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THE LAST FRONTIER: RURAL EMERGENCY NURSES' PERCEPTIONS OF END-OF-LIFE CARE OBSTACLES

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Introduction: Caring for dying patients is part of working in a rural emergency department. Rural emergency nurses are prepared to provide life-saving treatments but find there are barriers or obstacles to providing end-of-life (EOL) care. This study was completed to discover the size, frequency, and magnitude of obstacles in providing EOL care in rural emergency departments as perceived by rural emergency nurses.

Methods: A 57-item questionnaire was sent to 52 rural hospitals in Idaho, Wyoming, Utah, Nevada, and Alaska. Respondents were asked to rate items on size and frequency of perceived obstacles to providing EOL care in rural emergency departments. Results were compared with results from 2 previous emergency nurses' studies to determine if rural nurses had different obstacles to providing EOL care.

Results: The top 3 perceived obstacles by rural emergency nurses were: (1) family and friends who continually call the nurse for an update on the patient's condition rather than calling the designated family member; (2) knowing the patient or family members personally; and (3) the poor design of emergency departments that does not allow for privacy of dying patients or grieving family members. The results of this study differed from the other 2 previous studies of emergency nurses' perceptions of EOL care.

Discussion: Nurses in rural emergency settings often work in an environment without many support personnel. Answering numerous phone calls removes the nurse from the bedside of the dying patient and is seen as a large and frequent obstacle. Personally knowing either the patient or members of the family is a common obstacle to providing EOL care in rural communities. Rural nurses often describe their patients as family members or friends. Caring for a dying friend or family member can be intensely rewarding but also can be very distressing.

Conclusion: Rural emergency nurses live and work on the frontier. Little EOL research has been conducted using the perceptions of rural emergency nurses possibly because of the difficulty in accurately accessing this special population of nurses. Rural emergency nurses report experiencing both similar and different obstacles compared with their counterparts working in predominantly non-rural emergency departments. By understanding the obstacles faced by emergency nurses in the rural setting, changes can be implemented to help decrease the largest obstacles to EOL care, which will improve care of the dying patient in rural emergency departments. Further research is needed in the area of rural emergency nursing and in EOL care for rural patients.

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

Death is inevitable, whether it is a sudden, unpredictable event, as in the case of cardiac arrest, or an expected event, as in persons with advanced age or terminal illness. Providing care for dying patients is a common event in the emergency department¹ and is one of the most demanding responsibilities

of a nurse.² In 2007, 139,000 patient deaths occurred in emergency departments in the United States, which accounted for approximately 0.1% of all ED patient visits.³ Emergency nurses are prepared to provide lifesaving treatments but often find obstacles to providing end-of-life (EOL) care.^{4,5}

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EOL care is designed specifically to alleviate patients' pain and suffering in the final stages of dying, when comfort becomes the main focus.⁶ Perceptions of a "good death" include the idea that the patient is comfortable and free of pain, the family is able to perform EOL rituals, others are respectful of the patient's dignity, and families have adequate time to say goodbye.⁷ The EOL experience can be enhanced by eliminating distracting activity and noise to create a quiet, calm atmosphere for the patient and family.⁶ Creating such an atmosphere is often difficult in a busy emergency department. Providing EOL care to chronically ill or terminally ill patients is challenging for emergency nurses because the focus of emergency resources is saving lives, not preserving dignity⁶ or providing EOL care. The model of rescue-oriented rather than dignity-preserving care has become the expectation in emergency departments. Successful heroic measures are seen by patients and families as the norm, and EOL care and comfort plans are rarely addressed.⁸

Nationally, nursing organizations have recognized the importance of providing competent care to dying patients. The American Nurses Association states that nurses have an ethical and moral obligation to relieve suffering and provide comfort to patients at the EOL.⁹ Similarly, the ENA states that every patient at the EOL deserves a dignified death.¹⁰ Emergency nurses have tremendous opportunities to affect EOL care regardless of location, size, or hospital affiliation.¹¹ Understanding the obstacles that prevent nurses from providing quality EOL care in emergency settings is crucial to providing the best care possible.

To understand more clearly the obstacles to providing EOL care in rural emergency departments, a literature search was performed using the following electronic databases: Premier, CINAHL, Health Source, Nursing/Academic Edition, MEDLINE, and PsychINFO. Search results were limited to human studies, English language, peer-reviewed, and research studies. The search term "rural emergency department EOL" was used. Although no dates were specified, no studies were found that specifically related to EOL care in rural emergency departments. The following discussion describes the obstacles to providing EOL care in emergency departments in general as reported by emergency nurses.

Obstacles to Providing EOL Care

The top obstacles preventing emergency nurses from providing EOL care to dying patients generally fit into 3 major categories: (1) issues with the patient's family, (2) issues with the ED environment, and (3) concerns about the

patient's wishes. Other less common obstacles include the public perception of emergency care and the limitation in EOL education for nurses.

FAMILY ISSUES

Family issues include dealing with angry or distraught family members, family members who do not understand what the term "lifesaving measures" mean, or family members who continually call the nurse for information about the patient.^{4,5} Two other family issues are insisting on the use of life-sustaining measures regardless of the patient's written advance directive and not accepting what the physician says about the patient's poor prognosis.⁴

ED ENVIRONMENTAL ISSUES

Nurses have reported that their workload in the emergency department is too high to adequately care for dying patients and their families^{4,5} and that sometimes they are called away from caring for a dying patient to admit another patient or help another nurse with a patient.⁵ Nurses also have reported that the design of the emergency departments do not allow for privacy of the patient or grieving family members.^{4,5}

Unfortunately, the emergency department is not typically conducive to providing quality EOL care.¹² Frequent environmental obstacles also include constant patient turnover, limited available space, and the hectic and noisy atmosphere.¹²

THE PATIENT'S WISHES

Emergency nurses report that an obstacle to providing EOL care is not knowing the patient's wishes regarding the continuation of treatments or tests because of the inability to communicate with the patient. The inability to communicate with patients regarding their wishes usually has to do with the use of sedation or the depressed neurological status of the patient.^{4,5}

PUBLIC PERCEPTIONS OF CARE IN EMERGENCY DEPARTMENTS

Patients and families come to the emergency department with unrealistic expectations of a positive outcome based on the portrayal of dying patients in the media. These unrealistic expectations may be cultivated and reinforced by media portrayal of miraculous emergency care provided to dying patients, which contributes to the perception that most ED deaths are preventable. One study of resuscitations performed on 3 popular emergency/rescue TV shows over one season demonstrated that 75% of patients immediately survived arrest and 67% recovered successfully enough to be discharged, which is a much

higher rate of success compared with real cardiac arrest survival rates.^{8,13} The portrayal of extraordinary abilities in emergency departments combined with reports of unprecedented technological advances may well contribute to the general perception that most ED deaths are preventable.^{8,13}

EOL EDUCATIONAL RESOURCES

No review of the amount of EOL content in emergency nursing textbooks could be found. One review of EOL content in 14 critical care nursing textbooks showed that none of the textbooks had information on all content areas outlined by the American Association of Critical Care Nurses' Teaching Competencies for EOL Care in Undergraduate Nursing Curriculum and 3 of the textbooks had no EOL content.¹⁴ In a similar analysis, researchers looked at medical textbooks for EOL care education and found that in 50 of the top-selling textbooks, only 2% of content was dedicated to EOL care.¹⁵ Furthermore, the EOL content in these textbooks was of questionable quality.¹⁵ Without quality educational resources, it is not surprising some nurses feel inadequately prepared to care for dying patients.

EOL Care in Rural Emergency Departments

The task of providing EOL care challenges emergency nurses in rural locations as much as their counterparts in more densely populated areas. Nearly 50 million Americans (17% of the population) live in rural areas in the United States.¹⁶ Thirty-one of the 50 states have more than 60% of their counties designated as rural, with rural residents residing across 80% of the land area.¹⁶

In 2008, the American Hospital Association determined that 1998 rural hospitals provided care to local residents, with 60% of these hospitals further designated as Critical Access Hospitals (CAHs). CAHs have been designated by state and federal governments to receive Medicare reimbursement to meet the needs of rural populations.¹⁷ To be a designated a CAH, the hospital must meet specific guidelines determined by the federal government (see Table 1). The National Institutes of Health and National Institute of Nursing Research have identified EOL and palliative care in rural and frontier areas a priority area of research and funding.¹⁸ However, little is known regarding EOL care provided to ED patients in rural settings.¹⁸ The purpose of this study was to determine the obstacles to rural emergency EOL care as perceived by rural nurses working in the Intermountain West region and Alaska.

TABLE 1

Critical Assess Hospital criteria

The following criteria must be met to become a CAH²¹:

1. The hospital is located in a state that has been established as a part of the Medicare Rural Hospital Flexibility Program by the Center for Medicare and Medicaid Services
2. The hospital has been designated by the state as a CAH
3. The hospital is currently participating in Medicare as a rural public, non-profit, or for-profit hospital or was a participating hospital that ceased operation during the 10-year period from November 29, 1989 to November 29, 1999 or is a health clinic or health center that was downsized from a hospital
4. The hospital is located in a rural area or is treated as rural
5. The hospital is located more than 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion in 15 miles)
6. The hospital maintains no more than 25 inpatient beds
7. The hospital maintains an annual average length of stay of 96 hours per patient for acute inpatient care
8. The hospital complies with all CAH Conditions of Participation, including the requirement to make available 24-hour emergency care services 7 days per week

CAH, Critical access hospital.

Research Questions

Specifically, the following questions were investigated in this study:

1. What are the size, frequency, and perceived magnitude scores of selected obstacles in providing EOL care in rural emergency departments as perceived by rural emergency nurses?
2. Do the size, frequency, and perceived magnitude scores of these obstacles for nurses providing EOL care in rural emergency departments differ from previous reports of emergency nurses?

Methods

STUDY DESIGN

This study used a cross-sectional survey research design.

DATA COLLECTION INSTRUMENT

The Rural Emergency Nurse's Perception of End-of-Life Care questionnaire was adapted from other questionnaires used in EOL studies conducted by Beckstrand and associ-

FIGURE 1

Frontier Counties of the United States, 2010. Reproduced with permission from the Rural Assistance Center. U.S. Department of Health and Human Services. <http://www.raconline.org/racmaps/mapfiles/frontier.png>.

ates.^{4,5} These 2 previous emergency EOL studies did not designate whether nurses worked in rural or non-rural emergency departments; however, the mean number of emergency beds per unit in both studies was greater than any CAH total bed number, implying that the previous samples did not include a majority of rural emergency nurses. The developed questionnaire measures nurses' perceptions of the size and frequency of occurrence of obstacles to providing EOL care.

The 57-item questionnaire was adapted to focus on a rural emergency perspective by using previous research in rural palliative care¹⁹ and expert opinion. The question-

TABLE 2

Questionnaires returned by state

State	Questionnaires returned n (%)
Idaho	113 (47.4)
Wyoming	57 (23.9)
Utah	29 (12.2)
Nevada	21 (8.8)
Alaska	18 (7.6)
Total	236 (100)

TABLE 3
Demographics of nurses^a

Characteristic	n	%	M	SD	Range
Sex					
Female	204	86.4			
Male	32	13.6			
Age (y)			46	10.1	24-71
Years as registered nurse			15.3	11.0	0-50
Years in emergency department			11.2	9.3	<1-41
Years in rural nursing			10.5	9.1	<1-41
No. hours worked/wk			32.0	12.2	0-80
No. of beds in emergency department			6.5	4.7	2-25
No. of dying patients cared for					
>30		36.2			
21-30		12.9			
11-20		17.4			
5-10		19.6			
<5		13.8			
Highest degree					
Diploma		4.0			
Associate		57.2			
Bachelor		32.2			
Master		5.3			
Other		1.3			
Ever certified as CEN					
Yes	36	16.0			
No	188	83.6			
Currently CEN					
Yes	27	44.3			
No	33	54.1			
Years as CEN			5.7	5.4	0-20
Practice area					
Direct care/bedside nurse		36.9			
Staff/charge nurse		46.2			
Clinical nurse specialist		0.9			
Other (manager, educator, etc)		16.0			
Hospital type					
Community, non-profit		58.5			
Community, profit		10.3			
County hospital		28.1			
Other		3.1			

CEN, Certified emergency nurse.

^aA total of 508 questionnaires were sent, of which 236 were returned for a 46.4% response rate.

TABLE 4

Size mean, SD, and rank; frequency mean, SD, and rank; and perceived obstacle magnitude score for obstacles at end-of-life care

Obstacles	Size M ^a	Size SD	Size rank	Frequency M ^b	Frequency SD	Frequency rank	POMS ^c
1. Family and friends who continually call the nurse for an update on the patient's condition rather than calling the designated family member for information	3.21	1.20	2	2.89	1.15	2	9.28
2. Knowing the patient or family members personally	2.85	1.43	14	3.17	1.13	1	9.03
3. Poor design of ED that does not allow for privacy of dying patients or grieving family members	3.24	1.40	1	2.76	1.31	3	8.94
4. Family members not understanding what "lifesaving measures" really mean, ie, that multiple needle sticks cause pain and bruising, that an ET tube won't allow the patient to talk, or that ribs may be broken during chest compressions	3.18	1.18	4	2.57	1.07	6	8.17
5. Patient care being fragmented in the rural ED because the nurse is required to fill many roles other than nursing	3.03	1.42	7	2.60	1.35	4	7.88
6. The availability of resource teams (eg, social workers and chaplains) to help with EOL care	2.97	1.39	9	2.58	1.35	5	7.66
7. The ED is not designed to provide EOL care	3.00	1.44	8	2.43	1.33	8	7.29
8. The nurse having to deal with distraught family members while still providing care for the patient	2.86	1.09	13	2.53	0.93	7	7.24
9. Not enough time to provide quality EOL care because the nurse is consumed with activities directed toward trying to save the patient's life	2.91	1.18	10	2.40	1.02	9	6.98
10. The nurse having to deal with angry family members	3.09	1.22	5	2.24	0.94	12	6.92
11. Being called away from the dying patient and his or her family because of the need to help other patients	2.87	1.28	12	2.32	1.12	10	6.66
12. Patients experiencing a sudden illness or injury that leaves them little time to discuss their wishes about what they want done at the EOL	3.05	1.25	6	2.16 ^d	0.97	14	6.58
13. The nurse not knowing the patient's wishes about continuing treatments and tests because of the inability to communicate because of a depressed neurological status or pharmacological sedation	2.89	1.28	11	2.16	0.99	17	6.24

TABLE 4 (continued)

Size mean, SD, and rank; frequency mean, SD, and rank; and perceived obstacle magnitude score for obstacles at end-of-life care

Obstacles	Size M ^a	Size SD	Size rank	Frequency M ^b	Frequency SD	Frequency rank	POMS ^c
14. The ED nurse having too high a workload to allow for adequate time to care for dying patients and their families	2.81	1.31	15	2.16	1.12	15	6.07
15. The patient having pain that is difficult to control or alleviate	2.70	1.17	16	2.11	0.89	19	5.70
16. Physicians who order unnecessary tests or procedures for dying patients just so they can say that every possibility was considered	2.68	1.32	18	2.11	1.16	20	5.67
17. Families not accepting what the physician is telling them about the patient's poor prognosis	2.60	1.17	19	2.17	0.89	13	5.64
18. No available support person for the family such as a social worker or religious leader	2.59	1.45	20	2.15	1.27	18	5.57
19. Being able to immediately meet bereaved family members upon their arrival at the ED	2.43	1.21	23	2.28	1.02	11	5.54
20. Restriction of family members in the ED room during resuscitation	2.25	1.38	29	2.16	1.27	16	4.86
21. Caring for a dying child in the ED	3.21	1.60	3	1.45	0.79	38	4.65
22. Intra-family disagreements about whether to approve the use of life support	2.53	1.31	22	1.83	0.96	23	4.63
23. Being related to the patient or family member	2.69	1.59	17	1.71	1.14	31	4.59
24. The family, for whatever reason, is not with the patient when he or she is dying	2.39	1.14	26	1.87	0.78	21	4.47
25. Providing treatments for a dying patient even though the treatments cause the patient pain or discomfort	2.39	1.22	25	1.80	0.92	24	4.30
26. Physicians who avoid having conversations with family members	2.59	1.57	21	1.64	1.12	34	4.25
27. Too many family members being allowed in the room during resuscitation	2.40	1.43	24	1.71	1.10	30	4.10
28. Having to make the death notification to the family after the patient has died	2.34	1.36	27	1.74	1.06	29	4.07
29. Lack of nursing education and training regarding family grieving and quality EOL care	2.18	1.34	34	1.86	1.08	22	4.05
30. Technologic interventions are used on patients who are very unlikely to survive	2.26	1.29	28	1.78	1.09	25	4.02

(continued on next page)

TABLE 4 (continued)

Size mean, SD, and rank; frequency mean, SD, and rank; and perceived obstacle magnitude score for obstacles at end-of-life care

Obstacles	Size M ^a	Size SD	Size rank	Frequency M ^b	Frequency SD	Frequency rank	POMS ^c
31. Use of EOL care protocols specifically written for the ED	2.24	1.48	30	1.76	1.45	27	3.94
32. Dealing with the cultural differences that families employ in grieving for their dying family member	2.18	1.22	35	1.76	0.99	26	3.84
33. Physicians who won't allow the patient to die from the disease process	2.20	1.47	31	1.64	1.10	32	3.61
34. ED patients varying in acuity so that it is difficult to discern if the patient should receive EOL care	2.19	1.36	32	1.64	1.11	33	3.59
35. Physicians who minimize or discourage nurses' input regarding patient care	2.18	1.50	33	1.58	1.06	36	3.44
36. Continuing resuscitation for a patient with a poor prognosis because of the real or imagined threat of future legal action by the patient's family	2.06	1.32	36	1.46	0.97	37	3.00
37. The nurses' opinion about the direction patient care should go is not requested, valued, or considered	1.81	1.32	37	1.59	1.07	35	2.88
38. The nurse is not comfortable caring for dying patients and/or their families	1.67	1.22	38	1.72	0.80	28	2.87
39. Pressure to limit family grieving after the patient's death to accommodate a new admitted patient to that room	1.66	1.39	39	1.19	0.96	39	1.98

ED, Emergency department; EOL, end of life; ET, endotracheal; POMS, perceived obstacle magnitude score.

^aSize of obstacle response choices were: 0 = not an obstacle to 5 = extremely large.

^bFrequency of obstacle response choices were: 0 = never occurs to 5 = always occurs.

^cPerceived obstacle magnitude score (obstacle size *M* multiplied by obstacle frequency *M*).

^dSome items were tied when rounded to the hundredth but these items were rank ordered based on number to the thousandth place.

naire included 39 Likert-type items, 3 open-ended questions, and 15 demographic questions. This adapted questionnaire was pilot tested by 15 nurses in 2 CAH emergency departments in Utah. Participants in the pilot study provided feedback on questions, content, and estimated completion time. Completion time ranged from 20 to 30 minutes. Cronbach's α for the 39 obstacle size items was high at .95. The Cronbach's α for the 39 obstacle frequency items was also high at .93.

Subjects were asked to rank all obstacle items for both size and frequency. The scale for obstacle size was from 0 (not an obstacle) to 5 (extremely large obstacle). A comparable scale for frequency of occurrence was used with 0 (never occurs) to 5 (always occurs). A rating of the obstacle's magnitude or significance was calculated by multiply-

ing each obstacle's mean score by the obstacle's mean frequency score²⁰ to obtain a Perceived Obstacle Magnitude Score (POMS). The POMS possible score range was 0 to 25 (as a multiple of the highest size score [5] and the highest frequency score [5]).

SAMPLE AND SETTING

According to the 2010 census data, the most rural areas in the United States by population densities per square mile are presented in Figure 1.²¹ To contact rural emergency nurses in some of these states, it was determined that nurses working at CAHs should be contacted because CAHs are only found in small rural communities.

States selected were in the Intermountain West region and Alaska because of the number of CAHs available.

STUDY PROCEDURES

After Institutional Review Board approval was obtained, ED managers in 73 CAHs in the Intermountain West region (Utah, Idaho, Nevada, and Wyoming) and Alaska were contacted by phone. Detailed phone messages were left for managers who could not be reached, up to as many as 4 times. Each ED manager who agreed to participate was sent a questionnaire packet that included a cover letter explaining the purpose of the study, a questionnaire, a stamped return envelope, and a \$1 bill as a thank you for the nurse's time and quick return of the completed questionnaire. The nurse manager or ED representative was asked to distribute the questionnaire packets to their nursing staff. No nurse was obligated to complete the questionnaire. Return of the questionnaire was deemed as consent to participate.

Fifty-four ED managers from the 73 CAHs answered or returned our calls. Ninety-six percent of the contacted managers ($n = 52$) in these 5 states consented to participate in the study (see Table 2). For those 52 hospitals, a total of 508 questionnaires were mailed and 236 completed questionnaires were returned for a return rate of 46.4%. Five licensed practical nurses and 3 paramedics also returned questionnaires that were included in the data analysis because rural facilities often hire licensed personnel other than registered nurses (RNs). Data were entered into IBM SPSS. Frequencies, measures of central tendency and dispersion, and reliability statistics were calculated for all obstacle size and frequency items.

Results

Of the 236 subjects who returned the questionnaire, 204 (86.4%) were women and 32 (13.6%) were men. The average age of subjects was 46 years. RNs who responded had been practicing for an average of 15.3 years and had worked in the emergency department for an average of 11.2 years. Other demographic data are shown in Table 3.

The perceived obstacle magnitude score (POMS) for all obstacle items ranged from a high of 9.28 to a low of 1.98 (Table 4). Items were ranked by their mean scores to 3 decimal places; however, scores were reported to 2 decimal places, accounting for the appearance of tied mean numbers. The top 5 highest perceived obstacles were, in descending order, (1) family and friends who continually call the nurse for an update on the patient's condition rather than calling the designated family member for information (POMS = 9.28); (2) knowing the patient or family members personally (POMS = 9.03); (3) poor design of emergency departments that does not allow for privacy of dying patients or grieving family members (POM = 8.94);

(4) family members not understanding what "lifesaving measures" really mean, that is, that multiple needle sticks cause pain and bruising, that an endotracheal tube won't allow the patient to talk, or that ribs may be broken during chest compressions (POMS = 8.17); and (5) patient care being fragmented in the rural emergency department because the nurse is required to fill many roles other than nursing (POMS = 7.88).

Other top 10 items included having to deal with either distraught family members (POMS = 7.24, item No. 8) or angry family members (POMS = 6.92, item No. 10) or not having enough time to provide quality EOL care because of being consumed with activities related to the attempt to save the patient's life (POMS = 6.98, item No. 9). The remaining top 10 items dealt with issues of resources and environment, including not having resource personnel such as social workers or chaplains available to help with EOL care (POMS = 7.66, item No. 6) or the emergency department not being designed to provide EOL care (POMS = 7.29, item No. 7).

The 3 lowest scoring POM obstacles were, in ascending order, pressure to limit family grieving after the patient's death to accommodate a new admission to that room (POMS = 1.98, item No. 39); the nurse not being comfortable caring for dying patients and/or their families (POMS = 2.87, item No. 38); and the nurse's opinion about the direction of patient care is not requested, not valued, or not considered (POMS = 2.88, item No 37).

Discussion

The item that rural nurses identified as their greatest obstacle to providing EOL care was family and friends who continually call the nurse for an update on the patient's condition. This obstacle also scored as the largest item in 2 other critical care EOL studies.^{7,22} However, in 2 ED studies,^{4,5} the item regarding answering telephone calls was ranked as the sixth-largest obstacle. For the critical care nurse samples, this item was highly rated because continual phone calls from family and friends took the nurses away from being at the bedside providing care. For rural emergency nurses, both being removed from directly caring for the patient and the possibility of having fewer support staff to answer numerous phone calls might be the reasons nurses ranked this item highly.

The second largest barrier to providing EOL care occurs when the nurse knows the patient or family personally. In small communities, close relationships with patients frequently exist outside the hospital. In many cases, nurses are called on to give care to patients, friends, and neighbors

after discharge because the rural emergency nurse lives in the same community.²² Rural nurses often describe their patients as family members or friends.²² Caring for a dying friend or family member can be intensely rewarding, but it also can be very distressing.¹⁹

The barrier listed as fourth in this study and third and fourth in 2 previous emergency department studies^{4,5} was that family members do not understand what “lifesaving measures” really mean. For example, family members frequently are unaware that multiple needle sticks will be required even though they cause pain and bruising, that an endotracheal tube will not allow the patient to talk, or that ribs may be broken during chest compressions. Unfortunately, the patient’s family often does not understand that lifesaving interventions usually means additional pain and suffering for the patient.⁷

ED DESIGN

Design issues also prevent rural emergency nurses from providing EOL care. Poor department design was among the top 3 obstacles to providing EOL care in both previous studies.^{4,5} Based on these responses of rural emergency nurses, poor design of emergency departments was identified as the third most significant barrier. The EOL experience is enhanced by eliminating distracting activity and noise and creating a quiet, calm atmosphere.²⁰ Having an adequate place for family members to sit together, grieve privately, or cry is very important, but rural emergency departments often lack these accommodations, which might account for nurses scoring poor design as a significant obstacle to providing EOL care.

RESOURCES

Caring for patients with chronic conditions requires a different nursing skill set than caring for a trauma victim.¹¹ Nurses often feel inadequately prepared to care for terminally ill or dying patients either because they lack resources, such as social workers or clergy being immediately available, or they have not received adequate education in EOL care.²³ Providing EOL care to dying patients in any emergency department can be difficult, but for emergency nurses in rural communities, it is even more challenging. Rural emergency nurses often must make difficult decisions with insufficient or non-existent resources.²⁴

The most significant resource issue for rural emergency nurses was the many roles they are required to fill, resulting in fragmented patient care. Fragmented patient care was identified as the sixth most significant obstacle. Rural nurses have been described as “specialized generalists” because of the necessity to be competent in a wide range of nursing and non-nursing roles.²² In addition to the typical nursing

responsibilities, rural nurses also are required to answer telephones, make arrangements for specialists to see patients, and clean rooms. These additional activities interrupt care that nurses provide to dying patients.

Another significant but unique barrier for the rural nurse is the lack of support teams for family members. This barrier was identified as the sixth most significant issue for rural nurses even though it was ranked lower in both of other emergency nurse studies.^{4,5} Having a social worker or religious leader assist family members during a patient resuscitation can greatly reduce the stress of the event for the nurse.⁶ The presence of additional licensed professionals allows the nurse to completely focus on providing care to the patient. Sparsely staffed hospitals can only pool the resources they have available when a critical or dying patient arrives. The job of caring for dying patients is challenging in any emergency department; in this high-intensity situation, extra resources can reduce the stress and give time to provide EOL care.

One difference in obstacle ranking between this study and previous studies^{4,5} was that emergency nurses reported having too high a workload to care for dying patients as the number 1 obstacle. In this study this item dropped to 14th, probably because of the fact that in busy non-rural emergency departments, rapid patient turnover with “throbbing” waiting rooms full of patients becomes a prominent barrier to providing EOL care. However, although patients also may be waiting in the rural ED setting, the rural nurse does not feel as pressured to rush EOL care. This attitude of having time for EOL care being ranked lower as a barrier in rural settings also was reflected in the lowest-rated item (No. 39), which was pressure to limit family grieving after death to accommodate a newly admitted patient.

LIMITATIONS

A limitation of this study is that the sample was not selected randomly but rather was a convenience sample of nurses from selected CAHs. Although the sample was not random, the response rate of 47% was very good. Another potential limitation was that health care providers other than RNs completed the questionnaire and were included in the study. This limitation is believed to be minor in that very few non-RN participants were included.

Conclusion

Rural emergency nurses live and work on the frontier. Little EOL care research has been conducted using the perceptions of rural emergency nurses, possibly because of the difficulty in accurately accessing this special population of nurses. Rural emergency nurses report experiencing both

similar and different obstacles compared with their counterparts who work in non-rural emergency departments. By understanding the obstacles faced by emergency nurses in the rural setting, changes can be implemented to help decrease the largest obstacles to EOL care, which will improve care of the dying patient in rural emergency departments. Further research also is warranted in the area of rural emergency nursing and in EOL care for rural patients.

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