**	**100**	**1,946**
	Community Hospitals	**14.4**	**21.6**	**37.0**	**18.8**	**8.2**	**100**	**389**
	A & E	1.6	3.9	12.4	14.7	67.4	100	129
	Intensive Care	0.0	2.3	20.6	46.4	30.7	100	388
	Surgical	0.0	3.1	18.8	36.1	42.0	100	388
	Medical	2.7	12.2	27.8	31.1	26.3	100	666
	Oncology	0.0	5.6	46.7	37.4	10.3	100	107
	Geriatric	15.1	24.3	36.1	18.1	6.5	100	465
	Other	3.6	9.9	29.7	35.9	20.8	100	192
	Nurse Manager	6.6	8.7	17.1	30.0	37.6	100	287
	Nurse	3.3	9.9	28.1	32.0	26.7	100	1,654
	Health Care Assistant	6.1	14.5	29.2	31.2	19.0	100	394
	Total	**4.2**	**10.5**	**26.9**	**31.6**	**26.8**	**100**	**2,335**

Table 4.4: Patient Dependency

Q4 C3	Ward Data	Very low %	Low %	Medium %	High %	Very High %	Total %	n
	Major Teaching Hospitals	0.9	2.3	27.1	39.8	30.0	100	787
	Major Regional Hospitals	0.7	2.8	25.2	38.8	32.5	100	286
	Other Acute Hospitals	0.1	2.4	19.9	46.8	30.7	100	869
	Acute Hospitals	**0.5**	**2.4**	**23.6**	**42.8**	**30.7**	**100**	**1,942**
	Community Hospitals	**1.0**	**3.1**	**18.2**	**42.5**	**35.3**	**100**	**391**
	A & E	0.8	1.6	25.2	41.7	30.7	100	127
	Intensive Care	0.3	1.0	18.5	35.5	44.7	100	389
	Surgical	0.3	2.6	31.8	42.4	23.0	100	387
	Medical	0.9	2.4	19.9	47.8	29.0	100	663
	Oncology	0.0	6.5	49.5	35.5	8.4	100	107
	Geriatric	0.9	3.0	13.2	43.1	39.9	100	469
	Other	0.5	3.1	28.8	44.5	23.0	100	191
	Nurse Manager	0.3	0.7	16.0	38.7	44.3	100	287
	Nurse	0.6	2.5	22.8	43.4	30.8	100	1,651
	Health Care Assistant	0.8	4.1	27.1	43.0	25.1	100	395
	Total	**0.6**	**2.5**	**22.7**	**42.7**	**31.5**	**100**	**2,333**

Table 4.5: Frequency of Patient Dying on Ward

Q4 C6	Ward Data	Nearly every day %	Nearly every week %	Nearly every two weeks %	Nearly every three weeks %	Nearly every month %	Less than once a month	n
	Major Teaching Hospitals	5.0	11.1	10.2	9.7	22.2	41.8	783
	Major Regional Hospitals	0.0	24.2	16.5	10.2	19.3	29.8	285
	Other Acute Hospitals	1.0	16.3	19.9	11.8	21.8	29.2	859
	Acute Hospitals	**2.5**	**15.4**	**15.5**	**10.7**	**21.6**	**34.4**	**1,927**
	Community Hospitals	**0.3**	**0.3**	**0.8**	**1.1**	**11.1**	**86.4**	**361**
	A & E	17.4	37.1	15.9	9.8	11.4	8.3	132
	Intensive Care	2.8	18.4	19.4	10.9	20.7	27.7	386
	Surgical	0.3	4.8	8.5	7.4	26.7	52.4	378
	Medical	1.8	18.0	18.9	13.3	20.8	27.1	660
	Oncology	0.0	22.6	17.0	13.2	24.5	22.6	106
	Geriatric	0.5	2.3	3.4	2.7	13.3	77.8	437
	Other	0.0	3.2	7.9	6.9	20.6	61.4	189
	Nurse Manager	3.5	17.4	11.5	9.7	18.1	39.9	288
	Nurse	2.1	13.5	13.9	9.3	20.6	40.6	1,628
	Health Care Assistant	1.3	7.3	11.0	8.3	18.5	53.5	372
	Total	**2.1**	**13.0**	**13.2**	**9.2**	**19.9**	**42.6**	**2,288**

Table 4.6: Sufficiency of Nursing Staff

Q4 C5	Ward Data	Definite-ly not enough %	Not enough %	Just enough %	Definite -ly enough %	Total %	n
	Major Teaching Hospitals	21.9	35.5	39.3	3.3	100	789
	Major Regional Hospitals	32.6	34.4	27.4	5.6	100	288
	Other Acute Hospitals	18.8	35.9	39.3	6.0	100	872
	Acute Hospitals	**22.1**	**35.5**	**37.6**	**4.8**	**100**	**1,949**
	Community Hospitals	**15.3**	**30.2**	**43.7**	**10.7**	**100**	**391**
	A & E	31.8	42.4	25.0	0.8	100	132
	Intensive Care	11.3	25.0	51.8	11.9	100	388
	Surgical	29.0	37.3	32.6	1.0	100	389
	Medical	25.9	39.5	32.2	2.4	100	664
	Oncology	13.1	31.8	49.5	5.6	100	107
	Geriatric	17.1	32.5	41.7	8.8	100	468
	Other	13.5	33.3	41.7	11.5	100	192
	Nurse Manager	27.9	35.2	33.1	3.8	100	290
	Nurse	19.8	34.5	39.8	5.9	100	1,653
	Health Care Assistant	20.7	34.8	37.5	7.1	100	397
	Total	**21.0**	**34.6**	**38.6**	**5.8**	**100**	**2,340**

Table 4.7: Staff Turnover

Q4 C4	Ward Data	Very low %	Low %	Mediu m %	High %	Very High %	Total %	n
	Major Teaching Hospitals	9.1	26.6	47.0	14.7	2.5	100	787
	Major Regional Hospitals	12.2	35.3	41.3	10.1	1.0	100	286
	Other Acute Hospitals	13.1	36.6	41.7	7.5	1.1	100	871
	Acute Hospitals	**11.4**	**32.4**	**43.8**	**10.8**	**1.7**	**100**	**1,944**
	Community Hospitals	**11.2**	**31.5**	**43.0**	**13.0**	**1.3**	**100**	**384**
	A & E	5.4	25.4	50.8	14.6	3.8	100	130
	Intensive Care	19.8	33.9	34.4	9.5	2.3	100	389
	Surgical	8.0	29.8	48.7	11.9	1.6	100	386
	Medical	8.9	33.5	45.7	10.5	1.4	100	665
	Oncology	13.1	34.6	47.7	4.7	0.0	100	107
	Geriatric	9.6	34.1	42.8	12.6	0.9	100	460
	Other	16.8	27.7	39.8	13.1	2.6	100	191
	Nurse Manager	17.3	35.3	37.4	8.7	1.4	100	289
	Nurse	10.7	32.2	44.8	11.0	1.3	100	1,644
	Health Care Assistant	9.6	30.1	43.3	13.7	3.3	100	395
	Total	**11.3**	**32.2**	**43.6**	**11.2**	**1.6**	**100**	**2,328**

Table 4.8a: Ward Rating as a Place to Work

Q4 D	Ward Data	very poor %	poor %	middle %	good %	very good %	n
1	As a place to work	2.3	5.2	21.5	42.1	29.0	2,331
2	Staff relationships	0.9	2.7	14.1	42.1	40.2	2,326
3	Facilities	5.5	11.7	25.8	34.6	22.3	2,336
4	Standard of Care	0.1	0.9	6.0	31.3	61.7	2,335
5	End-of-Life Care	6.1	7.9	16.5	31.4	38.1	2,326
6	Ward management	2.0	4.1	11.9	32.2	49.8	2,310
	Overall ward rating	**0.0**	**1.8**	**17.5**	**46.6**	**34.0**	**2,338**

Scores 1 or 2 = very poor; 3 or 4 = poor; 5 or 6 = middle; 7 or 8 = good; 9 or 10 = very good.

Table 4.8b: Ward Rating as a Place to Work

Q4 D	Ward Data	As a place to work	Staff relationships	Ward facilities	Standard of Care	End-of-Life Care	Ward management.	Overall ward rating	n
		Mean	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	
	Major Teaching Hospitals	7.5	8.0	6.9	8.6	7.4	8.3	7.8	776
	Major Regional Hospitals	6.7	7.8	5.8	8.4	6.7	7.7	7.2	282
	Other Acute Hospitals	7.3	8.0	6.5	8.7	7.1	7.9	7.6	842
	Acute Hospitals	**7.3**	**8.0**	**6.6**	**8.6**	**7.1**	**8.0**	**7.6**	**1,900**
	Community Hospitals	**7.7**	**7.7**	**7.1**	**9.0**	**8.1**	**8.2**	**8.0**	**378**
	A & E	6.3	7.7	5.7	7.7	4.8	7.6	6.6	130
	Intensive Care	7.3	7.8	7.2	8.9	7.1	7.9	7.7	379
	Surgical	7.3	8.0	6.4	8.6	7.0	7.8	7.5	379
	Medical	7.3	8.0	6.3	8.5	7.1	8.1	7.6	645
	Oncology	7.9	7.8	7.3	9.0	8.6	8.4	8.2	103
	Geriatric	7.7	7.9	7.0	9.0	8.1	8.3	8.0	454
	Other	7.6	8.2	6.8	9.0	7.8	8.3	8.0	188
	Nurse Manager	7.5	8.0	6.5	8.7	6.8	8.2	7.6	271
	Nurse	7.3	7.9	6.6	8.7	7.2	8.0	7.6	1,625
	Health Care Assistant	7.6	7.9	7.1	8.9	7.9	8.2	7.9	382
	Total	**7.4**	**7.9**	**6.6**	**8.7**	**7.3**	**8.1**	**7.7**	**2,153**

5 Work Satisfaction (Q4D, Q5C)

Table 5.1a: Work Satisfaction

Q4 D	Ward Data	Work Satisfaction (Q4D7.1)		
		Mean	n	% dissat-isfied*
	Major Teaching Hospitals	7.5	789	3.5
	Major Regional Hospitals	6.6	285	10.9
	Other Acute Hospitals	7.1	871	6.0
	Acute Hospitals	**7.2**	**1,945**	**5.7**
	Community Hospitals	**7.7**	**387**	**3.9**
	All HfH Hospitals	**7.3**	**2,332**	**5.4**
Q5 C1	**Hospital Data**			
	Major Teaching Hospitals	6.5	378	9.5
	Major Regional Hospitals	6.3	253	12.3
	Other Acute Hospitals	6.3	881	12.8
	Acute Hospitals	**6.3**	**1,512**	**11.9**
	Community Hospitals	**7.2**	**330**	**4.5**
	All HfH Hospitals	**6.5**	**1,842**	**10.6**

* coding: scores 1-3 = dissatisfied, scores 4-10 = acceptable

Table 5.1b: Work Satisfaction

Q4 D1	Ward Data	Work Satisfaction (Q4D7.1)		
		Mean	n	% dissat-isfied*
	A & E	6.1	133	15.8
	Intensive Care	7.4	385	3.9
	Surgical	7.0	387	8.5
	Medical	7.2	666	5.3
	Oncology	7.8	107	0.0
	Geriatric	7.7	463	3.5
	Other	7.6	191	3.1
	Nurse Manager	7.1	288	7.3
	Nurse	7.3	1,651	4.8
	Health Care Assistant	7.5	393	6.4
	Total	**7.3**	**2,332**	**5.4**
Q5 C1	**Hospital Data**			
	Management / Admin	6.4	553	11.2
	Medical / Dental	6.2	247	14.6
	Nursing Management	7.0	136	5.1
	Health Care Professionals	6.5	382	9.2
	General Support Staff	6.5	472	11.2
	Other Patient Care	7.4	52	3.8
	Total	**6.5**	**1,842**	**10.6**

* coding: scores 1-3 = dissatisfied, scores 4-10 = acceptable

6 End-of-Life Care (Q4E)

Table 6.1a: End-of-Life Care on the Ward

Q4E	Ward Data	very poor %	poor %	middle %	good %	very good %	n
1	Recognising EoL care	2.1	5.3	14.5	39.8	38.4	2,291
2	Communication with patient and relatives	0.7	3.0	11.6	38.8	45.9	2,307
3	Staff Communication	1.4	3.3	15.5	37.3	42.5	2,310
4	Coordination of EoL care	1.7	4.4	13.0	36.9	44.0	2,287
5	Facilitating patient	2.3	6.9	13.7	33.5	43.6	2,281
6	Facilitating relatives	1.6	5.7	13.5	33.2	45.9	2,283
7	Respecting patient's preferences	1.5	5.0	11.1	31.3	51.2	2,271
8	Managing symptoms	0.4	2.0	6.4	25.6	65.5	2,242
9	Comforting patient	1.2	3.4	10.3	28.9	56.3	2,235
10	Supporting relatives	0.7	2.4	7.6	27.0	62.3	2,248
11	Maintaining dignity	1.0	2.9	10.3	30.0	55.8	2,313
12	Respecting spiritual needs	1.1	3.2	10.2	27.8	57.7	2,267
13	Removal of patient	2.2	4.3	9.2	24.7	59.5	2,304
14	Mortuary facilities	2.8	3.3	8.1	22.3	63.5	1,996
15	Information for relatives	4.1	8.3	16.1	27.7	43.8	2,218
16	Policy and procedures	5.0	8.5	15.9	25.2	45.4	2,206
	Average	**0.2**	**2.3**	**12.1**	**40.3**	**45.1**	**2,338**

Scores 1 or 2 = very poor; 3 or 4 = poor; 5 or 6 = middle; 7 or 8 = good; 9 or 10 = very good.

Table 6.1b: End-of-Life Care on the Ward

		E1	E2	E3	E4	E5	E6	E7	E8	E9
Q4E	Ward Data	Recognising EoL care	Communication with patient and relatives	Staff Communication	Coordination of EoL care	Facilitating patient	Facilitating relatives	Respecting patient's preferences	Managing symptoms	Comforting patient afraid of dying
		Mean	Mean	Mean	Mean	Mean	Mean	Mean	Mean	Mean
	Major Teaching Hospitals	7.7	8.1	8.0	7.9	7.8	8.0	8.1	8.7	8.2
	Major Regional Hospitals	7.5	8.0	7.7	7.6	7.3	7.3	7.7	8.5	8.0
	Other Acute Hospitals	7.6	8.0	7.9	7.8	7.7	7.8	7.8	8.7	8.2
	Acute Hospitals	**7.6**	**8.0**	**7.9**	**7.8**	**7.7**	**7.8**	**8.0**	**8.6**	**8.2**
	Community Hospitals	**8.3**	**8.5**	**8.1**	**8.5**	**8.4**	**8.6**	**8.9**	**9.1**	**9.0**
	A & E	7.0	7.7	7.4	6.8	6.6	6.7	7.0	7.8	7.4
	Intensive Care	7.0	8.0	7.9	7.6	7.4	8.0	7.7	8.7	8.1
	Surgical	7.8	8.0	7.8	7.8	7.7	7.7	8.0	8.5	8.1
	Medical	7.7	7.9	7.8	7.8	7.6	7.6	8.0	8.6	8.1
	Oncology	8.6	8.6	8.3	8.6	8.7	8.7	8.8	9.2	9.0
	Geriatric	8.2	8.5	8.2	8.5	8.4	8.6	8.8	9.0	8.9
	Other	7.8	8.3	8.1	8.1	8.1	8.2	8.5	8.9	8.7
	Nurse Manager	7.6	8.0	7.9	7.8	7.5	7.8	7.8	8.6	8.2
	Nurse	7.6	8.1	7.9	7.8	7.7	7.9	8.0	8.7	8.2
	Health Care Assistant	8.3	8.5	7.9	8.3	8.2	8.4	8.8	9.1	8.9
	Total	**7.7**	**8.1**	**7.9**	**7.9**	**7.8**	**7.9**	**8.1**	**8.7**	**8.3**

Table 6.1c: End-of-Life Care on the Ward (selective items)

		E10	E11	E12	E13	E14	E15	E16	Tot	
Q4E	Ward Data	Supporting relatives or friends	Creating a sense of dignity and respect	Respecting spiritual needs of people	Removing dead person respectfully	Providing a mortuary	Supporting bereaved relatives	Clear policies and procedures	Overall Quality of End-of-Life care	
		Mean	Mean	Mean	Mean	Mean	Mean	Mean	Mean	n
	Major Teaching Hospitals	8.5	8.4	8.4	8.5	8.6	7.7	7.8	**8.1**	790
	Major Regional Hospitals	8.3	8.1	8.0	8.0	8.0	6.8	6.5	**7.7**	285
	Other Acute Hospitals	8.5	8.2	8.2	8.1	8.4	7.3	7.2	**8.0**	873
	Acute Hospitals	**8.5**	**8.3**	**8.3**	**8.2**	**8.4**	**7.4**	**7.3**	**8.0**	**1,948**
	Community Hospitals	**9.1**	**8.9**	**9.0**	**8.8**	**8.7**	**8.3**	**8.6**	**8.7**	**390**
	A & E	7.6	7.3	7.6	7.8	8.2	7.1	6.7	**7.3**	131
	Intensive Care	8.5	8.3	8.3	8.3	8.4	7.4	7.1	**7.9**	388
	Surgical	8.4	8.2	8.1	8.1	8.4	7.1	7.0	**7.9**	388
	Medical	8.4	8.2	8.3	8.2	8.3	7.4	7.4	**8.0**	666
	Oncology	9.0	9.0	8.6	8.5	8.7	8.0	7.6	**8.7**	107
	Geriatric	9.1	8.9	9.0	8.8	8.7	8.3	8.5	**8.7**	468
	Other	8.9	8.6	8.6	8.5	8.8	7.7	7.9	**8.3**	190
	Nurse Manager	8.4	8.2	8.2	8.3	7.7	7.2	6.9	**7.9**	289
	Nurse	8.5	8.3	8.3	8.3	8.5	7.5	7.5	**8.0**	1,653
	Health Care Assistant	8.9	8.8	8.8	8.7	8.9	8.2	8.5	**8.6**	396
	Total	**8.5**	**8.4**	**8.4**	**8.3**	**8.5**	**7.6**	**7.6**	**8.1**	**2,338**

7 Acceptability of Way Patients Die (Q4E, Q5D)

Table 7.1a: Acceptability of Patient's Dying Experience

Q4 E17	Ward Data	Acceptable for you			Acceptable for your family and friends		
		Mean	n	% not accept-able	Mean	n	% not accept-able
	Major Teaching Hospitals	7.2	783	10.7	7.0	774	11.6
	Major Regional Hospitals	6.3	279	16.1	6.2	276	17.8
	Other Acute Hospitals	6.9	863	10.8	6.9	846	11.9
	Acute Hospitals	**6.9**	**1,925**	**11.5**	**6.8**	**1,896**	**12.7**
	Community Hospitals	**8.0**	**381**	**4.5**	**8.0**	**378**	**5.6**
	All HfH Hospitals	**7.1**	**2,306**	**10.4**	**7.0**	**2,274**	**11.5**
Q5 D1	**Hospital Data**						
	Major Teaching Hospitals	5.8	373	16.9	5.7	356	18.5
	Major Regional Hospitals	5.7	234	19.2	5.6	227	20.7
	Other Acute Hospitals	6.2	849	12.6	6.2	813	13.7
	Acute Hospitals	**6.0**	**1,456**	**14.8**	**6.0**	**1,396**	**16.0**
	Community Hospitals	**7.0**	**323**	**6.8**	**6.9**	**302**	**7.6**
	All HfH Hospitals	**6.2**	**1,779**	**13.3**	**6.1**	**1,698**	**14.5**

* coding: scores 1-3 = not acceptable, scores 4-10 = acceptable

Table 7.1b: Acceptability of Patient's Dying Experience

Q4 D1-7	Ward Data	Acceptable for you			Acceptable for your family and friends		
		Mean	n	% not accept-able	Mean	n	% not accept-able
	A & E	5.4	128	25.8	5.3	127	28.3
	Intensive Care	7.0	384	10.2	6.9	377	10.6
	Surgical	6.8	382	11.0	6.7	372	11.8
	Medical	6.8	659	12.9	6.7	652	14.6
	Oncology	8.1	106	2.8	8.0	105	3.8
	Geriatric	7.9	460	5.4	7.8	456	6.6
	Other	7.6	187	6.4	7.6	185	6.5
	Nurse Manager	6.9	285	11.2	6.8	277	12.6
	Nurse	7.0	1,638	10.8	6.9	1,615	11.8
	Health Care Assistant	7.7	383	7.8	7.7	382	9.2
	Total	**7.1**	**2,306**	**10.4**	**7.0**	**2,274**	**11.5**
Q5 D1	**Hospital Data**						
	Management / Admin	6.3	524	11.8	6.3	506	12.8
	Medical / Dental	6.1	244	14.3	6.1	234	14.5
	Nursing Management	6.6	136	6.6	6.6	129	7.8
	Health Care Professionals	5.7	364	17.6	5.5	353	20.7
	General Support Staff	6.4	459	13.3	6.3	428	13.8
	Other Patient Care	6.7	52	11.5	6.4	48	12.5
	Total	**6.2**	**1,779**	**13.3**	**6.1**	**1,698**	**14.5**

* coding: scores 1-3 = not acceptable, scores 4-10 = acceptable

8 Education, Training & Preparedness for End-of-Life

Table 8.1a: Quality of Education and Training provided by Hospital

Q4 H1-6	Ward Data	Training on End-of-Life Care	Training on Communication skills	Training on diff. cultures of death	Training in understanding loss and grief	Training on legal and ethical issues	Training on palliative care
		Mean	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**
	Major Teaching Hospitals	4.8	4.8	4.2	4.5	4.5	6.6
	Major Regional Hospitals	3.1	3.0	2.4	2.7	2.7	5.7
	Other Acute Hospitals	4.0	4.0	3.3	3.5	3.4	6.0
	Acute Hospitals	**4.2**	**4.2**	**3.5**	**3.8**	**3.7**	**6.2**
	Community Hospitals	**5.5**	**5.6**	**4.9**	**5.1**	**4.9**	**5.6**
	All HfH Hospitals	**4.5**	**4.5**	**3.8**	**3.9**	**4.0**	**6.1**
	n	1,973	2,010	1,946	1,960	1,928	2,088
Q5 G1-6	**Hospital Data**						
	Major Teaching Hospitals	4.5	4.8	3.7	4.2	3.7	6.9
	Major Regional Hospitals	4.4	4.3	2.8	3.6	3.2	6.4
	Other Acute Hospitals	4.4	4.6	3.2	3.9	3.3	6.6
	Acute Hospitals	**4.4**	**4.6**	**3.3**	**3.9**	**3.4**	**6.7**
	Community Hospitals	**5.5**	**5.3**	**4.1**	**4.6**	**4.2**	**5.3**
	All HfH Hospitals	**4.6**	**4.8**	**3.5**	**4.1**	**3.6**	**6.4**
	n	1,027	1,062	950	993	935	1,146

Table 8.1b: Quality of Education and Training provided by Hospital

Q4 H1-6	Ward Data	Training on End-of-Life Care	Training on Communication skills	Training on diff. cultures of death	Training in understanding loss and grief	Training on legal and ethical issues	Training on palliative care
		Mean	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**
	A & E	4.5	4.5	3.5	3.9	3.9	5.4
	Intensive Care	3.6	3.7	3.0	3.3	3.2	5.3
	Surgical	3.6	3.7	3.1	3.3	3.4	6.3
	Medical	4.2	4.2	3.5	3.8	3.7	6.5
	Oncology	4.6	4.4	3.9	4.1	3.9	6.7
	Geriatric	5.6	5.6	5.0	5.2	5.0	5.9
	Other	5.3	5.1	4.3	4.6	4.6	6.4
	Nurse Manager	4.2	4.4	3.3	3.6	3.4	6.4
	Nurse	4.4	4.3	3.7	3.9	3.9	6.1
	Health Care Assistant	5.1	5.1	4.4	4.7	4.6	5.8
	Total	**4.5**	**4.5**	**3.8**	**3.9**	**4.0**	**6.1**
Q5 G1-6	**Hospital Data**						
	Management / Admin	5.1	5.2	3.9	4.6	3.9	6.3
	Medical / Dental	3.9	4.0	2.9	3.4	3.3	7.0
	Nursing Management	4.5	4.8	3.2	3.6	3.0	6.1
	Health Care Professionals	4.2	4.4	2.9	3.7	3.2	6.4
	General Support Staff	4.9	4.9	3.8	4.4	3.9	6.1
	Other Patient Care	5.0	5.9	4.5	4.6	4.2	7.4
	Total	**4.6**	**4.8**	**3.5**	**4.1**	**3.6**	**6.4**

Table 8.1a: Quality of other Supports provided by Hospital

Q4 H7-11	Ward Data	Debriefing and reflection	Encouraging team work	Post death reviews	Providing leadership	Policies and procedures	Overall Quality of Education
		Mean	Mean	Mean	Mean	Mean	Mean
	Major Teaching Hospitals	5.1	6.6	4.5	6.9	7.2	**5.7**
	Major Regional Hospitals	3.9	5.5	2.8	5.1	5.5	**4.2**
	Other Acute Hospitals	4.2	5.6	3.0	5.6	6.0	**4.7**
	Acute Hospitals	**4.5**	**6.0**	**3.6**	**6.1**	**6.4**	**5.0**
	Community Hospitals	**5.0**	**6.7**	**4.7**	**7.0**	**7.6**	**5.8**
	All HfH Hospitals	**4.6**	**6.1**	**3.8**	**6.2**	**6.6**	**5.2**
	n	1,981	2,129	1,631	2,143	2,075	2,286
Q5 G7-11	**Hospital Data**						
	Major Teaching Hospitals	4.9	6.4	4.3	5.0	5.6	**5.4**
	Major Regional Hospitals	4.8	5.9	3.5	4.7	5.1	**5.2**
	Other Acute Hospitals	5.1	6.0	3.7	5.2	6.1	**5.3**
	Acute Hospitals	**5.0**	**6.1**	**3.8**	**5.1**	**5.8**	**5.3**
	Community Hospitals	**4.4**	**6.6**	**4.3**	**6.7**	**7.0**	**5.7**
	All HfH Hospitals	**4.9**	**6.2**	**3.9**	**5.4**	**6.1**	**5.4**
	n	1,017	1,192	790	1,055	1,032	1,413

Table 8.1b: Quality of other Supports provided by Hospital

Q4 H7-11	Ward Data	Debriefing and reflection	Encouraging team work	Post death reviews	Providing leadership	Policies and procedures	Overall Quality of Education
		Mean	Mean	Mean	Mean	Mean	Mean
	A & E	4.6	5.7	3.1	5.3	6.0	**4.8**
	Intensive Care	4.2	5.2	3.2	5.7	6.0	**4.6**
	Surgical	4.3	5.7	3.6	5.7	6.2	**4.7**
	Medical	4.6	6.3	3.5	6.2	6.5	**5.1**
	Oncology	4.8	6.3	2.9	6.6	6.3	**5.2**
	Geriatric	5.1	6.8	4.9	7.1	7.6	**6.0**
	Other	4.7	6.2	4.1	6.7	7.4	**5.6**
	Nurse Manager	4.5	6.0	2.6	6.2	6.0	**4.7**
	Nurse	4.5	6.0	3.9	6.1	6.6	**5.1**
	Health Care Assistant	5.1	6.5	4.4	6.7	7.4	**5.7**
	Total	**4.6**	**6.1**	**3.8**	**6.2**	**6.6**	**5.2**
Q5 G7-11	**Hospital Data**						
	Management / Admin	5.3	6.4	4.4	5.9	6.7	**5.9**
	Medical / Dental	4.3	6.4	4.5	4.5	4.8	**5.0**
	Nursing Management	5.1	6.3	3.3	5.9	6.0	**4.8**
	Health Care Professionals	4.6	6.3	3.3	4.9	5.8	**5.3**
	General Support Staff	4.9	5.6	3.6	5.6	6.3	**5.4**
	Other Patient Care	5.7	7.0	4.9	6.6	7.8	**6.0**
	Total	**4.9**	**6.1**	**3.8**	**5.4**	**6.1**	**5.4**

Table 8.2a: Formal Training on End-of-Life Care

Q4 F	Ward Data	Formal training on End-of-Life care			
		% attending	Mean length (days)	n	% provided in-house
	Major Teaching Hospitals	18.2	9.6	125	53.3
	Major Regional Hospitals	17.9	16.1	45	32.7
	Other Acute Hospitals	20.7	26.4	159	42.7
	Acute Hospitals	**19.2**	**18.6**	**329**	**45.7**
	Community Hospitals	**30.6**	**12.2**	**106**	**46.3**
	All HfH Hospitals	**21.1**	**17.0**	**435**	**45.8**
Q5 E	**Hospital Data**				
	Major Teaching Hospitals	11.3	7.8	34	37.0
	Major Regional Hospitals	7.1	24.4	10	10.0
	Other Acute Hospitals	11.2	9.5	73	25.0
	Acute Hospitals	**10.6**	**10.3**	**117**	**26.5**
	Community Hospitals	**15.9**	**9.3**	**44**	**32.8**
	All HfH Hospitals	**11.5**	**10.0**	**161**	**28.1**

* coding: scores 1-2 = unprepared, scores 3-4 = prepared

Table 8.2b: Formal Training on End-of-Life Care

Q4 F	Ward Data	Formal training on End-of-Life care			
		% attending	Mean length (days)	n	% provided in-house
	A & E	20.9	13.1	25	36.7
	Intensive Care	12.2	21.0	43	31.7
	Surgical	19.5	11.9	69	48.2
	Medical	19.0	16.3	109	43.1
	Oncology	32.4	74.5	28	40.6
	Geriatric	29.8	11.1	120	52.0
	Other	22.9	4.2	41	56.9
	Nurse Manager	35.4	18.2	93	32.4
	Nurse	18.9	13.8	280	44.5
	Health Care Assistant	19.8	29.9	62	65.3
	Total	**21.1**	**17.0**	**435**	**45.8**
Q5 E	**Hospital Data**				
	Management / Admin	5.4	13.6	25	34.3
	Medical / Dental	14.6	20.0	21	18.8
	Nursing Management	35.0	9.6	38	16.7
	Health Care Professionals	12.8	7.8	42	41.7
	General Support Staff	5.5	5.1	21	41.5
	Other Patient Care	46.2	4.0	14	4.2
	Total	**11.5**	**10.0**	**161**	**28.1**

* coding: scores 1-2 = unprepared, scores 3-4 = prepared

Table 8.3a: Professional and Personal Preparation

Q4 F	Ward Data	Feeling professionally prepared for dealing with the death of a patient			Feeling personally prepared for dealing with the death of a patient		
		pre-pared * %	unpre-pared * %	n	pre-pared * %	unpre-pared * %	n
	Major Teaching Hospitals	91.1	8.9	738	89.4	10.6	742
	Major Regional Hospitals	91.4	8.6	257	87.5	12.5	257
	Other Acute Hospitals	91.1	8.9	795	90.1	9.9	798
	Acute Hospitals	**91.1**	**8.9**	**1,790**	**89.4**	**10.6**	**1,797**
	Community Hospitals	**93.5**	**6.5**	**354**	**94.9**	**5.1**	**354**
	All HfH Hospitals	**91.5**	**8.5**	**2,144**	**90.3**	**9.7**	**2,151**
Q5 E	**Hospital Data**						
	Major Teaching Hospitals	63.4	36.6	306	68.0	32.0	309
	Major Regional Hospitals	59.3	40.7	182	66.7	33.3	186
	Other Acute Hospitals	62.0	38.0	715	67.4	32.6	726
	Acute Hospitals	**61.9**	**38.1**	**1,203**	**67.4**	**32.6**	**1,221**
	Community Hospitals	**71.2**	**28.8**	**274**	**76.9**	**23.1**	**273**
	All HfH Hospitals	**63.6**	**36.4**	**1,477**	**69.1**	**30.9**	**1,494**

* coding: scores 1-2 = unprepared, scores 3-4 = prepared

Table 8.3b: Professional and Personal Preparation

Q4 F	Ward Data	Feeling professionally prepared for dealing with the death of a patient			Feeling personally prepared for dealing with the death of a patient		
		pre-pared * %	unpre-pared * %	n	pre-pared * %	unpre-pared * %	n
	A & E	90.2	9.8	122	91.0	9.0	122
	Intensive Care	92.2	7.8	357	91.1	8.9	359
	Surgical	83.5	16.5	351	82.3	17.7	351
	Medical	93.9	6.1	610	91.7	8.3	613
	Oncology	93.1	6.9	102	88.2	11.8	102
	Geriatric	93.9	6.1	423	94.6	5.4	424
	Other	92.2	7.8	179	90.6	9.4	180
	Nurse Manager	95.6	4.4	270	94.8	5.2	269
	Nurse	91.4	8.6	1,537	89.5	10.5	1,539
	Health Care Assistant	88.7	11.3	337	90.7	9.3	343
	Total	**91.5**	**8.5**	**2,144**	**90.3**	**9.7**	**2,151**
Q5 E	**Hospital Data**						
	Management / Admin	42.4	57.6	370	47.3	52.7	372
	Medical / Dental	87.7	12.3	243	91.0	9.0	245
	Nursing Management	96.3	3.7	136	95.6	4.4	135
	Health Care Professionals	53.8	46.2	351	63.7	36.3	355
	General Support Staff	63.1	36.9	336	69.5	30.5	344
	Other Patient Care	92.7	7.3	41	93.0	7.0	43
	Total	**63.6**	**36.4**	**1,477**	**69.1**	**30.9**	**1,494**

* coding: scores 1-2 = unprepared, scores 3-4 = prepared

9 Supports for Staff Very Upset After Patient's Death (Q4G, Q5F)

Table 9.1a: Feeling Upset by a Patient's Death

Q4 F	Ward Data	having felt upset	needed to talk	n	talked to person inside hospital	talked to person outside hospital	n
		%	%		%	%	
	Major Teaching Hospitals	55.3	54.3	440	54.8	33.9	239
	Major Regional Hospitals	54.1	58.0	157	39.6	46.2	91
	Other Acute Hospitals	55.4	57.8	488	54.6	29.1	282
	Acute Hospitals	**55.2**	**56.4**	**1,085**	**52.5**	**33.5**	**612**
	Community Hospitals	**32.2**	**42.1**	**126**	**66.0**	**15.1**	**53**
	All HfH Hospitals	**51.4**	**54.9**	**1,211**	**53.5**	**32.0**	**665**
Q5 E	**Hospital Data**						
	Major Teaching Hospitals	38.6	32.5	209	44.9	42.0	69
	Major Regional Hospitals	40.9	41.8	134	38.6	45.6	57
	Other Acute Hospitals	33.6	32.0	460	43.6	38.9	149
	Acute Hospitals	**36.0**	**33.7**	**803**	**42.9**	**41.1**	**275**
	Community Hospitals	**34.9**	**26.4**	**178**	**44.7**	**34.0**	**47**
	All HfH Hospitals	**35.8**	**32.4**	**981**	**43.2**	**40.1**	**322**

Table 9.1b: Feeling Upset by a Patient's Death

Q4 F	Ward Data	having felt upset	needed to talk	n	talked to person inside hospital	talked to person outside hospital	n
		%	%		%	%	
	A & E	64.9	62.1	87	61.1	25.9	54
	Intensive Care	57.3	60.0	225	51.9	31.9	135
	Surgical	52.6	57.6	205	59.3	28.8	118
	Medical	52.8	53.8	355	45.0	40.3	191
	Oncology	67.6	61.6	73	60.0	33.3	45
	Geriatric	35.0	40.9	164	64.2	20.9	67
	Other	51.4	53.9	102	49.1	29.1	55
	Nurse Manager	59.2	50.9	173	62.5	26.1	88
	Nurse	51.8	57.8	863	52.5	34.5	499
	Health Care Assistant	43.6	44.6	175	50.0	23.1	78
	Total	**51.4**	**54.9**	**1,211**	**53.5**	**32.0**	**665**
Q5 E	**Hospital Data**						
	Management / Admin	28.9	18.6	258	38.0	40.0	50
	Medical / Dental	48.4	44.0	166	46.6	41.1	73
	Nursing Management	37.6	44.3	79	60.0	34.3	35
	Health Care Professionals	31.9	38.0	187	44.4	38.9	72
	General Support Staff	37.6	27.7	267	37.3	37.3	75
	Other Patient Care	42.9	70.8	24	29.4	64.7	17
	Total	**35.8**	**32.4**	**981**	**43.2**	**40.1**	**322**

Table 9.2a: Future Supports if Very Upset at Patient Dying

Q4 F	Ward Data	In-house counsel-ling	Collea-gues	Manager	Change shift patterns	Time off work	Other
		%	%	%	%	%	%
	Major Teaching Hospitals	71.5	93.5	89.2	30.1	25.1	23.4
	Major Regional Hospitals	63.2	95.1	80.0	22.3	11.3	21.9
	Other Acute Hospitals	71.6	94.5	82.4	33.6	23.4	21.5
	Acute Hospitals	**70.4**	**94.2**	**84.9**	**30.5**	**22.3**	**22.4**
	Community Hospitals	**68.6**	**93.3**	**90.2**	**41.5**	**42.0**	**27.9**
	All HfH Hospitals	**70.1**	**94.0**	**85.7**	**32.3**	**25.5**	**23.2**
	n	1,507	2,139	2,056	1,730	1,703	746
Q5 E	**Hospital Data**						
	Major Teaching Hospitals	73.8	92.9	68.9	22.0	35.7	37.8
	Major Regional Hospitals	77.6	91.4	69.7	19.5	29.2	37.5
	Other Acute Hospitals	79.4	95.6	72.4	20.1	37.5	36.5
	Acute Hospitals	**77.7**	**94.3**	**71.1**	**20.5**	**35.8**	**37.0**
	Community Hospitals	**70.8**	**94.6**	**87.3**	**38.6**	**38.5**	**32.8**
	All HfH Hospitals	**76.5**	**94.3**	**74.1**	**23.6**	**36.3**	**36.3**
	n	953	1,358	1,189	980	1,000	380

Table 9.2b: Future Supports if Very Upset at Patient Dying

Q4 F	Ward Data	In-house counsel-ling	Collea-gues	Manager	Change shift patterns	Time off work	Other
		%	%	%	%	%	%
	A & E	73.0	97.6	89.1	24.3	24.5	20.5
	Intensive Care	73.3	94.8	84.1	30.7	23.4	24.2
	Surgical	69.7	94.6	80.7	30.1	18.4	17.1
	Medical	69.7	93.4	86.2	31.7	23.4	22.1
	Oncology	71.0	92.9	90.7	43.8	30.9	40.6
	Geriatric	68.9	92.5	88.2	37.8	37.8	27.1
	Other	65.8	95.0	86.7	28.6	19.1	20.3
	Nurse Manager	81.6	94.6	88.8	31.8	24.5	25.3
	Nurse	66.6	95.0	86.0	31.7	23.0	22.7
	Health Care Assistant	73.5	88.9	82.1	35.3	37.0	23.6
	Total	**70.1**	**94.0**	**85.7**	**32.3**	**25.5**	**23.2**
	n	1,507	2,139	2,056	1,730	1,703	746
Q5 E	**Hospital Data**						
	Management / Admin	82.9	94.9	79.9	27.2	43.1	36.0
	Medical / Dental	37.9	95.2	30.7	9.7	17.2	28.0
	Nursing Management	90.0	98.5	90.2	47.5	49.5	70.3
	Health Care Professionals	81.8	95.1	82.2	12.1	32.0	36.2
	General Support Staff	80.7	89.5	77.4	33.5	42.0	27.6
	Other Patient Care	63.0	100.0	76.5	20.0	40.0	58.3
	Total	**76.5**	**94.3**	**74.1**	**23.6**	**36.3**	**36.3**
	n	953	1,358	1,189	980	1,000	380

10 Hospital Priorities (Q4J, Q5H)

Table 10.1a: Hospital Priorities (Items 1-7)

Q4 J1-7	Ward Data	Active treatment	Optimising Quality of Life	Ensuring quality of End-of-Life care	Controlling Infection	Person centred approach to patient	Person centred approach to staff	Increasing patient independence
		Mean	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**
	Major Teaching Hospitals	8.2	7.9	7.7	7.8	7.3	6.6	7.1
	Major Regional Hospitals	7.4	6.9	6.8	6.7	6.1	5.1	6.0
	Other Acute Hospitals	7.7	7.4	7.3	7.7	7.0	6.0	6.6
	Acute Hospitals	**7.9**	**7.5**	**7.4**	**7.6**	**7.0**	**6.1**	**6.7**
	Community Hospitals	**8.5**	**8.5**	**8.7**	**8.6**	**8.3**	**7.3**	**7.9**
	All HfH Hospitals	**8.0**	**7.7**	**7.6**	**7.7**	**7.2**	**6.3**	**6.9**
	n	2,311	2,298	2,282	2,318	2,268	2,253	2,288
Q5 H1-7	**Hospital Data**							
	Major Teaching Hospitals	8.2	7.1	6.9	7.4	6.3	5.3	6.0
	Major Regional Hospitals	8.0	7.2	6.9	6.9	6.1	5.2	6.0
	Other Acute Hospitals	8.2	7.7	7.4	7.9	7.1	6.1	6.6
	Acute Hospitals	**8.1**	**7.5**	**7.2**	**7.6**	**6.7**	**5.8**	**6.4**
	Community Hospitals	**8.3**	**8.2**	**8.2**	**8.4**	**7.9**	**7.1**	**7.5**
	All HfH Hospitals	**8.2**	**7.6**	**7.4**	**7.8**	**6.9**	**6.0**	**6.6**
	n	1,545	1,516	1,450	1,614	1,436	1,446	1,370

Table 10.1b: Hospital Priorities (Items 1-7)

Q4 J1-7	Ward Data	Active treatment	Optimising Quality of Life	Ensuring quality of End-of-Life care	Controlling Infection	Person centred approach to patient	Person centred approach to staff	Increasing patient independence
		Mean	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**
	A & E	7.6	7.0	6.8	6.8	6.3	5.4	5.8
	Intensive Care	7.9	7.3	6.9	7.8	6.9	5.9	6.2
	Surgical	7.7	7.3	7.2	7.4	6.8	5.8	6.7
	Medical	7.9	7.6	7.5	7.5	7.0	6.3	6.9
	Oncology	8.3	8.0	8.0	8.0	7.5	6.6	7.2
	Geriatric	8.4	8.4	8.6	8.4	8.2	7.3	7.8
	Other	8.2	7.9	7.8	8.0	7.5	6.5	7.0
	Nurse Manager	8.1	7.7	7.3	7.9	7.2	6.1	6.6
	Nurse	7.9	7.6	7.4	7.6	7.1	6.2	6.8
	Health Care Assistant	8.3	8.2	8.4	8.2	7.8	7.1	7.8
	Total	**8.0**	**7.7**	**7.6**	**7.7**	**7.2**	**6.3**	**6.9**
Q5 H1-7	**Hospital Data**							
	Management / Admin	8.3	7.9	7.9	8.0	7.3	6.4	7.0
	Medical / Dental	8.4	7.4	6.9	7.4	6.3	5.5	6.2
	Nursing Management	8.3	7.6	7.3	8.3	7.6	6.4	6.6
	Health Care Professionals	8.1	7.2	6.8	7.6	6.6	5.4	6.1
	General Support Staff	7.8	7.7	7.7	7.6	6.9	6.2	6.9
	Other Patient Care	8.6	7.9	7.7	8.6	7.8	7.0	7.0
	Total	**8.2**	**7.6**	**7.4**	**7.8**	**6.9**	**6.0**	**6.6**

Table 10.1a: Hospital Priorities (Items 8-13)

Q4 J1-7	Ward Data	Ensuring equality of treatment	Career development	Supporting staff	Respect of hospital ethos	Avoiding legal risks	Carrying out innovative research	Hospital Priorities
		Mean	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**
	Major Teaching Hospitals	7.8	7.1	6.5	7.3	7.7	6.8	**7.4**
	Major Regional Hospitals	6.7	4.9	4.7	5.9	6.6	4.6	**6.1**
	Other Acute Hospitals	7.5	5.8	5.6	6.6	7.0	5.1	**6.8**
	Acute Hospitals	**7.5**	**6.2**	**5.9**	**6.8**	**7.3**	**5.7**	**6.9**
	Community Hospitals	**8.4**	**7.2**	**7.2**	**8.1**	**8.2**	**6.3**	**8.0**
	All HfH Hospitals	**7.7**	**6.3**	**6.1**	**7.0**	**7.4**	**5.8**	**7.1**
	n	2,314	2,306	2,194	2,201	2,077	1,859	2,341
Q5 H1-7	**Hospital Data**							
	Major Teaching Hospitals	6.8	6.1	6.0	6.3	7.5	6.3	**6.7**
	Major Regional Hospitals	6.7	5.4	5.7	6.0	7.0	4.6	**6.4**
	Other Acute Hospitals	7.3	6.0	6.4	6.7	7.4	4.9	**7.0**
	Acute Hospitals	7.1	5.9	6.2	6.5	7.4	5.3	**6.8**
	Community Hospitals	**8.2**	**6.7**	**7.3**	**7.5**	**7.9**	**5.7**	**7.7**
	All HfH Hospitals	**7.3**	**6.1**	**6.4**	**6.7**	**7.5**	**5.3**	**7.0**
	n	1,541	1,536	1,156	1,460	1,461	1,223	1,740

Table 10.1b: Hospital Priorities (Items 8-13)

Q4 J1-7	Ward Data	Ensuring equality of treatment	Career development	Supporting staff	Respect of hospital ethos	Avoiding legal risks	Carrying out innovative research	Hospital Priorities
		Mean	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**
	A & E	7.1	6.0	5.6	6.6	6.8	4.9	**6.4**
	Intensive Care	7.3	5.7	5.5	6.5	7.0	5.3	**6.7**
	Surgical	7.3	5.7	5.4	6.5	7.1	5.2	**6.7**
	Medical	7.7	6.4	6.1	6.9	7.3	6.0	**7.1**
	Oncology	7.8	7.1	6.0	7.2	7.5	6.8	**7.4**
	Geriatric	8.3	7.2	7.2	8.1	8.2	6.5	**7.9**
	Other	7.7	6.5	6.3	7.0	7.8	5.9	**7.3**
	Nurse Manager	7.5	6.5	5.8	6.8	7.1	5.5	**6.9**
	Nurse	7.6	6.1	5.9	6.9	7.3	5.7	**6.9**
	Health Care Assistant	8.1	7.1	7.0	7.8	8.3	7.0	**7.8**
	Total	**7.7**	**6.3**	**6.1**	**7.0**	**7.4**	**5.8**	**7.1**
Q5 H1-7	**Hospital Data**							
	Management / Admin	7.7	6.2	6.8	7.0	7.6	5.9	**7.3**
	Medical / Dental	7.1	5.9	5.7	6.2	7.2	4.5	**6.6**
	Nursing Management	7.6	6.8	6.8	6.9	7.4	4.7	**7.1**
	Health Care Professionals	6.7	5.4	5.5	6.2	7.4	4.7	**6.5**
	General Support Staff	7.4	6.2	6.7	7.0	7.5	6.4	**7.1**
	Other Patient Care	7.8	7.3	7.1	7.7	8.1	6.4	**7.7**
	Total	**7.3**	**6.1**	**6.4**	**6.7**	**7.5**	**5.3**	**7.0**

11 Religious Ethos (Q4J, Q5H)

Table 11.1: Religious Ethos

Q4A1	Ward Data	Ward Data			Hospital Data		
		Non-religious	Fairly religious	Very religious	Non-religious	Fairly religious	Very religious
ID	**Hospital**	**%**	**%**	**%**	**%**	**%**	**%**
A01	Cork University	9.9	71.1	19.0	17.5	76.3	6.3
A02	Limerick Mid-Western	3.2	74.4	22.4	13.1	78.6	8.3
A03	Cavan General	9.5	76.2	14.3	11.9	67.8	20.3
A04	Monaghan General	6.7	50.0	43.3	50.0	50.0	
A05	Lourdes Drogheda		67.4	32.6	4.7	70.6	24.7
A06	Our Lady's Navan	2.3	65.1	32.6	2.9	52.9	44.1
A07	Louth County Dundalk	10.0	70.0	20.0	10.0	90.0	
A08	Kerry General Tralee	4.8	74.6	20.6	2.0	92.2	5.9
A09	Wexford General	11.1	70.4	18.5	21.4	67.9	10.7
A10	St James's Dublin	10.9	67.7	21.4	30.2	64.6	5.2
A11	Sligo General		81.4	18.6	8.2	80.3	11.5
A12	Mater University		47.1	52.9	8.7	69.6	21.7
A13	Connolly Hospital	10.0	60.9	29.1	20.9	71.6	7.5
A14	Letterkenny General	2.4	68.2	29.4	8.3	70.8	20.8
A15	St Luke's Rathgar	3.6	75.0	21.4	10.2	79.6	10.2
A16	Portlaoise Regional	17.6	79.4	2.9	24.1	70.7	5.2
A17	Beaumont	7.5	66.8	25.6	22.7	69.1	8.2
A18	Waterford Regional	10.9	71.9	17.2	5.9	82.4	11.8
A19	South Tipp General	4.4	80.0	15.6	3.6	81.8	14.5
A20	St Luke's Kilkenny		75.0	25.0	10.5	75.4	14.0
A21	Tallaght Hospital	8.3	63.5	28.1	26.1	63.0	10.9
A22	Nenagh Mid-Western	5.0	70.0	25.0	1.6	68.9	29.5
A23	Naas General	10.3	67.6	22.1	15.1	70.9	14.0
A24	Tullamore Regional	3.9	82.4	13.7	18.4	71.1	10.5
C55	St. Mary's Phoenix Park		53.1	46.9	2.0	70.0	28.0
C56	St John's Hospital, Sligo	2.2	44.4	53.3	3.0	57.6	39.4
C70	Dublin Group**	3.9	48.1	48.1	8.6	68.6	22.9
C80	North East Group**		53.2	46.8	3.3	58.3	38.3
	Major Teaching Hospitals	7.2	63.0	29.7	22.2	68.8	9.0
	Major Regional Hospitals	8.4	73.9	17.8	13.2	78.0	8.8
	Other Acute Hospitals	4.8	70.5	24.7	10.3	73.8	16.0
H87	**Acute Hospitals**	**6.3**	**68.0**	**25.7**	**13.8**	**73.2**	**13.1**
H88	**Community Hospitals**	**1.6**	**50.4**	**48.0**	**6.0**	**65.7**	**28.3**
H89	**All HfH Hospitals**	**5.5**	**65.1**	**29.4**	**12.3**	**71.8**	**15.8**

12 Endnotes:

Grouping of Community Hospitals:

1. Completion rates are calculated only for those hospitals which have 150 deaths or more in a year and which could meet the target of completing the audit on 50 deaths in a four month period. Thus the overall completion rate for these hospitals is calculated as the number of deaths in the audit as a percent of 50 deaths. Completion rates were also calculated for A&E, Intensive Care, and Other Wards and expressed as the percent of audited deaths in each area of the hospital relative to their percentage share in total deaths.

2. Due to the small number of deaths in some community hospitals, the analysis reclassified these hospitals as follows:

• St. Mary's Phoenix Park • St John's Hospital, Sligo • Dublin Group comprising: ✓ Royal Hospital Donnybrook ✓ Bru Chaoimhin ✓ Bellvilla ✓ Meath Community Unit ✓ Leopardstown Park Hospital ✓ Peamount Hospital, Newcastle	• North East Group comprising: ✓ St. Joseph's Hospital, Trim ✓ St. Mary's, Castleblayney ✓ Oriel House, Monaghan Town ✓ Breffni Care Unit, Ballyconnell, Co. Cavan ✓ Virginia Healthcare Unit, Cavan ✓ Lisdaran Unit, Cavan ✓ Boyne View, Drogheda ✓ Cottage Hospital, Drogheda ✓ St. Mary's Hospital, Drogheda ✓ Sullivan Centre, Cavan ✓ St. Joseph's Hospital, Ardee

Grouping of Acute Hospitals into Teaching Hospitals, Regional Hospital and Other Hospitals:

Major Teaching Hospitals ▪ St James's Dublin ▪ Beaumont ▪ Mater University ▪ Tallaght (AMNCH) ▪ Cork University **Major Regional Hospitals** ▪ Waterford Regional ▪ Limerick Mid-Western ▪ Portlaoise Regional	**Other Acute Hospitals** ▪ St Luke's Rathgar ▪ Our Lady's Navan ▪ Louth County Dundalk ▪ Nenagh Mid-Western ▪ Monaghan General ▪ St Luke's Kilkenny ▪ Kerry General Tralee ▪ South Tipp General ▪ Cavan General ▪ Wexford General ▪ Naas General ▪ Letterkenny General ▪ Connolly Hospital ▪ Sligo General ▪ Lourdes Drogheda ▪ Tullamore Regional