Rural Emergency Nurses' End-of-Life Care Obstacle Experiences: Stories from the Last Frontier

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Introduction: Rural emergency nurses face unique obstacles to providing quality end-of-life (EOL) care. Stories provided by emergency nurses embody their most difficult EOL care obstacles.

Methods: A questionnaire was sent to 53 rural hospitals. Respondents were asked to share stories that epitomized the obstacles faced while providing EOL care in the rural emergency setting.

Results: The lack of an ideal death (eg, the nurse personally knows the patient, issues with family members, and unknown patient wishes) was the top obstacle. Other reported obstacles were insufficient ED staff and power struggles between nurses and physicians.

Discussion: Rural emergency nurses often provide EOL care to friends and family members, whereas their urban counterparts are likely to transfer care to nurses with no relation to the dying patient. Not only does caring for patients whom the nurse knows or is related to cause great distress to rural emergency nurses, but this unfortunately common situation also may prevent patients from receiving the highest quality EOL care.

Key words: Emergency; End of life; Obstacles; Emergency nurse; Rural; Rural nursing

When a patient dies in the emergency department, emergency nurses play a significant role in providing bedside end-of-life (EOL) care. Administering EOL care in a compassionate and professional manner can be one of the most stressful and difficult facets of nursing care.[1] Whereas maintaining the highest level of comfort possible for the patient and family can be difficult under the best conditions, providing comfort becomes even more complicated in the chaotic environment of the emergency department, where quality EOL care is often overshadowed by resuscitation efforts and emergency procedures.

According to data from the 2010 National Hospital Ambulatory Medical Care Survey, 240,000 patients died in emergency departments in the United States in 2010, representing a 72% increase in the number of ED deaths reported in 2007.[2] The increased rate of deaths was due to traumatic and chronic causes.[3] An increase in ED deaths of this magnitude stands to place even more burden on already strained emergency nurses.

In the past decade, considerable efforts have been made to understand the obstacles that prevented emergency nurses from providing high-quality EOL care. Emergency nurses have reported many obstacles to providing optimal EOL care, including poor ED design, lack of adequate privacy, inadequate palliative care training, and family issues.[4-6] Although these reports have played an important role in understanding the obstacles to providing EOL care in emergency departments, all have been national random samples and thus have focused primarily on urban populations without specifically considering rural ED counterparts.

Rural populations can present unique complications in all aspects of health care. To understand the specific EOL care obstacles faced by rural emergency nurses, a literature search was conducted. Search terms were "rural,"

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This study was funded through a research grant from Brigham Young University College of Nursing, Provo, UT.

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J Emerg Nurs 2017;43:40-8.
Available online 26 September 2015
0099-1767

http://dx.doi.org/10.1016/j.jen.2015.08.017

"emergency department," and "end-of-life." CINAHL, MEDLINE, and PsychINFO were the databases included in the query. The search returned a single article on the obstacles noted in caring for dying rural ED patients.[7] A separate search of the databases for emergency nurses' EOL stories returned no pertinent results. The minimal published research on rural emergency nursing demonstrates a need for increased understanding of the obstacles to EOL care in rural emergency departments. This study will report the first-person experiences or stories of rural emergency nurses who have cared for dying patients and the obstacles these nurses encountered while attempting to provide EOL care.

The research question for this study was, "What are the shared experiences (stories) that epitomize obstacles to providing EOL care to dying patients in rural emergency departments?" Rural emergency nurses were asked to respond to the following open-ended question: "Can you share with us an experience you have had when caring for a dying patient in a rural setting that epitomizes the obstacles to providing EOL care in this setting?"

Methods

STUDY DESIGN

This study was conducted as a cross-sectional mailed survey sent to rural emergency departments selected from a convenience sample of 5 states with high proportions of designated rural areas as defined by the presence of critical access hospitals (CAHs).

DATA COLLECTION INSTRUMENT

Qualitative data for this report were collected using the Rural Emergency Nurses' Perception of End-of-Life Care questionnaire. This rural questionnaire was adapted from a previous EOL questionnaire used to conduct research with a national random sample of emergency nurses who mostly worked in urban areas.[8] The rural adaptation was designed to measure rural emergency nurses' perceptions of the size and frequency of EOL care obstacles and to allow rural nurses to share personal experiences/stories and recommendations in a free response format.[8,9]

The Rural Emergency Nurses' Perception of End-of-Life Care questionnaire was composed of 39 Likert-type questions, 3 open-ended questions, and 15 demographic questions. The instrument was pretested by 15 rural emergency nurses from Utah. Nurses who were asked to complete the pretest instrument assessed the content of the questionnaire and helped to determine the average completion time, which was 25 minutes.

SAMPLE AND SETTING

The most rural areas in the United States by low population densities, according to the 2010 census data, are presented in Figure.[7,10] CAH emergency departments provide emergency service to rural communities; therefore, emergency nurses working in the emergency departments of CAHs were identified as being appropriate to provide information regarding rural emergency EOL care. Based on areas of rural population, a convenience sample of 4 states in the Intermountain West region plus the state of Alaska were chosen to participate because of their numbers of designated CAHs.

STUDY PROCEDURES

After obtaining Institutional Review Board approval, ED managers were contacted by phone for the 73 listed CAHs from the Intermountain West region (consisting of Idaho, Nevada, Utah, and Wyoming) and Alaska. If the managers were unavailable or did not answer, detailed messages were left requesting study participation. Contact was attempted up to 4 times. If the manager agreed to distribute the study questionnaires, he or she was sent the appropriate number of questionnaire packets, each containing an explanation of the study in the form of a cover letter, a questionnaire, a self-addressed stamped return envelope, and a $1 bill attached to each questionnaire to thank the nurse for participating in the study. Managers were asked to distribute questionnaire packets to emergency nurses in their departments with no obligation to participate. The return of a completed questionnaire was considered consent to participate.

Contact was made with 56 of the 73 CAH ED managers, and 53 (94.6%) agreed to participate in the study (see Table 1 for return by state). A total of 508 questionnaire packets were mailed. Completed and returned questionnaires totaled 246, for a response rate of 46.4%. The respondents were primarily registered nurses (RNs) but also included 5 licensed practical nurses and 3 paramedics. Responses of non–RNs were not included in this data analysis.

Inclusion criteria consisted of the ability to read English, having worked in a rural emergency department, and a history of providing care for at least one dying rural ED patient. All responses were entered into a Word database.

DATA ANALYSIS

Five nursing experts including an experienced researcher, a qualitative researcher, an advance practice nurse researcher, an advance practice nurse with 11 years of ED experience, and a graduate student individually reviewed and coded