Faculty Publications

2006-10-13

Emergency Nurses' Perceptions of Obstacles and Supportive Behaviors in End-of-Life Care

Sondra Heaston

Brigham Young University - Provo

Renea L. Beckstrand

Brigham Young University - Provo, renea@byu.edu

A. Elaine Bond

Brigham Young University - Provo

Sheri P. Palmer

Brigham Young University - Provo

Follow this and additional works at: <https://scholarsarchive.byu.edu/facpub>

Part of the [Other Nursing Commons](#), and the [Palliative Nursing Commons](#)

Original Publication Citation

Heaston, S., Beckstrand, R. L., Bond, A. E., & Palmer, S. P. (2006). Emergency nurses' perceptions of obstacles and supportive behaviors in end-of-life care. *Journal of Emergency Nursing*, 32(6), 477-485.

BYU ScholarsArchive Citation

Heaston, Sondra; Beckstrand, Renea L.; Bond, A. Elaine; and Palmer, Sheri P., "Emergency Nurses' Perceptions of Obstacles and Supportive Behaviors in End-of-Life Care" (2006). *Faculty Publications*. 5301.

<https://scholarsarchive.byu.edu/facpub/5301>

This Peer-Reviewed Article is brought to you for free and open access by BYU ScholarsArchive. It has been accepted for inclusion in Faculty Publications by an authorized administrator of BYU ScholarsArchive. For more information, please contact ellen_amatangelo@byu.edu.

Emergency Nurses' Perceptions of Obstacles and Supportive Behaviors in End-of-Life Care

Authors: Sondra Heaston, MS, NP-C, CEN, Renea L. Beckstrand, PhD, RN, CCRN, A. Elaine Bond, DNSc, APRN, CCRN, and Sheri P. Palmer, RN, MS, Provo, Utah

Sondra Heaston, *Northern Utah Chapter*, is Assistant Teaching Professor, Brigham Young University, Provo, Utah.

Renea L. Beckstrand, *Timpanogos Chapter*, is Associate Professor, Brigham Young University, Provo, Utah.

A. Elaine Bond, is Associate Professor, Brigham Young University, Provo, Utah.

Sheri P. Palmer, *Timpanogos Chapter*, is Assistant Professor, Brigham Young University, Provo, Utah.

This study was partially funded by Brigham Young University.

For correspondence, write: Renea L. Beckstrand, PhD, RN, CCRN, Brigham Young University, College of Nursing, 422 SWKT, PO Box 25432, Provo, UT 84602-5432; E-mail: renea_beckstrand@byu.edu.

J Emerg Nurs 2006;32:477-85.

0099-1767/\$32.00

Copyright © 2006 by the Emergency Nurses Association.

doi: 10.1016/j.jen.2006.07.013

CE Earn Up to 8 CE Hours. See page 552.

Introduction: Little is known about emergency nurses' perceptions of either obstacles or supportive behaviors for providing end-of life (EOL) care to dying patients. The purpose of this study was to determine the perceived obstacles and supportive behaviors in providing EOL care to dying patients in emergency departments.

Methods: In this survey research, a 73-item questionnaire regarding EOL care was mailed to a geographically dispersed national random sample of 300 members of the Emergency Nurses Association. Descriptive statistics were calculated for the 54 Likert-type items and demographic items. Two open-ended questions were analyzed using content analysis.

Results: Returns after 3 mailings yielded 169 usable questionnaires from 284 eligible respondents for a return rate of 59.5%. The greatest obstacles were: (1) emergency nurses having too great a work load to care for dying patients; (2) emergency nurses having to deal with angry family members; and (3) the poor design of emergency departments that do not allow for privacy of dying patients or grieving family members. The most supportive behaviors were: (1) good communication between the physician and RN caring for the dying patient; (2) physicians meeting in person with the family after the patient's death; and (3) an emergency department designed so that the family has a place to grieve in private.

Discussion: Having a better understanding of emergency nurses' perceptions of obstacles and supportive behaviors in providing end-of-life care could help decrease the stress of caring for dying patients. Actions could be taken to decrease the highest rated obstacles and increase the ratings of supportive behaviors that may ultimately result in better end-of-life care for dying patients and their families in the emergency setting.

Too often, death comes as an unwelcome event to patients and families while being cared for in the Emergency Department (ED). In 2002, approximately 272,000 patients were either dead-on-arrival or died in emergency departments in the United States.¹ The average age of persons treated in emergency departments has risen 8% since 1992 and people 75 years and older had the highest emergency department visit rate in 2002.¹ By 2020 approximately 17% of the population will be over the age of 65.² Although the current number of ED deaths is high, future increases are likely given that baby boomers will begin turning 65 in 2011.³ At a time when the United States population is rapidly aging, the total number of emergency departments has decreased by 15% between 1992 and 2002.¹ The anticipated effect of these trends are fewer emergency departments to care for a larger number of patients, many of whom will die while there.

Emergency nurses work in high-stress, fast-paced environments caring for patients who experience unexpected illness or injury. Nearly 1 of every 100 ED visits requires immediate resuscitation or urgent intervention because of a patient's decreased level of consciousness.¹ Emergency nurses frequently are faced with making quick clinical decisions based on minimal patient information or vague or incomplete histories. Sometimes death is viewed as preventable, leading to feelings of guilt, incompetence, or defeat among healthcare workers.⁴

The profession has been challenged to include more content on end-of-life care in nursing curricula and publications.^{3,5} In a position statement, the Emergency Nurses Association (ENA) emphasized that emergency nurses should engage in research on end-of-life issues to promote a better understanding of these issues and develop interventions for end-of-life.⁶ However, there are few reports in the literature regarding end-of-life care in the ED setting. Published studies include those that focused on providing care to hospice patients in the ED⁷; common physical symptoms, cultural and religious practices, and resuscitation directives that accompany terminally ill ED patients⁸; and the culture and characteristics of emergency departments and the applicability of some end-of-life care models.⁹ In an effort to provide better care to dying patients, more research, education, policies, and improved practice in end-of-life care are needed.¹⁰

Little evidence exists of emergency nurses' perceptions of end-of-life care. Given the increasing number of older ED patients, it is imperative that emergency nurses recognize the potential obstacles and behaviors that inhibit or support providing the best care to dying patients. The purpose of this study was to determine emergency nurses' perceptions of the greatest obstacles and most supportive behaviors to providing care to dying patients in the emergency department. Two research questions were addressed in this study: (1) What are emergency nurses' perceptions of the greatest obstacles to providing end-of-life care in emergency departments? (2) What are emergency nurses' perceptions of the most supportive behaviors for providing end-of-life care in emergency departments?

Methods

SAMPLE

After Institutional Review Board approval of this study, a geographically dispersed random sample of 300 potential emergency nurse participants was selected from the ENA membership records. The total membership of ENA, at the time of this study, was approximately 26,500.¹¹ Participants met the following inclusion criteria: worked at least part-time in an emergency department, lived in the United States, were able to read English, and had cared for at least 1 patient who was at the end of life. Return of the questionnaire was deemed consent to participate.

INSTRUMENT

The *Survey of Emergency Nurses Perceptions of End-of-Life Care* questionnaire was adapted from a similar study conducted with critical care nurses.¹² The questionnaire was revised to more closely relate to emergency nursing. To strengthen content validity, information from the literature and expert opinion were used to revise the initial lists of obstacles and supportive behaviors. These lists were then reviewed by an experienced emergency nurse and developed into a 70-item questionnaire, containing 51 Likert-type items, 5 open-ended questions, and additional questions soliciting demographic information.

The questionnaire was pilot-tested on 18 experienced emergency nurses employed at several different emergency

departments in one inter-mountain state. Changes to the questionnaire were made based on recommendations of the pilot test group. Three additional Likert-type items were added, resulting in a revised questionnaire of 73 items. Time for completion of the piloted questionnaire was 28 minutes for the 15 nurses who recorded a completion time.

PROCEDURES

Names of ENA members providing bedside care in emergency departments were randomly selected from the membership list. Mailing addresses were obtained from the national ENA office. Questionnaires were mailed with a cover letter explaining the purposes of the study. A self-addressed stamped envelope was included for return of the questionnaire. As an expression of the investigators' appreciation for prompt return of the questionnaire, a one-dollar bill was included in the initial mailing.

Two follow-up mailings were sent to non-respondents. The second mailing consisted of a reminder postcard ($n = 172$) that was sent 1 month after the initial mailing. The third mailing, sent to the remaining 157 non-responders, consisted of a new cover letter, a second copy of the questionnaire, and a self-addressed stamped envelope. The third mailing was sent 1 month after the postcard reminder had been mailed. Respondents were assigned a numerical code to allow for confidentiality of responses. The list matching names and numerical codes was kept in a locked office. Respondents were informed that they could opt to complete an online version of the questionnaire by entering the numerical code at a designated website. Sixteen respondents completed the on-line version of the questionnaire.

Emergency nurses were asked to rate the magnitude of obstacles and supportive behaviors to providing EOL care. Nurses were also asked to list additional obstacles and supportive behaviors they had encountered while caring for dying patients. SPSS^{®13} was used to analyze frequencies, measures of central tendency and dispersion, and reliability of the instrument subscales (obstacles and supportive behaviors). To determine the greatest obstacles and most supportive behaviors, items were ranked from highest to lowest based on the mean scores. Content analysis was used to analyze and categorize responses to the 2 open-ended questions. Like items were placed in the same category and frequencies were calculated.

Results

Of 300 potential respondents, 16 were eliminated from the study either because the questionnaire could not be delivered ($n = 2$) or because the recipients reported that they were ineligible ($n = 14$). The primary reason given for ineligibility was that respondents had stopped working as an RN in an emergency department and did not meet the inclusion criteria. Usable questionnaires were received from 169 nurses, yielding a response rate of 59.5%, less than 1% of the total ENA membership as of June 2005. Demographic information is shown in [Table 1](#).

OBSTACLES TO PROVIDING END-OF-LIFE CARE

There were 31 obstacle items. On a scale of 0 (not an obstacle) to 5 (extremely large obstacle), obstacle magnitude ranged from 1.63 to 3.80 ($M = 2.86$, [Table 2](#)). Cronbach's alpha for the 31 items was .94, indicating high subscale internal consistency. The obstacle with the greatest magnitude to providing end-of-life care was the heavy nurse workload that made it impossible to provide adequate time to care for dying patients and their families ($M = 3.80$).

Emergency nurses also reported that some family behaviors were obstacles for providing end-of-life care. These behaviors included dealing with angry ($M = 3.71$) or distraught ($M = 3.36$) family members, frequent phone calls from a family member for patient condition updates ($M = 3.48$), family members who wanted to initiate or continue life-sustaining measures even though the patient had advanced directives requesting no such treatment ($M = 3.27$), and families not accepting the patient's prognosis ($M = 3.27$).

Three items were perceived by emergency nurses to create the smallest obstacles: the nurse knowing about the patient's poor prognosis before the family is told ($M = 1.63$), continuing to provide advanced treatments to dying patients because of financial benefits to the hospital ($M = 1.80$), and physicians who are overly optimistic to the family about the patient surviving ($M = 2.03$).

Twenty-eight respondents (16.6%) responded to the open-ended question regarding perceived additional obstacles. The most common responses related to lack of privacy for families ($n = 5$), families' disagreement about or lack of knowledge regarding DNR orders ($n = 5$), not knowing the DNR status of the patient ($n = 3$), no time to debrief the

TABLE 1
Demographic characteristics of respondents

Sex			
Male (%)		23 (13.6)	
Female (%)		144 (85.2)	
Did not report (%)		2 (1.2)	
	<i>M</i>	<i>SD</i>	Range
Age	46.4	9.5	24-68
Years as RN	18.5	8.2	3-50
Years in ED	15.4	7.0	2-40
Hours worked/week	31	12	0-60
Number of ED beds	25.4	8.1	1-88
No. of dying patients cared for (%):			
>30	68.5		
21-30	9.8		
11-20	8.6		
≤10	3.9		
Highest degree (%):			
Diploma	14		
Associates	19.4		
Bachelors	51.7		
Masters	14.1		
Doctoral	.8		
Ever certified as a CEN? (%)			
Yes	73.4		
No	26.6		
Current CEN certification (%)			
Yes	68.4		
No	9.6		
No answer	22		
Years as CEN	9.14	4.8	1-24
Position held (%):			
Staff nurse		42.5	
Charge nurse/staff nurse		39.5	
Nurse manager		7.2	
Clinical nurse specialist		1.2	
Other		9.6	
Hospital type (%):			
Non-profit, community		65.5	
For-profit, community		16.7	
University medical centers		7.1	
Other		10.7	

staff after a traumatic death ($n = 2$), no nursing experience with some of the issues around dying ($n = 2$), doctors or nurses not allowing the presence of families during resuscitation ($n = 2$), the lack of needed equipment because the crash cart had not been restocked properly, and needing less frequently used items for specialized populations ($n = 1$). The remaining responses included not having enough time to care for the dying patient and family, not having clergy present, prolonged resuscitation efforts, and dealing with angry family members.

SUPPORTIVE BEHAVIORS FOR PROVIDING END-OF-LIFE CARE

On a scale of 0 (not a support) to 5 (extremely supportive), supportive behavior item scores ranged from 3.29 to 4.57 ($M = 4.08$, Table 3). Cronbach's alpha for the 23 support items was .87, indicating very good internal consistency. The most supportive behaviors related to issues of communication, making the patient's death easier for the family, the availability of staff support, and the family accepting that the patient was dying. Communication issues included good communication between the physician and RN ($M = 4.57$), physicians communicating with the family after the patient's death ($M = 4.55$), having 1 family member designated to be the contact person for all other family members regarding information about the patient ($M = 4.35$), and having the physicians involved in the patient's care agree about the direction care should proceed ($M = 4.31$). Items related to making the patient's death easier for the family included an emergency department designed so that grieving families have a place to go ($M = 4.51$), allowing family members adequate time to be alone with the patient after death ($M = 4.43$), and providing a peaceful, dignified bedside scene for the family ($M = 4.41$). Additional highly supportive behaviors were staff support for the necessary paper work after a patient's death ($M = 4.36$), availability of a social worker or religious leader to care for the grieving family ($M = 4.31$), and the family accepting that the patient was dying ($M = 4.45$).

The least supportive behaviors were physicians who put hope in real tangible terms ($M = 3.29$), having unlicensed personnel available to help care for dying patients ($M = 3.45$), and paramedic personnel assisting with resuscitation efforts of the dying patient ($M = 3.53$).

TABLE 2

Average obstacle scores reported by emergency nurses with regard to end-of-life care

	<i>M</i>	<i>SD</i>	<i>n*</i>
1. ED nurse having too high of a workload to allow for adequate time to care for dying patients and their families.	3.80	1.20	166
2. ED nurse having to deal with angry family members.	3.71	1.25	167
3. Poor design of emergency departments that do not allow for privacy of dying patients or grieving family members.	3.60	1.44	169
4. Family members not understanding what "life-saving measures" really mean, i.e., 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.	3.57	1.20	165
5. Not enough time to provide quality end-of-life care because the nurse is consumed with activities that are trying to save the patient's life.	3.53	1.16	166
6. Family and friends who continually call the nurse wanting an update on the patient's condition rather than calling the designated family member for information.	3.48	1.39	167
7. Nurse not knowing the patient's wishes regarding continuing with treatments and tests because of the inability to communicate due to a depressed neurological status or due to pharmacologic sedation.	3.42	1.31	167
8. Nurse having to deal with distraught family members while still providing care for the patient.	3.36	1.10	169
9. Employing life-sustaining measures at the families' request even though the patient had signed advanced directives requesting no such treatment.	3.27	1.54	169
9. (tie) Families not accepting what the physician is telling them about the patient's prognosis.	3.27	1.12	169
11. Being called away from the patient and their family because of the need to help with a new admit or to help another nurse care for his/her patients.	3.26	1.37	167
12. Physicians who avoid having conversations with family members.	3.23	1.59	167
13. Physicians who order unnecessary tests or procedures for dying patients just so they can say that every possibility was checked.	3.14	1.35	166
14. The family, for whatever reason, is not with the patient when he or she is dying.	3.07	1.13	166
15. When the nurses' opinion about the direction patient care should go is not requested, not valued, or not considered.	2.98	1.46	166
16. The patient having pain that is difficult to control or alleviate.	2.93	1.16	169
17. Providing treatments for a dying patient even though the treatments cause the patient pain or discomfort.	2.92	1.38	165
18. Intra-family fighting about whether to approve the use of life support.	2.89	1.42	166
19. Multiple physicians, involved with 1 patient, who differ in opinion about the direction care should go.	2.87	1.59	165
20. Pressure to limit family grieving after the patient's death to accommodate a new admit to that room.	2.86	1.61	166
21. Dealing with the cultural differences that families employ in grieving for their dying family member.	2.75	1.34	168
22. Physicians who won't allow the patient to die from the disease process.	2.72	1.61	165
23. The nurse not being comfortable caring for dying patients or their families.	2.66	1.67	166
24. No available support person for the family such as a social worker or religious leader.	2.56	1.73	169
25. Restriction of family members in the ED room during resuscitation.	2.54	1.61	168
26. Lack of nursing education and training regarding family grieving and quality end-of-life care.	2.51	1.46	166
27. 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.	2.44	1.57	167
29. Physicians who are overly optimistic to the family about the patient surviving.	2.03	1.39	168
30. Continuing to provide advanced treatments to dying patients because of financial benefits to the hospital.	1.80	1.92	164
31. The nurse knowing about the patient's prognosis before the family is told the prognosis.	1.63	1.66	169

*Reflects the number of respondents rating this item.

TABLE 3

Average supportive behavior scores reported by emergency nurses with regard to end-of-life care

	<i>M</i>	<i>SD</i>	<i>n</i> *
1. Good communication between the physician and RN who are caring for the dying patient.	4.57	0.64	166
2. Having the physician meet in person with the family after the patient's death to offer support and validate that all possible care was done.	4.55	0.65	166
3. An emergency department designed so that the family has a place to go to grieve in private.	4.51	0.78	166
4. Having family members accept that the patient is dying.	4.45	0.73	166
5. Allowing family members adequate time to be alone with the patient after he or she has died.	4.43	0.73	165
6. Providing a peaceful, dignified bedside scene for family members once the patient has died.	4.41	0.85	165
7. After the patient's death, having support staff compile all the necessary paperwork for you, which must be signed by the family before they leave the department.	4.36	0.95	164
8. Having 1 family member be the designated contact person for all other family members regarding patient information.	4.35	0.89	166
9. Letting the social worker or religious leader take primary care of the grieving family.	4.31	0.90	164
9. (tie) Having the physicians involved in the patient's care agree about the direction care should go.	4.31	0.83	164
11. Teaching families how to act around the dying patient such as saying to them, "She can still hear. . .it is OK to talk to her."	4.21	.94	166
12. Having family members thank you or in some other way show appreciation for your care of the patient who has died.	4.16	.93	166
13. Having enough time to prepare the family for the expected death of the patient.	4.13	.99	165
14. Having a fellow nurse take care of your other patient(s) while you get away from the department for a few moments after the death of your patient.	4.04	1.14	165
15. Having a fellow nurse tell you that, "You did all you could for that patient," or some other words of support.	3.88	1.19	165
16. Having a support person outside of the work setting who will listen to you after the death of your patient.	3.85	1.34	165
17. Talking with the patient about his or her feelings and thoughts about dying.	3.81	1.22	164
17. (tie) The nurse drawing on his/her own previous experience with the critical illness or death of a family member.	3.81	1.13	164
19. Allowing families unlimited access to the dying patient even if it conflicts with nursing care at times.	3.77	1.34	164
20. Having a fellow nurse put his or her arm around you, hug you, pat you on the back or give some other kind of brief physical support after the death of your patient.	3.66	1.38	165
21. Paramedic personnel assisting with resuscitation efforts of the dying patient.	3.53	1.37	165
22. Having un-licensed personnel available to help care for dying patients.	3.45	1.47	159
23. Physicians who put hope in real tangible terms by saying to the family that, for example, only 1 of 100 patients in this patient's condition will completely recover.	3.29	1.56	163

*Reflects the number of respondents rating this item.

Twenty-four respondents (14.2 %) added responded to the open-ended question, identifying additional supportive behaviors. The most common of these were having the family's own clergy member or some type of social support present in the ED (*n* = 5), debriefing staff members after a traumatic death (*n* = 3), and having educational

courses on caring for dying patients and their families (*n* = 3). Remaining responses related to the physician communicating with the family, not having family presence during resuscitation, crowd control by hospital security, and staff members assisting with the necessary paperwork.

Discussion

The emergency care environment is stressful, and may be emotionally and physically traumatic.¹⁴ One of the major sources of stress is caring for acutely ill, traumatically injured, or dying patients on a daily basis. Having a better understanding of emergency nurses' perceptions of the obstacles and supportive behaviors in providing end-of-life care could help decrease the stress of caring for dying patients.

OBSTACLES TO CARE

The mean scores for obstacle magnitude were lower than expected but similar to the ranges reported by Kirchhoff and Beckstrand.¹² Because of the unpredictable nature of the emergency environment where nurses are never certain what the next challenge will be, this highly-experienced sample of nurses may be more accustomed to working with challenges and obstacles from many different sources. Perhaps the specific obstacles surrounding care of dying patients were not perceived as out of the nurses' control, and therefore, were rated more moderately than expected. A sample taken from nurses with less experience may have rated the listed obstacles of greater magnitude.

Emergency nurses perceived the greatest obstacles to providing end-of-life care to be heavy nursing workloads, difficulties with the behaviors of family members, the poor design of emergency departments, not knowing the patient's wishes regarding the extent of desired treatments or tests, or not following the patient's known wishes as written in their advance directive. With visits to emergency departments steadily increasing over the last decade and the total numbers of emergency departments decreasing, the workload of the emergency nurse has increased. Many emergency nurses feel that a needed area of improvement for providing better patient care would be a decrease in the nurse's present workload to provide more time to meet patient needs.¹⁵

Emergency department designs that do not allow for a private, quiet area for the family to grieve were ranked among the greatest obstacles. Because of increasing patient visits, some emergency departments have found it necessary to sacrifice a room originally created for family grieving to accommodate another patient bed. This sacrifice of family comfort and privacy becomes an obstacle that is compounded by increasing patient volume and the potential for increased emergency department deaths.

Family behaviors that were obstacles primarily fell into 2 categories: behaviors that removed the nurse from the patient and behaviors that did not follow the patient's wishes for care. Interestingly, 4 of the greatest obstacles cited by respondents (dealing with angry family members, the family not understanding the concept of "life-saving measures," family members continually calling the nurse, nurses not knowing the wishes of the patient) were also perceived by critical-care nurses as some of the greatest obstacles,^{12,16} suggesting that these issues may transcend the location of dying. Rather, these are central issues when caring for dying patients regardless of the unit or department location.

The ranking of 2 obstacles as least important (physicians being overly optimistic about patient survival, knowing the patient's prognosis before the family was told) may have reflected nurses' and physicians' experience in quickly determining the prognosis of various patients. Instead of being overly optimistic to families, these experienced health care providers may tend to prepare families for the reality of their loved ones' imminent death.

Of those respondents who reported additional obstacles, one of the most frequent themes was the lack of privacy for grieving families. Interestingly, this was already a questionnaire item. There may be several reasons that respondents repeated an item already present on the questionnaire. First, nurses are caring individuals and want grieving families to be as comfortable as possible during such a stressful and life-altering time as the death of a loved one. Second, nurses also recognize that other ED patients and families can become uncomfortable, stressed, or upset by the open grieving of a dying patient's family. Third, nurses are caught in the middle of trying to reassure other patients and family members that everything is under control while also following the strict HIPPA requirements of not sharing private patient information about the dying patient.

Additional comments relating to family disagreement or lack of knowledge about the DNR status and the nurse not knowing the DNR status were also stated. These comments regarding already stated items reflect that either these truly are great obstacles or that the written obstacles on the questionnaire did not fully address respondents' concerns. Repeating these items might also reflect the

length of the questionnaire in that respondents may not have remembered previously scored items.

SUPPORTIVE BEHAVIORS

The supportive behavior items had a higher score range than did the obstacle items. A possible explanation for the higher ranges could be due to an appreciation for any help in this unpredictable environment by experienced nurses.

Nurses perceived positive communications as supportive of end-of-life care. The most helpful communication items related to effective physician and nurse communication regarding patient care and nurses' perceptions that physicians communicated effectively with the patient's family after death. Other highly rated supportive behaviors were allowing family members adequate time to be alone with the patient after death and having a peaceful, dignified bedside scene. These might have been highly rated because they are behaviors controlled by the nurse; therefore, they are seen as very helpful in end-of-life care.

Heavy nurse workload may also explain why the remaining most supportive behaviors were so highly rated. Having staff support to prepare needed paperwork, having the availability of a social support person to care for the grieving family, and having the family accept that the patient was dying may provide relief amidst the many demands placed on the nurse when the patient dies. Having a social support person to help care for the family was also identified as a highly supportive behavior in the open-ended items.

Other open-ended items perceived as supportive behaviors were opportunities provided by emergency departments for debriefing of staff after a traumatic or highly intense patient death. Debriefing may be seen as important because it is a peer-driven process that focuses on psychological and emotional aspects of the event.¹⁷

The least supportive behavior was physicians who put hope in real tangible terms. This may have been rated as such because emergency nurses perceive their physician colleagues as realists who are unafraid to address with families the poor prognosis of the patient.

This study had several limitations. The respondents were members of one professional emergency nursing organization and may have views that are different from nurses who are not members. Although the results are not

generalizable to all emergency nurses, the results are generalizable to members of the Emergency Nurses Association because the sample was randomly selected from a geographically dispersed membership and the response rate after 3 mailings was excellent at 59.5%. Further, although obstacles and supportive behaviors were ranked by mean size, we did not determine the frequency of occurrence of each item to evaluate whether the greatest obstacles and most supportive behaviors were also the most frequently occurring obstacles and behaviors. Highly rated obstacles and behaviors should not be interpreted as those that also occur frequently in emergency departments.

Conclusions/Implications

The purposes of this study were to determine the greatest obstacles and most supportive behaviors surrounding end-of-life care in emergency departments. Although the respondents reflected only a small percentage of ENA members, important information was obtained from this experienced group of nurses.

Recommendations for decreasing the magnitude of the greatest obstacles include providing staffing that allows the nurse enough time to care for dying patients, encouraging emergency department designs that allow for privacy of dying patients and grieving families, developing educational offerings for families that teach the specifics of "life-saving measures," and designating a family member as a lead contact for all patient information.

Although some of these recommendations may be difficult to implement in a fast-paced emergency department, these results show the importance in doing so to assure that patients who die in emergency departments and their families receive the best care possible at the end of life.

REFERENCES

1. McCaig LF, Burt CW. National hospital ambulatory medical care survey: 2002 emergency department summary. Advance data from vital and health statistics (no. 340). Hyattsville, Maryland: National Center for Health Statistics. Retrieved September 23, 2004. Available from: URL: www.cdc.gov/nchs/data/ad340.pdf.
2. Population Projections Program, Population Division, United States Census Bureau (2000). Predictions of total resident population by 5-year age groups, race, and Hispanic origin with special age categories: middle series 2016-2020. Retrieved

- September 23, 2004. Available from: URL: www.census.gov/populations/nation/summary/np-t4-e.txt.
3. Robinson R. End-of-life education in undergraduate nursing curricula. *Dimens Crit Care Nurs* 2004;23:89-92.
 4. Olsen JC, Buenefe ML, Falco WD. Death in the emergency department. *Ann Emerg Med* 1998;31:758-65.
 5. Ferrell B, Virani R, Grant M. Analysis of end-of-life content in nursing textbooks. *Oncol Nurs Forum* 1999;26:869-76.
 6. Emergency Nurses Association. Position statement: end-of-life care in the emergency department. ENA Board of Directors revised and approved March 1-6, 2005.
 7. Reeves K. Hospice care in the emergency department: Important things to remember. *J Emerg Nurs* 2000;26:477-8.
 8. McClain K, Perkins P. Terminally ill patients in the emergency department: a practical overview of end-of-life issues. *J Emerg Nurs* 2002;28:515-22.
 9. Chan GK. End-of-life models and emergency department care. *Acad Emerg Med* 2004;11:79-86.
 10. Chan GK. End-of-life and palliative care in the emergency department: a call for research, education, policy, and improved practice in this frontier area. *J Emerg Nurs* 2006;32:101-3.
 11. Howard P. ENA celebrates 35 years of progress and potential. *ENA Connect* 2005;29:1.
 12. Kirchhoff KT, Beckstrand RL. Critical care nurses' perceptions of obstacles and helpful behaviors in providing end-of-life care to dying patients. *Am J Crit Care* 2000;9:96-105.
 13. SPSS Inc. SPSS® [Computer software]. Chicago: Author, 1999.
 14. Emergency Nurses Association. Position statement: stress management strategies. ENA Board of Directors revised and approved September 1-3, 2002.
 15. Jezewski MA, Meeker MA, Robillard I. What is needed to assist patients with advance directives from the perspective of emergency nurses. *J Emerg Nurs* 2005;31:150-5.
 16. Beckstrand RL, Kirchhoff KT. Providing end-of-life care to patients: critical care nurses' perceived obstacles and supportive behaviors. *Am J Crit Care* 2005;14:395-403.
 17. Pulley SA. Critical incident stress management. Retrieved June 17, 2005. Available at: URL: www.emedicine.com/emerg/topic826.htm.