Emergency Nurses' Perceptions of Providing End-of-Life Care in a Hong Kong Emergency Department: A Qualitative Study

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Introduction: Provision of end-of-life (EOL) care in the emergency department has improved globally in recent years and has a different scope of interventions than traditional emergency medicine. In 2010, a regional hospital established the first ED EOL service in Hong Kong.

Methods: The aim of this study was to understand emergency nurses' perceptions regarding the provision of EOL care in the emergency department. A qualitative approach was used with purposive sampling of 16 nurses who had experience in providing EOL care. Semi-structured, face-to-face interviews were conducted from May to October, 2014. All the interviews were transcribed verbatim for content analysis.

Results: Four themes were identified: (1) doing good for the dying patients, (2) facilitating family engagement and involvement, (3) enhancing personal growth and professionalism, and (4) expressing ambiguity toward resource deployment.

Discussion: Provision of EOL care in the emergency department can enhance patients' last moment of life, facilitate the grief and bereavement process of families, and enhance the professional development of staff in emergency department. It is substantiated that EOL service in the emergency department enriches EOL care in the health care system. Findings from this study integrated the perspectives on ED EOL services from emergency nurses. The integration of EOL service in other emergency departments locally and worldwide is encouraged.

End-of-life (EOL) care is an important component of palliative care (PC) and aims to provide patient care during the last stage of life. The scope of care has shifted to include making dying patients as comfortable as possible by minimizing invasive and life-prolonging therapies and helping patients and their families adapt to mourning. Health professionals not only provide treatment to relieve symptoms and control pain but also respond to the psychosocial and spiritual needs of patients and families and emphasize dying with dignity.[1–3]

The World Health Organization has estimated that the proportion of the world's population that is older than 60 years will double from 11% to 22% between 2000 and 2050.[4] The Hong Kong (HK) government estimates that the population older than 65 years will increase from 13% to 30% between 2011 and 2041.[5] Although people now have longer life spans, quality of dying and death issues have been overlooked. Large numbers of people are expected to be treated in emergency departments during the EOL stage, increasing the demand for EOL services.[6]

Death in an emergency department can be classified as either unexpected or expected. Bailey, Murphy, and Porock[6] categorized these trajectories into 2 groups: spectacular, which refers to unexpected death in an emergency department and usually involves trauma or acute illness, and subtacular, which

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refers to expected death and advanced or terminal illness. Traditional emergency medicine training focuses on acute medical treatment, lifesaving resuscitation, and trauma care,[1,7] but the subtacular trajectory is commonly found in emergency departments.[6] Foreseeing a service gap in outpatient PC services,[3,8] a review of the ED EOL service is recommended to deal with the aging population and the increase in dying and terminally ill ED patients.

Emergency nurses are key to EOL services.[6,9] ED health professionals have generally been found to be lacking in EOL knowledge but are trained to provide immediate response to patients' health conditions.[1,6] Although some emergency nurses have indicated that they consider an emergency department to be an unsuitable setting for a good death, there is a need for EOL care.[10] Many studies focus on how health professionals perceive the effectiveness of pain and symptom control at EOL.[1,3,11] The ENA generated a position statement for emergency nurses in EOL care, stating that the goals of EOL services are to minimize patients' suffering due to pain and other symptoms, consider their cultural and religious beliefs, and promote dying with dignity.[2] In numerous studies, emergency nurses encountered difficulties in providing EOL care in emergency departments because of a lack of EOL knowledge and training,[1,12] difficulty handling relationships between families and health care professionals,[1,11,13] and EOL-related ethical and social concerns.[17] However, few studies have examined emergency nurses' experiences in providing EOL services.

In the United States, curricula in PC and EOL care in emergency medicine have been established for health professionals, including nurses who work in emergency departments.[14] Numerous emergency departments in the US and in European countries have established EOL services to provide appropriate care to dying patients.[15]

In 2010, the largest regional acute hospital in HK, the Queen Elizabeth Hospital (QEH), initiated an EOL service in the emergency department with the aim of providing high-quality care for EOL patients (defined as patients with advanced medical diseases or those for whom death is imminent) and their families to meet the demand for ED EOL services. The QEH was the pioneer emergency department in HK to initiate the ED EOL service for patients and their families. After 2011, this special service was extended to medical unit inpatients when the ED EOL service is not engaged by ED patients.

The aim of this study was to explore the perceptions and reflections of emergency nurses with experience in providing EOL care. Although numerous studies regarding ED EOL care have been performed, this study provides an initial understanding of the HK situation.

Methods

This qualitative study was conducted in the largest regional acute hospital in HK. A total of 195,280 patients visited the emergency department in 2013/2014; approximately 36% (67,236 patients) required hospital admission and 0.22% (406 patients) died in the emergency department.[16,17] A multidisciplinary team including emergency physicians, nurses, a clinical psychologist, a chaplain, and a social worker were involved and cooperated in service provision under the ED service. The service included a spacious single private room, named *Osiris*, and an emergency nurse who had previously received basic training for ED EOL service in the emergency department and was assigned to provide and arrange one-on-one psychosocial and spiritual care.

Ethical approval for the study was granted by the ethics committees of the university and hospital with which the researchers are affiliated. Sixteen registered nurses with at least 6 months' experience in providing EOL care in an emergency department since service commencement were recruited. The Table provides the demographics of the participants.

Semi-structured, face-to-face interviews were conducted using guiding questions to encourage the participants to verbalize more of their personal experiences and perspectives regarding the ED EOL service. For example, the participants were asked, "Could you share with me the most memorable case(s) that you experienced in the ED EOL service?" Participants were encouraged to share their experiences and views regarding EOL care anonymously (without the use of personal identifiers) to ensure privacy and confidentially. Prior to the interview, the research purpose, methodology, voluntary participation, and dissemination of research findings were explained to all participants during the consent process. All the participants had the right to withdraw from the study at any time without penalty or disclosure of the personal identifiers. None of the participants withdrew from the study. Interviews were audio recorded and transcribed verbatim. Transcripts were collated with the researchers' field notes and distributed to the researchers with the recordings to facilitate discussion, confirmation, and validation of the themes and subthemes.

Content analysis was conducted. Similar key units were grouped into subthemes and categorized into 4 interrelated themes. Data saturation occurred after 16 individual interviews. Multiple meetings were held among the researchers to ensure credibility. An audit trail was created to ensure confirmability and allow others to trace the course of the study and verify decisions made regarding the procedure. Reflective commentary was maintained to allow