Rural Emergency Nurses' Suggestions for Improving End-of-Life Care

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Introduction: Many patient visits to emergency departments result in the patient dying or being pronounced dead on arrival. The numbers of deaths in emergency departments are likely to increase as a significant portion of the U.S. population ages. Consequently, emergency nurses face many obstacles to providing quality end-of-life (EOL) care when death occurs. The purpose of this study was to identify suggestions that emergency nurses have to improve EOL care, specifically in rural emergency departments.

Methods: A 57-item questionnaire was sent to 53 rural hospitals in 4 states in the Intermountain West, plus Alaska. One item asked nurses to identify the one aspect of EOL care they would change for dying patients in rural emergency departments. Each qualitative response was individually reviewed by a research team and then coded into a theme.

Results: Four major themes and three minor themes were identified. The major themes were providing greater privacy during EOL care for patients and family members, increasing availability of support services, additional staffing, and improved staff and community education.

Discussion: Providing adequate privacy for patients and family members was a major obstacle to providing EOL care in the emergency department, largely because of poor department design, especially in rural emergency departments where space is limited. Lack of support services and adequate staffing were also obstacles to providing quality EOL care in rural emergency departments. Consequently, rural nurses are commonly pulled away from EOL care to perform ancillary duties because additional support personnel are lacking. Providing EOL care in rural emergency departments is a challenging task given the limited staffing and resources, and thus it is imperative that nurses' suggestions for improvement of EOL care be acknowledged. Because of the current lack of research in rural EOL care, additional research is needed.

Key words: End-of-life care; Rural; Emergency department; Emergency nurses; Obstacles; Suggestions

Death is a part of life that can be neither avoided nor predicted. In 2010, of the 129 million visits to the emergency department, 240,000 resulted in the patient dying or being pronounced dead on arrival.[1] Although care in the emergency department is focused on saving lives and returning patients to a healthy state, death cannot always be prevented.[2]

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As the population of the United States continues to age, ED visits of the aging population also continue to rise.[1] It is estimated that 1 in 5 persons will be age 65 years and older by the year 2030.[3] Consequently, the number of patients who are at the end of life (EOL) or dying will increase, further taxing the already limited resources available to provide EOL care in the emergency department. Thus it is imperative that both obstacles and helpful or supportive behaviors to providing EOL care in the emergency department be identified.

Providing care to dying patients, regardless of their age, is a responsibility that all emergency nurses assume at some point in their careers. However, because emergency nurses are primarily trained to save lives, they often encounter obstacles to providing EOL care to dying patients, especially in rural settings where staffing and resources are limited.[2]

Background

From the nurses' perspective, EOL research in the emergency department has generally focused on 3 primary aspects: issues regarding the nurse's workload while caring for dying patients, care of family members in addition to care of dying patients, and difficulties in providing quality EOL care in emergency departments with poor department design.

The workload of nurses who are caring for dying patients has been reported in several studies. In 2 previous studies, randomly selected nurses who were ENA members reported that their assigned workloads were too high to provide quality EOL care.[4,5] Additionally, nurses reported being pulled away from EOL care to assist with other patients and department obligations, resulting in disjointed care for the dying patient.[2,6] To improve and provide optimal EOL care, nurses suggested increasing the amount of time available to spend with dying patients, recommending one-to-one nursing care for EOL patients.[6]

Care of family members of dying patients has been a second focus of previous studies. In a study of 236 nurses working in rural emergency departments, emergency nurses reported frequent calls from both family members and friends seeking patient condition updates as a major obstacle to providing EOL care.[2] Additionally, as a liaison, nurses often intercepted distraught and angry family members,[4] preventing nurses from spending valuable time with the dying patient. This lack of intermediary staff was especially evident in rural facilities where the presence of family support services such as social workers and religious leaders was limited.[2]

Regarding ED design, nurses from rural and urban emergency departments reported that ED designs did not allow for adequate privacy for dying patients and grieving family members.[2,4] When asked how to improve EOL care, a national, random sample of 230 emergency nurses suggested greater privacy for patients and family, including provision of a separate family grief room.[6] These nurses suggested a designated grief room that would allow family members to grieve privately, away from the noise and distraction of the busy emergency department.

Given the ever-increasing aged population and the rate of death that occurs in emergency departments nationally, it is imperative that both supportive behaviors and obstacles to providing EOL care in emergency departments be identified. Because research regarding EOL care in rural emergency departments is limited, the purpose of this study was to identify suggestions emergency nurses might have to improve EOL care in rural emergency departments. Therefore, the research question posed to rural emergency nurses for this study was, "If you had the ability to change just one aspect of the end-of-life care given to dying ED patients in a rural setting, what would it be?"

Methods

STUDY DESIGN

A cross-sectional survey research design was used for this study. Included in this design were 3 open-ended questions.

INSTRUMENT

The Rural Emergency Nurse's Perception of End-of-Life Care questionnaire was used to assess nurses' perceptions of the magnitude and frequency of a set of listed obstacles to providing EOL care in rural emergency departments.[2] The questionnaire was modified from questionnaires used in previous ED EOL care studies and was then adapted to focus specifically on emergency care in rural settings.[5] This 57-item questionnaire included 39 Likert-type items, 15 demographic questions, and 3 open-ended questions. The questionnaire was pretested by 15 nurses in 2 rural emergency departments in the Intermountain West. Feedback concerning content, questions, and completion time was obtained from the ED nurses. The amount of time required to complete the questionnaire was approximately 25 minutes. Findings for the quantitative data were published previously.[2] Participants were also asked to answer 3 open-ended questions for qualitative purposes. This article reports findings from the open-ended questions.

SETTING, SAMPLE, AND STUDY PROCEDURES

Five states were selected to participate in the study based on the number of Critical Access Hospitals (CAHs) available in each of the states (see the Figure).[7] CAHs are hospitals certified under a set of Medicare Conditions of Participation and located in rural areas of the United States.[8] The 5 states selected were Utah, Idaho, Nevada, Wyoming, and Alaska.

Sample inclusion criteria included nurses who worked in a rural emergency department, could read English, and had cared for at least one dying patient in an ED setting. Responses to the qualitative questions were entered into a word database. Each qualitative response was individually reviewed by 4 different nurse experts and coded using content analysis. The coders included an experienced researcher, an advance practice nurse researcher, a qualitative researcher, and a graduate student with 5 years of ED experience. After individual review, responses were divided into major and minor themes based on the number of items included in that theme.

After Institutional Review Board approval was obtained, ED managers in 73 CAHs in the 5 states were contacted by phone. Phone messages were left for managers who were unavailable at the time of contact. Contact was attempted as many as 4 times. Managers who agreed to participate in the study were mailed study packets to be distributed among emergency nurses. Each packet contained a cover letter, a questionnaire, a self-addressed stamped return envelope, and a $1 bill as compensation for completing the questionnaire. The packets were distributed to nursing