Documenting end-of-life family meetings in patients' medical notes in acute care

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Background

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Diagnostic/prognostic conversations around life-limiting illness in regional Victorian inpatient settings are often led by generalist clinicians in the acute wards

Background continued

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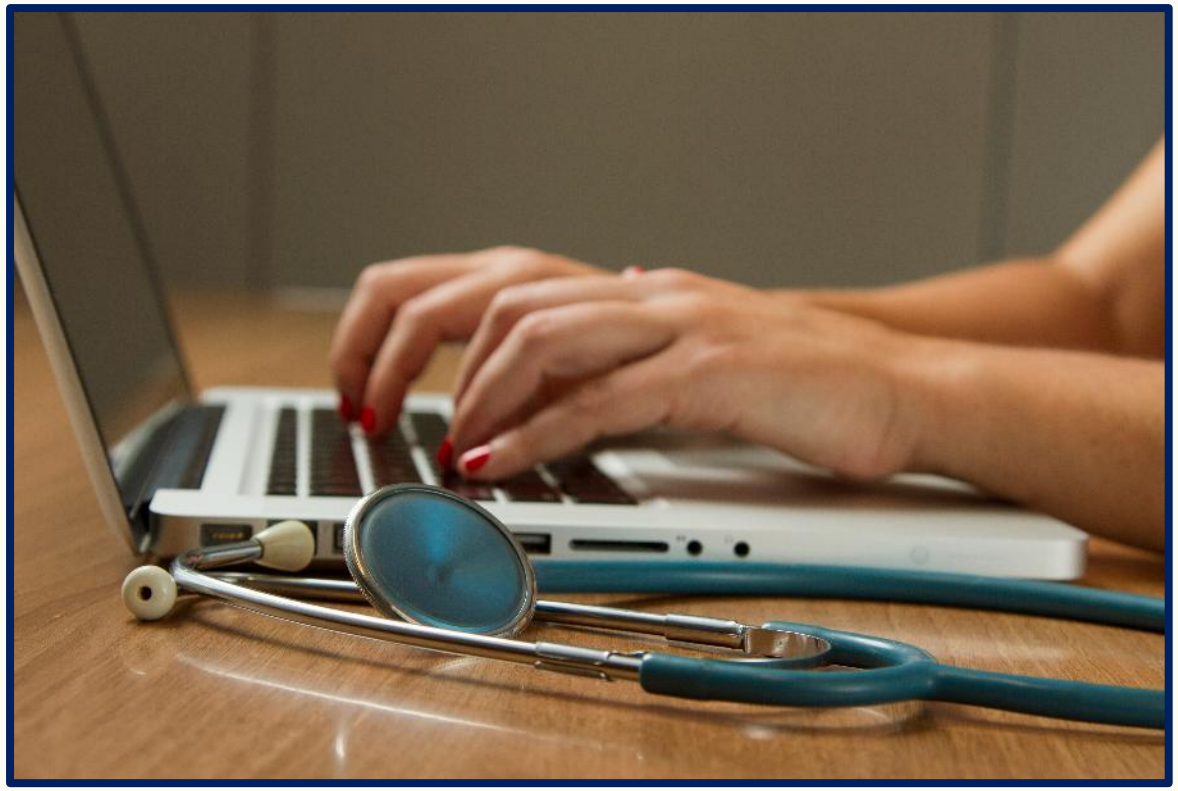
Generalist clinicians without palliative care training often find diagnostic/prognostic conversations difficult

(Berkey et al., 2018; Miller et al., 2022)

Background continued



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Clinician discomfort with EOL communication is reflected in how and what is written in the medical notes (Dillon et al., 2022)

Background continued

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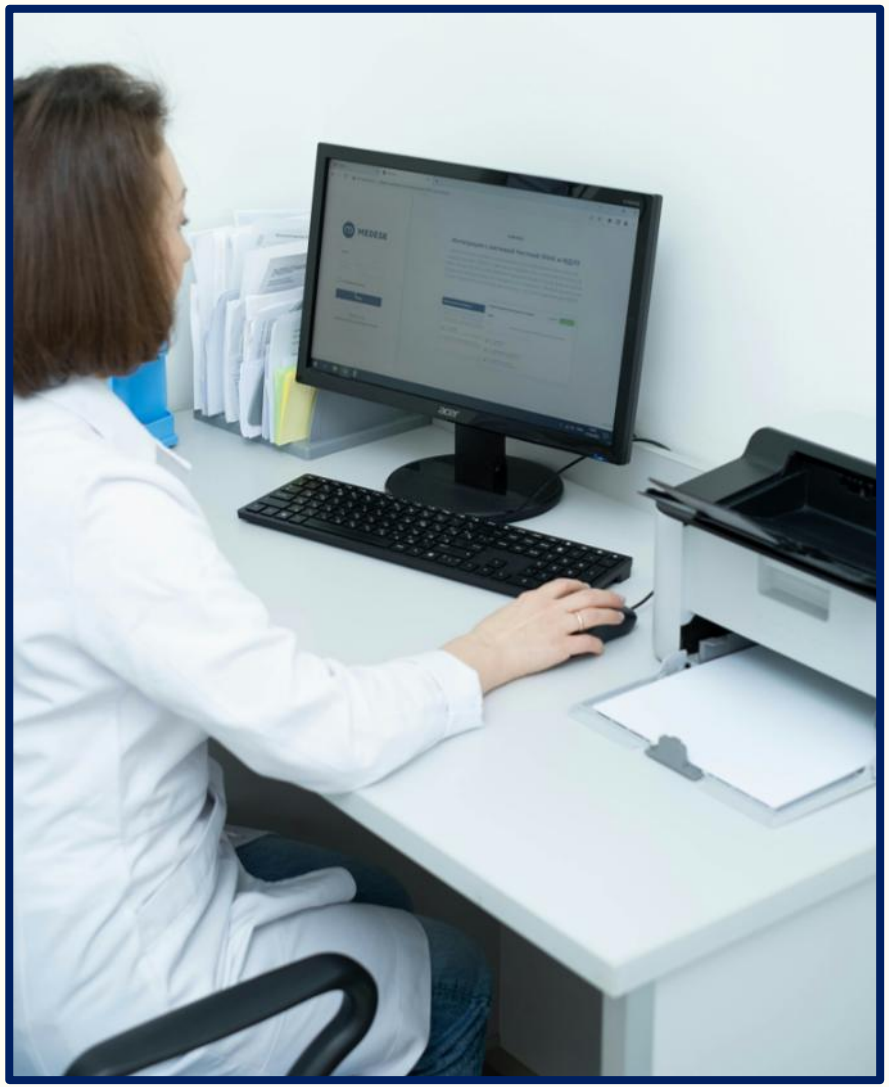
Multiple healthcare teams rely on the accuracy of the notes to provide safe person-centred care

(Australian Commission on Safety and Quality in Health Care (ACSQH) 2021; Rowlands et al., 2022; Wentlandt et al., 2018)

Background continued



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Incomplete, vague or missing information in the patient notes presents a safety risk

(Berkey et al., 2018)

Aim

To understand how family meeting notes were written in a regional inpatient setting, the medical note audit aimed to:

- Understand what type of information and language is recorded in the notes;
- Explore how healthcare professionals document diagnostic/prognostic conversations in family meetings.

Methodology

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Design:

A retrospective audit of 221 patient notes using qualitative content analysis

(Graneheim et al., 2017; Ngulube, 2015)

Setting:

A regional Victorian hospital without a dedicated palliative care unit

Methodology

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Data:

Analysis of 17 formal pre-arranged family meetings involving diagnostic and prognostic discussions

Ethics and Context:

Approved. Study part of broader case study examining experiences of receiving bad news of a life-limiting illness

Results: Note completeness scores

Of the17 family meeting notes:

- Meeting purpose documented: **18%**
- Who led the meeting: **6%**
- Patient/family's understanding: **88%**
- Patient/family's emotional responses: **18%**
- Mean completeness score: **54%**

Miller et al. (2026). Documenting end-of-life family meetings in patients' medical notes in acute care

Results: Documented Language

Common terms were "***deteriorating***", "***decline***", "***life expectancy***", "***being made comfortable***", "***comfort care***", "***dignity***", and "***quality of life***".

*"Pt's choices have accelerated **death**."* (File 154)

"***Given not improving***, *impression is **terminal event** – For palliative pathway"* (File 90)

"*SW touched base re options if **gets through** the weekend"* (File 89)

Results: Documented Language

"*Explained that if **continues to deteriorate for palliation** over the weekend or early next week*" (File 89)

"*Given all above problems **palliation is the approach that offers the least suffering** and reflects her prognosis*" (File 35)

"*Ongoing inpatient palliative care input **as appropriate***" (File 186)

"?days to weeks" (File 11) and ***"Life expectancy now days-week"*** (File 98)

Only 2/17 patients (Files 75, 186) had PC involvement, despite a prognosis of days, weeks or months.

Discussion

- Softened language and euphemisms in documentation soften the reality and dilute the message (McLennon et al., 2013; Miller et al., 2022) and omit critical emotional context.

- "Comfort care", used synonymously with EOLC is broad, holding subjective meaning (e.g. no pain) (Chan et al., 2018; Dickerson et al., 2022).

Discussion

- PC appeared to be viewed negatively and often as a last resort, reflecting a lack of understanding of the value of PC (Chan et al., 2018) and failure to recognise dying (Bloomer et al., 2011).

- The curative focus reflects "full-bore v. full-stop" mentality (Dickerson et al., 2022).

- Reflects broader discomfort with death and dying, which are often treated as taboo topics in society (Miller et al., 2023).

Discussion

- Comprehensive documentation by the PCNP highlights the importance of expertise and role modelling in improving the quality of medical records (Dillon et al., 2021; Hudson et al., 2008).

Implications and Conclusions

1. Internal audits with structured tools like the Miller Palliative Family Meeting Audit Tool help identify gaps and model best practice.
2. Normalising early palliative care and using clear terminology enhances understanding among patients, families, and healthcare teams.
3. Consistent documentation of meeting purpose, attendees, and prognostic language improves palliative care quality and understanding.
4. Clear, comprehensive documentation supports safer, compassionate, and person-centred end-of-life care in hospital settings.

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Thank you for listening!

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