



Research paper

End-of-life care practices of critical care nurses: A national cross-sectional survey



Kristen Ranse RN, PhD^{a,*},
Patsy Yates RN, PhD^b,
Fiona Coyer RN, PhD^b

^a *Disciplines of Nursing & Midwifery, Faculty of Health, University of Canberra, Australia*

^b *School of Nursing & Institute of Health and Biomedical Innovation, Queensland University of Technology, Australia*

ARTICLE INFORMATION

Article history:

Received 13 April 2015

Received in revised form 22 June 2015

Accepted 8 July 2015

Keywords:

End-of-life care

Nursing

Critical care

Survey

Factor analysis

Practices

ABSTRACT

Background: The critical care context presents important opportunities for nurses to deliver skilled, comprehensive care to patients at the end of life and their families. Limited research has identified the actual end-of-life care practices of critical care nurses.

Objective: To identify the end-of-life care practices of critical care nurses.

Design: A national cross-sectional online survey.

Methods: The survey was distributed to members of an Australian critical care nursing association and 392 critical care nurses (response rate 25%) completed the survey. Exploratory factor analysis using principal axis factoring with oblique rotation was undertaken on survey responses to identify the domains of end-of-life care practice. Descriptive statistics were calculated for individual survey items.

Results: Exploratory factor analysis identified six domains of end-of-life care practice: information sharing, environmental modification, emotional support, patient and family centred decision-making, symptom management and spiritual support. Descriptive statistics identified a high level of engagement in information sharing and environmental modification practices and less frequent engagement in items from the emotional support and symptom management practice areas.

Conclusions: The findings of this study identified domains of end-of-life care practice, and critical care nurse engagement in these practices. The findings highlight future training and practice development opportunities, including the need for experiential learning targeting the emotional support practice domain. Further research is needed to enhance knowledge of symptom management practices during the provision of end-of-life care to inform and improve practice in this area.

© 2015 Australian College of Critical Care Nurses Ltd. Published by Elsevier Ltd. All rights reserved.

1. Introduction

The provision of end-of-life care to patients and their families in the curative context of critical care presents unique challenges and important opportunities for nurses engaged in this work.¹ Patients are admitted to critical care units during an acute phase of illness or following traumatic injury, potentially limiting the time for the nurse to establish a relationship with the patient and the patient's family.^{2–4} Communication between the patient and nurse may also be impeded with up to 95% of critically ill patients cognitively impaired as a result of their illness, injury and/or medical

management.⁵ In addition, the length of time between the withdrawal of life-sustaining treatment and subsequent death of the patient is relatively short and it is this period of care that is the focus of this study. In a chart audit, undertaken over a 12-month period in an Australian metropolitan intensive care unit (ICU), the median time from withdrawal of life-sustaining treatment to death was 105 min, with 72% of patients dying within 6 h of withdrawal of life-sustaining treatment.⁶ This is consistent with figures reported in epidemiological studies in ICUs internationally.^{7,8} Thus, critical care nurses have limited time to establish relationships and provide comprehensive care to the patient at the end of life and to the patient's family. This presents a challenge and stressor for critical care nurses engaged in this work.⁹

Critical care nurses work in a context that supports high nurse-to-patient ratios. This context presents important opportunities for nurses to deliver skilled, comprehensive care to patients at the

* Corresponding author at: Building 10, Disciplines of Nursing & Midwifery, Faculty of Health, University of Canberra, ACT 2601, Australia. Tel.: +61 2 6201 2029.

E-mail address: Kristen.Ranse@canberra.edu.au (K. Ranse).

Table 1
Comparison of Clarke et al.'s²¹ domains of end-of-life care, Ranse et al.'s¹ exploratory qualitative study and initial a priori scales in the survey instrument.

Clarke et al. ²¹	Ranse et al. ¹	A priori scale in instrument
Patient and family centred decision making	Facilitating the family's experience: providing options and respecting choices	Patient and family centred decision making
Communication within the team and with patients and families	Facilitating the family's experience: explaining and providing information	Explaining and providing information
Continuity of care	–	Continuity of care
Emotional and practical support for patients and families	Humanising the patient Facilitating the family's experience	Emotional and practical support for patients and families
Symptom management and comfort care	Modifying the bedside environment Comfort care	Comfort care – environmental factors Symptom management and comfort care
Spiritual support for patients and families	–	Spiritual support

end of life and their families. However, evidence indicates critical care nurses are not adequately prepared to provide care to patients at the end of life and their families. In a recent survey completed by 475 critical care nurses in the United States, only 15.5% of participants reported that their initial nursing training included compulsory content pertaining to withdrawal of life-sustaining treatment and 44% of participants indicated that they had attended in-service about withdrawal of life-sustaining treatment.¹⁰ To evaluate and improve the care that dying patients and their families receive and to support nurses in the provision of optimal end-of-life care, a better understanding of the current end-of-life care practices of critical care nurses is needed.

1.1. Background

Previous research exploring critical care nurses' experiences of end-of-life care has been reported.^{11–19} These studies provide some insight into the end-of-life care experiences of critical care nurses but the ability to generalise the findings beyond the settings of the studies is limited. More recently, the findings from audits of medical records of patients who had died in an Australian ICU have been published.^{6,20} While these studies provide important information regarding end-of-life care in critical care, including patients' diagnosis, family presence and treatments withdrawn or withheld, the use of chart audit as the primary source of data is limited because it assumes that such information is consistently documented by care providers. Indeed, the authors noted the absence of documentation regarding communication between the nurse and family in their setting.²⁰

Few studies have focused on the actual end-of-life care practices of critical care nurses. Clarke et al., using a modified Delphi approach involving 36 expert clinicians, identified seven domains of end-of-life care: patient and family centred decision making, communication, continuity of care, emotional and practical support, symptom management and comfort care, spiritual support, and emotional and organisational support for intensive care clinicians.²¹ These domains were reviewed by 15 nurse–physician pairs to identify interventions and behaviours for each domain. However, empirical testing and validation of the findings of this study with larger samples was not undertaken.

Despite an extensive search of the literature, no validated tools were found that could be used to identify the end-of-life care practices of nurses in the critical care context. Research is needed to identify the current practice of critical care nurses during the provision of end-of-life care. Knowledge gained from this study can inform the development of strategies to support and improve the provision of end-of-life care in critical care settings.

2. Methods

2.1. Design

The findings reported in this paper are a component of a larger national cross-sectional survey that aimed to identify the end-of-life care practices of critical care nurses and the factors influencing these practices. The focus of this paper is on the end-of-life care practices section of the survey. The factors influencing the provision of end-of-life care section of the survey instrument using the same method and national sample has been reported elsewhere.²²

2.2. Development and testing of the critical care nurses' end-of-life care practices section of the survey

To determine the a priori scales of the end-of-life care practices section of the survey, the six domains of end-of-life care identified by Clarke et al. that relate to the care of the patient and their family, were compared to the findings of an Australian descriptive qualitative study that explored the end-of-life care beliefs and practices of five intensive care nurses (see Table 1).^{1,21} The a priori scales provided a framework to ensure coverage of all areas of end-of-life care practice through inclusion of items representing practices from each a priori scale. Initially, 42 items were empirically derived from a review of the literature on end-of-life care in critical care settings and the findings of an earlier descriptive exploratory qualitative study.¹ The survey required respondents to rate how often they undertake select practices when caring for a patient at the end-of-life using a 5-point rating scale where 1 = never, 2 = rarely, 3 = sometimes, 4 = often and 5 = always.

2.2.1. Content validity testing

The newly developed survey was reviewed by a panel of six Registered Nurses with expertise in end-of-life care, palliative care, critical care and/or instrument development to obtain preliminary evidence of the validity of the survey in measuring the content of interest in this study. The experts provided comment regarding the coverage of the a priori scales and suggested the addition, modification or deletion of individual items. In addition, experts rated the relevance of each item (1 = not relevant; 2 = somewhat relevant; 3 = quite relevant; 4 = highly relevant), permitting the calculation of individual and overall content validity index. An individual content validity index (I-CVI) of 0.80 and an overall content validity index (S-CVI) of 0.90 was considered satisfactory.^{23,24} Items with an I-CVI of less than 0.80 were reviewed, modified and/or deleted. Three items were deleted and one item added to the end-of-life care practices section of the survey. The survey was then returned to the expert panel for further comment. The overall content

Download English Version:

<https://daneshyari.com/en/article/5863198>

Download Persian Version:

<https://daneshyari.com/article/5863198>

[Daneshyari.com](https://daneshyari.com)