FACULTÉ DES ÉTUDES SUPÉRIEURES ET POSTOCTORALES

uOttawa

L'Université canadienne
Canada's university

FACULTY OF GRADUATE AND POSDOCTORAL STUDIES

Kerry-Anne Hogan
AUTEUR DE LA THÈSE / AUTHOR OF THESIS

M.Sc. (Nursing)
GRADE / DEGREE

School of Nursing
FACULTÉ, ÉCOLE, DÉPARTEMENT / FACULTY, SCHOOL, DEPARTMENT

Caring for Adult patients Who Die in the Emergency Department:
Reflections of Emergency Room Nurses

TITRE DE LA THÈSE / TITLE OF THESIS

Dr. Frances Fothergill-Bourbonnais
DIRECTEUR (DIRECTRICE) DE LA THÈSE / THESIS SUPERVISOR

Dr. Susan Braitman
CO-DIRECTEUR (CO-DIRECTRICE) DE LA THÈSE / THESIS CO-SUPERVISOR

EXAMINATEURS (EXAMINATRICES) DE LA THÈSE / THESIS EXAMINERS

Keith Wilson

Meryn Stuart

Gary W. Slater
Le Doyen de la Faculté des études supérieures et postdoctorales / Dean of the Faculty of Graduate and Postdoctoral Studies

Caring for Adult Patients Who Die in the Emergency Department: Reflections of Emergency Room Nurses

Kerry-Anne Hogan BSc RN BN ENC(c)

Thesis submitted to the Faculty of Graduate and Postdoctoral Studies
In partial fulfillment of the requirements for the degree of Master's of Science in Nursing

School of Nursing
Faculty of Health Sciences
University of Ottawa

Library and
Archives Canada

Published Heritage
Branch

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque et
Archives Canada

Direction du
Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 978-0-494-51837-3
Our file Notre référence
ISBN: 978-0-494-51837-3

NOTICE:
The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:
L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

Canada

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LYRICS FOR SONG: "LIFE HOLDS ON"

Artist/Band: Nielsen Chapman Beth
Lyrics for Album: Greatest Hits

I was swinging on the swings when I was a little girl
Trying to get a handle on the big, wide world
When I noticed all the grass in the cracks in the concrete
I said, "Where there's a will, there's a way around anything"

CHORUS:
Life holds on
Given the slightest chance
For the weak and the strong
Life holds on

There was a third grade boy that we knew in school
He was found face down in a swimming pool
And as they worked on that kid every minute was an hour
And when his eyes fluttered open we could feel that power

CHORUS

Sirens screaming down my street
Fading as they go
Whining somewhere far away
To someone I don't know
Still, I say a little prayer
There's always hope
Life holds on

Through the window in the kitchen I can see outside
My kids taking turns coming down the slide
I try not to worry as they grow a little every day
I've just got to believe they're gonna find their way

CHORUS

ACKNOWLEDGMENTS:

This is probably one of the most difficult pieces of the thesis to write; how do you pay tribute to the many people who helped you, guided you, supported you and made this dream a reality on one page?

I am forever grateful to:

My dad, who left his life 'Down East' and moved to Kanata to become my overworked, underpaid full-time nanny and personal assistant and to my mom who let him do it and came with him. To my husband Mike, who is an amazing daddy and learned to manage the entire household while I completed this journey. To my children, Emily, Ben and Julia who may not yet understand the importance of having a mom who is also a student, but inspired me to keep going.

My supervisors, Dr. Frances Fothergill-Bourbonnais and Dr. Susan Brajtman. Frances has such wisdom and experience, I truly admire her and aspire to one day have an outstanding reputation like her. And to Susan, who has guided and supported me every step of the way and became a friend in the process. And to my other committee members Dr. Keith Wilson, who always gave constructive feedback and added a few kind words to maintain my motivation. To Susan Phillips, Geriatric Nurse Specialist at The Ottawa Hospital, who listened to me, supported me and kept me on track, always over dinner of course!

My colleagues at the Queensway Carleton Hospital, for listening to my stories, ideas, questions, complaints, for sharing their stories and giving me feedback when my study was in its infancy stages. Thank you for supporting me through this long journey.

To my friends Dawn, Mary Ann, Prudy and Brandi who have intimately been a part of this project. Thank you for your friendship and support.

To the key people at The Ottawa Hospital, John, Betty, AnneMarie and Wendy, for your interest in my study and for your support. And to the emergency room nurses at The Ottawa Hospital for your time and for sharing your stories; without you, this would never have been possible.

I would also like to acknowledge the financial support I received throughout my MScN program: CIHR Strategic Training Program in Palliative Care Research, RNAO nursing initiative, The Camille Reid Palliative Care Bursary and the Queensway Carleton Hospital Endowment Fund Bursary.

Thank-you!

ABSTRACT

Background:

Emergency room nurses work in an area in which the workload is unpredictable and chaotic. Treatment measures are usually aggressive and the goal of care in the emergency department is to restore physiological stability in a sick or injured person. As treatment measures usually occur quickly and nurses care for many patients throughout their shifts, there is often a lack of time to establish relationships with patients and/or family members. In a situation when treatment is needed immediately, there may not be enough time to discuss advanced directives with patients and/or family members. Although most patients are seen, treated and sent home or are admitted and recover, more than 7000 lives end in Canadian emergency departments each year (CIHI, 2006).

Death in an emergency department is almost always considered a tragic event, regardless of whether the event was unexpected or expected. This view contrasts with the idealistic view of death occurring in a hospice or at home, free of pain and suffering and surrounded by loved ones. In an emergency department, treatment of critical illnesses and/or injuries begins immediately, leaving nurses or other members of the team little time to discuss advance directives or establish rapport with patients and/or family members.

Purpose:

The purpose of this research study was to improve our understanding of the experience of emergency room nurses when caring for an adult who dies in the emergency department.

Methods:

Semi-structured interviews were carried out with eleven emergency room nurses from a large multi-site academic health sciences centre. A naturalistic inquiry paradigm (Lincoln & Guba, 1985) and interpretive descriptive methodology (Thorne, Reimer Kirham & MacDonald, 1997) provided the supportive framework for this study.

Findings:

Thematic analysis was used to derive the following three themes: *"It's not a nice place to die"*, *"I see the grief"*, and *"Needing to know you've done your best"*. The findings of this study revealed that emergency room nurses felt that factors such as the unpredictability, the busy-ness, the noise, the lack of privacy and the need to care for many patients created a less than ideal environment to care for dying patients and their family members.

Nurses in this study agreed that when a patient died in the emergency department, they become the primary caregivers for the suddenly bereaved family members and this was viewed as one of the most challenging aspects of their role. Nevertheless, nurses believed they did their best in all circumstances to provide end-of-life care interventions that were perceived as being important in contributing to a 'good death'. In doing their best, these nurses reported a sense of satisfaction within their professional role.

TABLE OF CONTENTS

CHAPTER 1 – INTRODUCTION

At 3pm on a busy shift in an emergency department, the waiting room is filled with people, each with his/her own emergency, many of them frustrated and angry with the triage nurse because the wait time to see a doctor is approximately four hours. The triage nurse struggles to keep her composure as the patrons in the waiting room continue to ask her questions about the wait time while a continuous stream of new patients come in. A young mom stands in the corner trying to console her 16 month old baby who has had a fever for three days and has just been given his first dose of an anti-pyretic, a construction worker whose chief complaint is 'back pain for six months' approaches the triage desk and angrily demands to see a doctor now. Meanwhile, all of the hospital beds are full and the hospital is in a situation of 'overload' (meaning there are more admitted patients than there are beds) and all of the department's stretchers are occupied. The stretchers are occupied with patients with multiple other medical and/or surgical emergencies, patients waiting for the operating room, to see specialists, to receive their diagnostic results or for a non-urgent ambulance ride back to their nursing home. A critically ill 53-year-old man with an acute myocardial infarction is keeping staff busy while a 97-year-old woman is dying with a lone family member at her bedside. Other patients have to wait their turns while the nursing staff quickly prioritize what to do next. Then, the patch phone rings signalling that another critically ill patient is en route to the hospital. The little information that is received through the airwaves is that it is a 31-year-old male who collapsed while riding his bike and is now VSA (vital signs absent). Paramedics are implementing advanced life-saving directives.

The image created by this scenario is one that has and does occur in many emergency departments on any given day or time.

1.1 Background

1.1.1 The Emergency Department

The majority of emergency department (ED) visits are unexpected, unscheduled and require immediate assessment (Emergency Nurses Association [ENA], 2003). Patients do not arrive with a diagnosis and the triage nurse must make decisions about treatment needs very quickly. There are times when the illness or injury may be life threatening and immediate actions need to be taken. The workload in an ED is constantly changing; it is unpredictable and often chaotic.

1.1.2 Emergency Room Nurses

According to the Emergency Nurses Association (ENA), emergency nursing is defined as "a specialty in which nurses care for patients in the emergency or critical phase of their illness or injury and are adept at discerning life-threatening problems, prioritizing the urgency of care, rapidly and effectively carrying out resuscitative measures and other treatment, acting with a high degree of autonomy and ability to initiate needed measures without outside direction, educating the patient and his family with the information and emotional support needed to preserve themselves as they cope with a new reality" (ENA, 2004).

Beginning at the triage desk, and continuing through to treatment and discharge, emergency room (ER) nurses are the primary caregivers to both the patient and their families. ER nurses are a unique subset of nurses as they quickly and efficiently care for patients of all ages and with all aspects of illness and disease during the critical phase of illness and/or injury. Often the first contact a patient and family has with the health care system, the ER nurse works with patients who may not have received a diagnosis, may be presenting with new problems or may have a temporary and immediate crisis arising from a pre-existing disease process.

An experienced ER nurse possesses rapid assessment skills, high level of specialized knowledge, keen intuition, autonomous decision-making power, and the ability to work closely with a diverse health care team focused on the restoration of health in an individual. They are able to simultaneously manage many stable and/or unstable patients who may require varying degrees of medical treatments, and provide care for many different patients each shift.

In addition to being skilled at providing and initiating medical treatments, the ER nurse must also communicate with patients and families in crisis, and provide them with education and support in less than ideal conditions. These interventions often involve dealing with emotional and psychosocial issues in a sensitive manner without having a previously established patient-family-nurse relationship. As most patients seen in the ED are assessed, treated and discharged, the ER nurse is also expected to be knowledgeable about appropriate and available community resources and able to access them within a short time.

1.1.3 Death in the Emergency Department

End-of-life care in an ED often begins with rapid life-saving interventions. In an ED, there is little or no time for the team to discuss advance directives or establish rapport with patients or family members. The need to treat critical symptoms quickly means these rapid sequenced life-saving interventions often begin before the patient's history is heard and before advanced directives or patient/family wishes are made known to the health care team. When a patient arrives in the ED with vital signs absent (VSA) or with life-threatening illness and/or injury, the urgency to initiate life-saving interventions is the priority for the health care team.

Death may be related to advanced age or disease process, or may be unexpected, such as from traumatic events, which can occur at any age. Death in an ED is unanticipated by family members, usually occurs in crisis and is almost always considered a tragic event, regardless of whether or not the event was unexpected or expected (Malone, 2000).

Although most people seen in EDs are treated and sent home, or are hospitalized and recover, over 7000 lives end in Canadian EDs each year (Canadian Institute for Health

Information [CIHI], 2006). When death occurs in an ED, nurses become the primary caregivers of the suddenly bereaved.

1.2 My Story

My professional experience as a palliative care nurse and as an ER nurse provided the basis for the objectives for this study. I began emergency nursing after working in palliative care for several years. I quickly learned that not everyone who comes into the ED is treated and discharged. Although most are, others are stabilized and admitted to the hospital, and some die. It was the caring for patients and families experiencing death in the ED that caused me to reflect on what we do as nurses during this process.

As a palliative care nurse, I was very comfortable working with the patient and family. In many ways, the relationship that was developed over time became an important part of the dying process and creation of final moments for myself, the patient and the patient's family. In contrast, the ED is busy, noisy and there is rarely enough time to establish a relationship with patients and family members, and you are often not able to accomplish what you desire. In the ED the dying process is on fast-forward, and sometimes there is not enough time for the family to say good-bye. Too often the death is unexpected and there is no established relationship between the family and the nurse. In my experience in the ED, when a patient was dying, or had already died, I became the caregiver for the distraught family. Even though I would do my best to try and make the situation better under the circumstances, it never seemed like it was enough.

Deaths that occur in the ED are experiences filled with intensity. For example, as an ER nurse, I have seen a sobbing mother walk childless out of my department, I've watched a young pregnant woman, freshly widowed, unable to stand due to the intensity of her grief, I've put an elderly woman alone in a taxi cab in the middle of the night after losing her soul mate and I've waited patiently for a dying person's family to come who never did. These experiences provided the impetus for me to further investigate what it is like for ER nurses to care for patients who die in the ED.

1.3 Purpose of the Study

The purpose of this study is to improve our understanding of the experience of ER nurses when caring for an adult who dies in the ED.

1.4 Study Objectives

The objectives for this study include:

1. To describe the experiences of nurses when caring for adults who die in the ED
2. To improve our understanding of the care nurses provide to adults who die in the ED
3. To describe factors that facilitate the care nurses provide to adults who die in the ED
4. To describe factors that challenge the care nurses provide to adults who die in the ED

CHAPTER 2 - LITERATURE REVIEW

This chapter will discuss the literature related to caring for patients and families, the role of nurses, death, and end-of-life care all within the context of the ED.

A review of the literature from 1995-2007 was performed using the following electronic databases: CINAHL, PubMED, Cochrane, and psychLIT. Reference lists of retrieved articles were scanned, personal library files were reviewed and colleagues were polled for relevant papers. Search terms included: death, emergency rooms, nurses; terms were used alone, together, and in combination with others (Appendix A further documents search terms). Published results in non-English language were excluded. While the literature encompassed many disciplines including nursing, sociology, psychology and philosophy, to be included in the literature review, articles had to involve ER nurses, and/or caring for dying patients in the context of the ED. Most of the papers identified in the literature search were descriptive. Much of the literature pertaining to emergency nursing was published in journals in the United Kingdom.

Pediatric trauma and death constituted the largest volume of literature. Pediatric death was described as being one of the worst aspects of emergency nursing as it was largely due to traumatic events, perceived as devastating, and viewed as a life that ended prematurely. It was suggested that pediatric death created grief in all involved (including family, friends and health care professionals) (Knapp & Mulligan-Smith, 2005).

2.1 Caring for Patients and Families in the Emergency Department

Each year, people make approximately 15 million visits to Canadian EDs, each person with his/her own ‘emergency’ (CIHI, 2006). Canadian EDs are public institutions, typically a subsection of a hospital and provides triage and initial treatment to patients of all ages presenting with a wide range of illness and/or injury.

When a patient presents to the ED, whether by ambulance or private transportation, (s)he is immediately assessed by a triage nurse and assigned an initial triage level based upon the assessment. This assessment is used to determine the urgency with which this patient requires care relative to his/her severity of injury or illness and the other patients waiting to be seen.

Often a critically ill patient arrives at the ED via ambulance. The paramedic crew will radio the receiving institution to alert the staff of the status of the patient being transported. This allows the medical team to announce overhead a 'trauma code' (meaning that the team needs to prepare to deal with a patient who may have life threatening injuries resulting from a traumatic event) or a 'code blue' (meaning the incoming patient is coming in VSA, vital signs absent). These few minutes enable the team to assemble in the resuscitation room and prepare their equipment.

A visit to the ED creates a temporary state of crisis for patients and their family members. The presence of a large number of concerned family members can be quite problematic due to the lack of physical space in the department and the care needs of the patient. When a patient dies in the ED, nurses become the primary caregivers for the suddenly bereaved family members. In caring for these family members, ER nurses are also able to influence the family's initial grieving process.

Two major identified problems that interfere with the provision of care for patients in the ED are overcrowding (Canadian Association of Emergency Physicians (CAEP) and the National Emergency Nurses Affiliation (NENA), 2006) and a lack of nursing staff (Boykin, Bulfin, Baldwin & Southern, 2004; Emergency Nurses Association (ENA), 2003;

Helps, 1997). Both of these issues make caring for dying patients and their family members challenging due to the demands continuously being placed on nurses.

According to CAEP and NENA (2006), overcrowding is a national problem creating a situation where the demand for service exceeds the ability to provide care within a reasonable time. Factors that contribute to overcrowding include: lack of access of beds for admitted patients, lack of access to family physicians, specialty physicians or nurse practitioners in the community, shortage of nursing and physician staff, increased complexity and acuity of patients presenting to the ED, large volumes of patients with non-urgent problems who could be assessed in another setting, and lack of alternative facilities for diagnostic testing.

Overcrowding has been linked to inadequate patient care, prolonged delays in the treatment of pain and suffering, long wait times and patient dissatisfaction, ambulance diversion /critical bypass (an ambulance transporting a critically ill patient bypasses the closest hospital due to the high patient volume), decreased nurse/physician satisfaction, increased risk of patients leaving without being seen (Boykin et al., 2004; CAEP & NENA, 2006; Doughtery, 2005; Huryk, 2006).

Findings from an observational study examining ED patient volume and time nurses spent at the bedside, confirmed that as the ED became more crowded (i.e. the volume of patients in the ED increase), the demands placed on the nurses were increased (Hobgood, Villani, & Quattlebaum, 2005). Consequently, the greater the demands placed on the nurse, the less time was spent with each patient.

Another major problem that may interfere with caring for patients and family members in the ED is a lack of nurses. Inadequate staffing may result in frustration, tiredness, burnout, depersonalization, and the inability to complete the basic aspects of care

(Boykin et al., 2006; ENA, 2003; Helps, 1997). These feelings were linked to professional discontent, such as nurses feeling that they were unable to touch lives in more personal ways, or in essence, feeling as though they were not *nursing* (Boykin et al., 2006).

2.2 Nursing in the Emergency Department

Peterson (1996) used a phenomenological approach to examine the lived experience of ER nurses. Individual interviews were conducted with eight ER nurses (female-6, male 2) with at least five years of consecutive emergency nursing experience. The study revealed four themes related to the lived experience of ER nurses; 1) *interaction to person and practice*, 2) *evolution of emergency room experience: the progression from novice to expert*, 3) *the job pressures*, and 4) *coping with the job pressures.*

The first theme, *interaction to person and practice* described what initially attracted nurses to the ED. Many were attracted to the fast pace, the challenge, caring for sick people and the adrenaline rush of providing emergency care. Findings also indicated that these nurses felt their practice had influenced their lives in a personal way.

The second theme, *evolution of emergency room experience: the progression from novice to expert,* described the evolution of a novice ER nurse to an expert ER nurse. At the time of Petersen's study ER nurses were all required to have had other nursing experience before going to the ED, yet they still encountered a huge learning curve and evolved from being skill-focussed to becoming 'intuitive' experts who could mentor other staff and visually assess a patient.

Included in the themes *job pressures* and *coping with the job pressures* were the thoughts and emotions associated with exposure to tragic emergency situations and how the team was able to cope with these situations through the use of humour and team support.

These nurses were subject to the pressures of time and performance and as they dealt with the tragedy of watching people die, they collected stories in their minds of the details of the traumas, of people and of situations. These situations held meaning for these individuals and for their emergency nursing peer group.

The nurses struggled to understand the meaning of the situations that they participated in and at times struggled to find the meaning in life. These 'meanings' were difficult to understand by people outside of their peer group. The participants expressed a sense of conflict between how 'human' they could allow themselves to be without compromising their skills and the speed required to perform them. The participants shared stories of crying while continuing to work effectively, of carrying emotional baggage home after witnessing tragedies, of anger, and of feeling helpless while participating in resuscitative codes for terminally ill patients. The participants felt that seeing children die was the hardest aspect of their practice.

One of the job pressures identified by participants was being exposed to tragedy in a high-pressure life or death environment. Along with the pressure of the environment was the expectation that nurses could 'handle it' and not be overwhelmed. Participants identified a struggle when dealing with families who were unable to accept the severity of the situation and were not ready to let their loved one die. There was a comparison made between ICU, where there was time to formulate strategies and make plans versus the ED where things happened so fast. The ER nurses in this study recognized that the use of humour was one mechanism that enabled them to cope with the pressures of the job. The team members also helped each other reduce their own stress.

One of the major limitations of Peterson's phenomenological study was the investigator's self acknowledged inexperience in conducting research which may have restricted the data collection and analysis. Other limitations were that the participants were very experienced ER nurses and were working in a small north-western town in Alaska, which limited transferability of findings to other settings such as large trauma centers.

2.4 Death in the Emergency Department

Through a review of the literature, Olsen, Buenefe, and Falco (1998) identified issues regarding deaths of patients in the ED. Identified issues included: the multiplicity of causes, such as: advanced age, trauma or disease, that it could be a devastating event for suddenly bereaved family members, and that it was frequently unexpected, often traumatic, and usually occured in crisis.

The environment of the ED itself provided many barriers for caring for dead or dying patients and their family members, making the ED a seemingly cold and uncaring place to mourn. Barriers to caring included: the busy ED setting which required staff to continuously care for other patients, which subsequently resulted in long wait times for family members waiting for information about their loved one, lack of a suitable place for families to grieve privately, and sometimes the unavailability of clergy and/or support staff to assist family members in the death notification and grieving process (Olsen et al., 1998).

Olsen et al. (1998) also identified that having to attend multiple patients, inadequate physician education on death notification, and having to approach family members about sensitive issues without having a previously established relationship compounded the stress of physicians in this situation.

Saines (1997a&b) studied Accident and Emergency nurses' (the British equivalent of North American ER nurses) experiences with sudden death. Using a phenomenological approach, the study was conducted with six Accident and Emergency (A&E) nurses (females-5, males-1) and identified four chronological themes: 1) *encountering*, 2) *facing*, 3) *dealing with*, and 4) *reflecting upon* the phenomenon of sudden death. Results acknowledged that coping with sudden death could be one of the most stressful aspects of an A&E nurse's role. Factors that made sudden death highly stressful included: provision of care without the benefit of an established rapport with family, the emotional pain and distress of the event, the inappropriate setting, and the unpredictable workload which impeded the provision of holistic and humanistic care.

Emotional labour was derived from the Saines' interviews when the subjects described the challenge of maintaining professional composure. The term emotional labor was first defined in 1983 by sociologist Arlie Russell Hocshchild as "the induction or suppression of feeling to sustain the outer appearance that results in others feeling cared for in a safe place" (Hocshchild, 2003, p. 7). Emotional labour is important in establishing a therapeutic relationship, but carries the risk of burnout if prolonged and intense (McQueen, 2004). According to Nairn (2004), the purpose of emotional labour in an emergency situation, such as caring for a trauma patient, is to allow the ER staff to suppress their emotional involvement in the tragedy and to allow the life-saving interventions to run smoothly.

One of the limitations with Saines' research is that it did not explore the perspective of having to provide end-of-life care to terminally ill patients and care for their family members in the ED.

2.5 End-of-Life Care in the Emergency Department

When a patient arrives who is critically ill or injured, treatment interventions are initiated immediately and continued until the patient is stabilized and transferred out of the department, or the decision is made to provide supportive comfort measures, or the patient dies. In addition to trauma or unexpected deaths, ER nurses also provide care for patients who have a terminal condition and whose death is expected. Payne, Dean & Kalus (1998), examined death anxiety in hospice nurses and ER nurses, and found that unlike hospice nurses, ER nurses report that death is an unfortunate consequence of the job and of not wanting to work with dying people.

Caring for terminal patients requires a different set of skills than caring for patients who die as a result of traumatic unexpected events. Although terminally ill patients require nursing skills such as physical assessment, medication administration and personal care, the goal of nursing care is to promote patient comfort. Terminally ill patients and their family members report a desire to be free from distressing symptoms such as pain and nausea, not to suffer, be kept clean, be touched, be in a supportive environment with open communication, and have family members in close proximity to the patients (Ciccarello, 2003; Levy, 2001).

In an article about how to maintain a comfortable, loving, supportive environment for a dying patient, Furman (2000), suggests that nursing care is highly focussed on "being", such as being with the patient in the moment and creating a safe and peaceful haven, and less focussed on the "doing" nature of our profession. This contrasts with care delivery in the ED, where nurses are continuously *doing* things and lack the time to spend *being* with patients.

Socorro, Tolson & Fleming (2001) studied the lived experience of Spanish ER nurses when caring for suddenly bereaved families. Using phenomenological methodology, the researchers interviewed seven ER nurses (female-5, male-2). The results showed that all the participants were affected emotionally by their experience of caring for suddenly bereaved relatives. Four themes emerged from the data: *knowing*, *relationships*, *culture,* and *reality*.

Knowing referred to participants feeling that they were not adequately prepared to care for suddenly bereaved relatives despite managing distressing situations on a regular basis. Although they learned from experience, the participants felt that experience alone seemed insufficient when dealing with suddenly bereaved relatives. The participants would have preferred to have some formal death education and training. *Relationships* referred to the way the nurse felt and behaved and how this was related to the relationship that was established with the families. The situation was deemed positive if the nurse was able to explain things properly, support relatives and show their own emotions. If a patient's dignity was not respected, the nurse felt the situation was negative. The participants felt valued in being useful and supportive during the death rather than being task focussed.

The theme *culture* captured the participants' recognition of the influence their personal beliefs, values and philosophies had in providing adequate care. For example, the participants identified that dealing with bereaved families was not a role for physicians only, but that part of their nursing skills included being caring and supportive with families. *Reality,* the final theme, captured the participants view that the environment of the ED did not support the dying process due to a lack of resources, such as a lack of bereavement follow-up and a lack of spiritual care (unless it was requested by the family).

Participants in Socorro et al.'s study identified feeling frightened and insecure when caring for the suddenly bereaved family and witnessing their grief, as it created an awareness of potential losses, and the nurses recognized that the roles could easily be reversed. One of the challenges after saying goodbye to suddenly bereaved relatives was that the skills of the nurse were in immediate demand and the nurse had to continue to care for other patients.

Limitations of the Socorro (1998) study included that the study was conducted in a country that was identified by the researcher as having a noted lack of palliative care education (both as a subject and a specialty), and that the organization did not promote reflective practice or encourage nurses to discuss distressing aspects of their work. These limitations might have limited the ability of Spanish ER nurses to cope with both the death of patients and caring for suddenly bereaved family members. Another limitation, which might have interfered with the collection of the data, was that all participants were colleagues of the researcher.

2.6 Summary of the Literature

Death in the ED created many challenges for nurses because of the constant care demands, the acuity of patients, lack of resources, lack of time to prepare for a death, the immediacy of decision making and interventions, and the lack of an established relationship, all of which impacted the care of dying patients and the family members.

Caring for dying patients, in all contexts, was identified as one of the most stressful aspects of nursing practice (Hopkinson, Hallett & Luker, 2005; Marino, 1998; Payne, Dean, & Kalus, 1998; Saines, 1997a&b). Caring for dying patients was recognized as challenging both personally and professionally, causing nurses to face their own mortality continuously (Payne et al., 1998, Socorro et al., 2001). In an ED, nurses bear witness to the intense pain and suffering of suddenly bereaved families but due to the volume of patients in the department, have been expected to immediately move on to the next person (Levetown, 2004; Malone, 2000). The life of each nurse is changed with every death (s)he is involved in. “When you take on care of the bereaved, you take on pain. A different, often newly discovered part of yourself is given to each family you care for” (Davies, 1997, p. 166).

A large portion of the available literature was focussed on sudden, traumatic deaths in the ED and discussed the role of the nurse in helping the bereaved family during the brief encounter in the ED. The few studies that have been conducted with nurses who experience caring for patients who die in the ED focussed on sudden, traumatic deaths. However, there were no studies that examined other types of deaths, such as non-trauma related deaths, and the factors that facilitated and/or challenged nurses when caring for patients who died and/or their grieving families. Therefore this study was warranted. Research in this underdeveloped area of nursing knowledge is likely to contribute to improving care and support of patients, families and health care professionals in Canada and elsewhere.

CHAPTER 3 – METHODS

This chapter will discuss the research method selected for this study. In addition, the sample, setting, procedures for data collection, the interview process, and data analysis will be reviewed in detail.

3.1 Research Design

The goal of qualitative research is to gain insight into social, emotional and experiential phenomena in an environment. "Many qualitative studies are based on the premise that gaining knowledge about humans is impossible without describing the human experience as it is lived and as it is defined by the actors themselves" (Polit & Hungler, 1995, p. 517).

This study used an interpretive descriptive approach to describe and improve our understanding of the experience of ER nurses in caring for adult patients in the specific context of the ED. Interpretive description is a relatively new research approach that was generated out of a need to expand on traditional methods used in qualitative research while maintaining research integrity (Thorne, Reimer Kirham & MacDonald-Emes, 1997).

The philosophical underpinnings of interpretive descriptive research incorporate the naturalistic inquiry paradigm as described by Lincoln and Guba (1985). This paradigm acknowledges that realities are shared, subjective, complex, constructed and holistic. The researcher and the participant interact and influence each other, inquiry is value-bound, all generalizations are bound by time and context and theory arises from the data. Naturalistic inquiry implies a commitment to study a phenomenon in its natural state through the use of techniques, such as semi-structured interviews, to allow the phenomenon under study to present itself.

According to Thorne et al. (1997), this approach uses narratives as the primary source of data collection, and inductive reasoning to generate ideas. Interpretive description seeks to uncover or deconstruct the meaning of a phenomenon and presumes that there is some theoretical knowledge, clinical pattern observation and scientific basis in which a study idea was generated. The aim of the research is to capture themes and patterns within subjective perceptions characterizing the phenomenon, to generate an interpretive description capable of informing clinical understanding and to highlight the phenomena in a new and meaningful manner (Thorne, Reimer Kirkham & O'Flynn-Magee, 2004).

According to Thorne et al. (1997), the intended products of interpretive design are to provide the profession with a 'tentative truth claim' about what is common with a clinical phenomenon (such as caring for an adult who dies in an ED), and have application potential (a clinician would be able to use this as a basis for implementing clinical practice change). "In the disseminated research report, such a claim would be rendered accessible to the practice of the discipline for the purpose of informing clinical reasoning, extending the available insight for practice decisions, and creating a sense-making structure for the eccentricities and variations that inevitably occur in the real world of health care application" (Thorne et al., 2004, p. 7).

3.2 Methodological Assumptions

As interpretive descriptive research expands on traditional qualitative research methodologies this study incorporates certain assumptions inherent to phenomenology. One assumption is that study participants are experts in the study topic by virtue of their experience with the phenomena and are capable of articulating these experiences (Morse & Field, 1995). Another assumption is that study participants are honest in their recollection of their experiences and do not intentionally misrepresent or fail to reveal aspects of their experiences.

According to Burns and Grove (2007), it is assumed that study participants are open to sharing their experiences and feelings about the study topic with the researcher and that subsequently, through this sharing of experience through narratives, both the researcher and the participant are changed by the encounter. The research-participant relationship (in this case ER nurse and ER nurse) also has an impact on the collection and interpretation of the data.

In this study, the researcher is also an expert ER nurse and is knowledgeable about the study topic. According to Milne and Oberle (2005), the expertise a researcher brings to the interview helps to inspire trust and enhance the ability to probe more deeply when required. The challenge is not letting the assumptions of a researcher affect the data analysis as each participant is also an expert with his/her own beliefs and experiences.

3.3 Setting

Study participants were recruited from the EDs of two sites (site A and site B) of a large multi-site university teaching hospital located in a large Canadian city. The participating hospital was selected because it has over 120,000 ED visits and has more than 200 deaths annually in the ED alone. Although the majority of these visits are by adults, approximately 5% of the visits to site A are pediatric visits. Site B has a geographically adjoining children's hospital and therefore does not see pediatric patients.

Site A is part of a 418-bed hospital that provides tertiary-level services and specialty care in both official languages. The ED employs approximately 120 full-time, part-time and casual registered nurses (female-102, male-12). Site B is part of a 459-bed hospital that also provides tertiary-level services and specialty care in both official languages. The ED of site B employs approximately 90 full-time, part-time and casual registered nurses (female-74, male-16).

The physical layout of the EDs at both sites is similar. Both sites include an area where incoming patients are triaged, placed in an appropriate treatment area and are seen according to triage level and wait time. The areas that patients can be seen and treated in include cubicles, observation, monitored observation and a resuscitation area.

The team that provides medical intervention to patients includes medical residents and interns, an emergency medical doctor, registered nurses, and respiratory therapists. Students in various health care related disciplines (nursing, respiratory therapy, medicine, social work, theology and clerical support), as well as, ECG technicians, pharmacists, volunteers, chaplains, social workers and administrative clerks also assist the medical team.

Both sites have as their mission to practice compassionate family-centred care and encourage family members to be present at the bedside of a dying patient as much as possible. Specifically, the participating hospitals have a policy that allows families the option of being present in the resuscitation room during tragic events. This initiative was started at site A about 10 years ago by two nurses who had a strong belief that, if desired, families should be allowed to be at the bedside with their loved ones. Using literature available from the United Kingdom, these two nurses started a practice that enabled loved ones to remain at the bedside of the patient.

To successfully implement a program that has family members at the bedside during critical and/or tragic moments, all ED staff are required to attend an education session on how to manage families at the bedside. Before a family is permitted to be at the bedside of their loved one, three strict criteria must be met. First, the family must want to be present.

Second, the family is not permitted to enter the room until the physician is ready, and finally there must be a resource person (such as a nurse, social worker or chaplain) present with the family at all times to facilitate the process and to explain what is happening. One of the most important factors in having families present is having a resource person available to them. This resource person cannot be actively involved in the resuscitation or supportive measures, but instead focuses his/her time and energy on the family members. The success of this program is evidenced by anecdotal reports provided by staff from the participating hospital, stating that after the event, families often contact them to thank them for letting them be a part of that experience as it allowed them the opportunity to say good-bye to their loved one, and to know that everything possible had been done.

If a death occurs between Monday to Friday from 8am to 8pm, a social worker is present in the ED and is available to assist the family. After 8pm, the ED team leader assumes the role of the resource person for families, but s(he) also has an ongoing shared role with the other team members and may be required to assist in the resuscitation efforts. If available, the hospital's nursing coordinator may come to assist staff and/or families. Although not in-house, pastoral care services are available on-call 24 hours a day. Local religious groups are very accommodating and the hospital can usually locate a member of the family's religious group within a short time frame.

After the deceased's family has gone home, staff may request that a social worker follow-up with a phone call to the family if they are concerned that the family may not have adequate resources to cope with the death of their loved one. The hospital does not have a bereavement program or yearly memorial service for deaths that occur in the ED, so staff do not know how the family managed after the initial bereavement phase. If distressed by an event, a staff member has the option to access the Employee Assistance Program, but no official debriefing procedures exist at either site.

3.4 Characteristics of Participants

The eleven participants in this study included six female nurses and five male nurses. The participants ranged in age from 28-60, with an average age of 37.4 years. Years of experience in nursing ranged from 5-25, with an average of 13.6 years. The range of years working in the ED ranged from 2-13 years with an average of 6.6 years. Five of the participants had ICU experience, 3 participants had only worked in emergency and none of the participants had worked on a palliative care unit or had any formalized end-of-life care training. All participants had experienced multiple deaths in the ED.

3.5 Eligibility Criteria

To participate in this study, participants were required to meet the following inclusion criteria:

1. Employed (casual, part-time, or full-time) as a registered nurse in the ED at one (or both) of the sites of the participating hospital during the study period
2. Experienced caring for patients who have died in the ED
3. Able to speak and understand English
4. Consent to share his/her experiences in a 30-60 minute audio-recorded interview.

As the focus of the study was on caring for adult patients who die in the ED, the first criterion was established to ensure that the sample included only registered nurses and excluded other ED staff. Although other ED staff, such as physicians, respiratory therapists, clergy, social work and other support staff are an integral part of the health care team, the registered nurse is often the primary and consistent caregiver of dead or dying patients and their families. Being currently employed was a part of the inclusion criteria to ensure that study participants have the perspective of working in the department with the challenges that currently exist in EDs (such as increased wait times, decreased staffing availability, and increased acuity of patients), which provides the study with a homogenous sample.

The second criterion ensured that the participants had experience in the area to be researched; caring for patients who died in the ED. The third criterion was required as the researcher is primarily English speaking and it was not feasible within the constraints of this study to hire a French-speaking interviewer and to have documents transcribed and translated. The fourth criterion ensured that the participants had informed consent about the research project and had volunteered to participate.

3.6 Sample Size

Because of the large amount of data generated in qualitative interviews, sample sizes are typically small (Knoll & Johnson, 2000). In qualitative research, the focus is on quality of data and information gathered, and not on the sample size (Sandelowski, 1995), and there are no strict criteria for sample size (Patton, 1990). Based upon other similar studies (Peterson, 1996 [n=8]; Saines, 1997 [n=6]; Socorro et al., 2001 [n=7]), the sample size was determined to be 10-15.

In this study, participants were purposefully recruited from the EDs of a large, multi-site, academic health sciences center in a large Canadian city. According to Patton (1990), purposive sampling is popular in qualitative studies and the subjects are selected because of a specific characteristic, in this case, ER nurses with the experience of caring for dying patients. Purposive sampling allows the researcher to select participants for the purpose of describing an experience in which they have participated (Speziale & Carpenter, 2007) and those participants are able to provide in-depth information relevant to the research question (Mason, 1998). Purposive sampling is the preferred method for interpretive descriptive methodology because it allows for selection of participants according to the objectives of the research study and their expertise in the phenomena being investigated (Thorne et al., 2004).

According to Lincoln & Guba (1985), sampling and data collection stop when the researcher does not collect any new data and the data collected are meaningful to report. By the eleventh interview, thick descriptions with commonalities about the experience of caring for adults who die in the ED were evident, indicating to the research committee that the number of participants interviewed was sufficient.

3.7 Process of Data Collection

As the research question was being developed, the researcher shared ideas with colleagues at the ED in which she was employed. The study idea was met with enthusiasm and the sharing of their personal experiences in caring for patients that died in the ED. In listening to their stories it was clear that there was a need to better understand this phenomenon.

The thesis committee decided that the relationship between the researcher and her colleagues might interfere with data collection and felt that it was essential to recruit from another organization. The researcher called the director of critical care and trauma services of a potential study organization and the nurse managers of both EDs for feedback on the proposed research study. Both nurse managers and the director of critical care and trauma services were very enthusiastic about participating in the study and offered their full assistance in recruitment. Letters of support were obtained from both nurse managers and the director of critical care and trauma services (Appendix B). Permission to conduct this study was obtained from the University of Ottawa Faculty of Health Sciences Research Ethics Committee and the research committee of the participating hospital.

3.7.1 Pilot Interview

Prior to the commencement of the actual study, a pilot interview was conducted with a colleague of the researcher. The purpose of a pilot interview was to assess the clarity of the interview questions (whether they were understood and if they yielded answers appropriate to the research question). In addition to assessing the clarity of the questions, the pilot interview provided an opportunity to ensure that technical equipment was functioning. The pilot interview was also to determine that the interview questions yielded answers that addressed the objectives of the study and ensured that the time frame of 30-60 minutes per interview was appropriate. The researcher had the opportunity to discuss with the participant her reactions to the study. The pilot interview allowed the researcher to practice interview skills and technical skills, including the use of a digital recorder and transcribing the interview into a word document.

No changes were made to the interview questions (Appendix C) but a need to use more probes in order to expand on the interview questions was identified. The interview was transcribed verbatim, but the data collected were not used in the study because the participant was not from the participating hospital and had consented to participate only to assist the researcher and not to be a participant in the study.

3.7.2 The Study

During the recruitment phase of the study, the researcher made a site visit to both EDs and met with the respective nurse managers. A poster (Appendix D) was displayed in the staff room at each site and a letter of information that explained the purpose of the study (Appendix E) was placed in the nursing staff's intradepartmental mailboxes. In addition to the poster and letter, both managers suggested that the researcher attend regularly scheduled staff meetings until the recruitment was complete.

Within a day of distributing the letter, study participants began contacting the researcher via telephone or through email, as was requested in the information letter. Within three weeks of distributing the letter, and without having attended face-to-face meetings with potential participants, the number of interested participants was eleven, which fell within the predetermined sample size range. At this point, it was decided to temporarily stop recruitment until these participants were interviewed and the data were transcribed.

All eleven participants met the inclusion criteria and gave consent to participate in the study. At the time of the interview, a formal written consent was obtained (Appendix F & G). The interviews took between 20-60 minutes to complete. The interviews were held a time and place convenient for the participant.

Prior to beginning the interview, the researcher reviewed the purpose of the study, reiterated confidentiality, and informed the nurse that the interview would be audio taped and transcribed. It was explained to the participants that they reserved the right to choose not to answer any questions that made them uncomfortable and could stop the interview at any time. Should the participant find the interview distressing, if desired, (s)he would be assisted in contacting the Employee Assistance Program (EAP) and the phone numbers for both French and English speaking counsellors were provided. After the participant verbally agreed to participate in the study interview, a formal consent was signed and both demographic and clinical data were collected from the participant.

The data collection tool used for the interview was a series of semi-structured open-ended questions developed by the thesis committee. Questions were based upon professional experience and developed to meet the objectives of the study. Probe questions were used to determine more about a particular incident and to expand on the participant's responses.

According to Lofland & Lofland (1984) an interview guide is a list of questions or general topics that the interviewer wants to explore during each interview. Although it is prepared to ensure that basically the same information is obtained from each person, there are no predetermined responses, and in semi-structured interviews the interviewer is free to probe and explore within these predetermined inquiry areas.

Field notes and a reflective journal were kept throughout the study. The field notes were descriptive and recorded the researcher's perception of the environment, and the non-verbal gestures of the participants. A reflective journal noting the thoughts and feelings of the researcher about the interview was kept for each interview. According to Long & Johnson (2000) reflection is an important part of qualitative research. The field notes and the journal were completed within 4 hours of each interview and the transcription was completed within 5 days of the interview.

Once all eleven interviews were transcribed and reviewed by the research committee, it was decided that that the sample size was adequate because the participants were sharing many common ideas and recruitment was stopped. The nurse managers were informed of this decision and posters were removed from staff areas. Prospective participants were thanked for their interest and informed that recruitment was complete.

3.8 Data Analysis

In this study, data analysis involved thematic analysis. Analysis in interpretive description utilizes an inductive approach to identify thematic patterns and commonalities believed to characterize the phenomenon being studied and answer questions that are important and relevant to a clinical discipline (Thorne et al., 2004). "The intended products of interpretive description would constitute not a new truth, but a sort of 'tentative truth claim' about what is common within a clinical phenomenon" (p. 7).

The initial step in the data analysis required the researcher to become familiar with the participants' description of the experience. Within 24 hours of the interview, the researcher listened to the audio recording and reviewed her field notes and journal. This was done to ensure the sound quality and completeness of the interview and to verify accuracy of the field notes and the journal. The transcription process began shortly after this audio check was complete. Within five days of each interview, each audio recording was transcribed verbatim and the audiotape was replayed to check the transcription for accuracy. During the second listening of the audiotape, notes were added to the transcript regarding changes in voice, pauses or other notations that the researcher recalled such as hand gestures.

Once the transcript was finalized, the researcher replayed the audio for a third time and submersed herself in the interview in an attempt to acquire a sense of what the participant was saying. After this process was complete, notes were made about what the researcher felt the participant was saying and key phrases about the phenomenon were highlighted. These notes were kept in a journal log as an audit trail for how decisions were made in the development of categories and themes.

In keeping with the aim of interpretive description, the researcher, through repeatedly listening to the interviews and reading the transcripts, focused on coming to know and understand the nursing experience of caring for adults who die in the ED. By listening repeatedly to the interviews and reading the transcripts, the researcher was able to recognize emerging and shared themes across these experiences.

According to Aronson (1994), there are five steps in thematic analysis that focus on identifying themes and patterns of living and/or behaviour. The first step involves reading the transcribed interviews and listing patterns of experience. The second step is to identify all data that relate to these classified patterns. The third step is to combine and catalogue the related patterns into sub-themes.

As the analysis proceeded, patterns emerged from the data and the properties of each category were identified and these categories were linked into themes. The research committee reviewed the categories and patterns and agreed on the emerging themes. Thomas (2003) explains that categories identified from the data are developed inductively, meaning that the researcher avoids using preconceived categories, but instead allows categories and names for categories to flow from the data.

The fourth step in thematic analysis is to build a justification for choosing the themes. The final step in thematic analysis is to formulate the theme statements with the available literature into a story line. This story line is used to increase our knowledge about the subject. "When the literature is interwoven with the findings, the story that the interviewer constructs is one that stands with merit. A developed story line helps the reader to comprehend the process, understanding and motivation of the interviewer" (Aronson, 1994, p. 3).

Participants appeared comfortable talking about their experiences in caring for adults who died in the ED and provided the researcher with rich, descriptive details of the event and many anecdotes to illustrate their role and perceptions of the experience. Many of the participants felt that the interview evoked emotional memories and that it was therapeutic to share these with the researcher. One participant suggested that the sharing of stories was so helpful and therapeutic, (s)he wished there were more opportunities such as this one.

3.9 Methods to Ensure Rigor

According to Streubert Speziale and Carpenter (2007), the goal of rigor in qualitative research is to represent the experience of participants accurately. According to Thorne et al. (2004), issues of rigor and credibility are important considerations in the creation of a product of interpretive description. As interpretive descriptive methodology aligns with naturalistic inquiry, strategies to enhance rigor in this study include the criteria described by Guba and Lincoln (1985); credibility, transferability, dependability and confirmability. These four criteria were used to evaluate the trustworthiness of the data.

3.9.1 Credibility (truth)

Credibility refers to the confidence in the truth of the data and the interpretations of them and includes activities that increase the probability that credible findings will be produced (Lincoln & Guba, 1985). The role of the researcher as an expert ER nurse, although a potential source of bias, can also be used to enhance credibility with the participants because of her awareness of the culture of the ED, training, qualifications and the ability to build trust with peers (Polit & Beck, 2004). According to Thorne et al. (2004), the best interpretive descriptions are those done by individuals with expert knowledge of the phenomenon.

Credibility was achieved through the following steps; interviews were transcribed verbatim and the researcher checked the accuracy of the document by two readings of the transcribed data while listening to the tapes. Once the transcripts were transcribed accurately and field notes were attached, they were sent to the two thesis supervisors for independent reading. The researcher and the two supervisors made individual notes on each transcript and as categories developed, the team met regularly to compare notes and ideas. As categories emerged from the data, the committee met and agreed on the findings.

Credibility was also enhanced through peer review. Peer review ensures stability of data and gives credibility to the study (Long & Johnson, 2000). In this study, peer review was done by sharing the study's findings with the thesis committee: a master's prepared expert in emergency nursing, one doctoral prepared nurse with an expertise in both critical care and end-of-life care and two doctoral prepared experts in end-of-life care. The study findings were also shared with various ER nurses and end-of-life care experts. The expert ER nurses who reviewed the findings all agreed that the findings captured the experience of caring for dying patients in the ED. The end-of-life experts reported feeling *"moved by"* the findings and agreed that the findings enabled them to have an understanding of the experience. Both the ER nurses and the end-of-life experts reported that the study findings were *"emotionally provocative"*.

3.9.2 Transferability (generalizability)

According to Polit and Beck (2004), the transferability of a study refers to the generalizabilty of the research or the probability that the study findings have meaning to others in similar situations. In this study, the transferability is limited to ER nurses who have experienced caring for patients and suddenly bereaved family members in the context of an ED. Emergency nursing is a specialty within nursing and due to the unique nature of the environment; the results of this study would not necessarily be relevant in other settings.

3.9.3 Dependability

Dependability refers "to the stability of data over time and conditions" (Polit & Beck, 2004, p. 434). The difficulty in examining the stability of the data is the need to be cognizant of the changes in nursing, such as staffing issues, patient acuity and the context of the organization. This study idea and design were derived from personal experience in collaboration with professional and academic peers and, although it may be an accurate reflection of the current experiences of nurses, as the context of the environment changes, so too shall the experiences of nurses.

3.9.4 Confirmability (objectivity)

Confirmability is the objectivity of the data and the possibility that the study can be replicated. The narratives from the interview transcripts support the themes derived from the analysis of the study. A journal log, as an audit trail, was kept throughout the data collection and analysis. This log outlined steps and decisions made to code the data. This log was developed using the field notes, reflective journal, and transcripts and included the raw data and decisions made about developing categories and placing the data in these categories. These categories lead to the development of the themes. If a secondary researcher were to follow the steps outlined in this log (s)he should have similar findings to this study.

3.10 Protection of Human Rights

This research study was approved by the research committee of the target hospital (Appendix F) and the University of Ottawa Faculty of Health Sciences Human Research Ethics Committee (Appendix G) and prior to the commencement of participant recruitment. Participation in the study was voluntary. Study participants contacted the researcher based upon information provided in a letter placed in their intra-departmental mailbox. This letter included an explanation of the study and an assumption was made that only participants interested in the study made contact with the researcher.

To protect the rights of individuals and the right to informed consent, prior to the commencement of the interview, the researcher reviewed the purpose of the study, the possible risks and benefits to the participants, the voluntary nature of the study, the time commitment and the right to not answer questions and/or withdraw from the study at any given time. Written consent was obtained and a copy of the consent form was given to each participant (Appendices H & I).

To assure privacy and confidentiality, the audio taped interviews were numbered and coded based on gender and site. When a participant used his/her own name, the name was removed from the transcript, but the name remained on the audio recording. During the study, all information, transcripts and technological devices (digital recorder, CD audio, USB drive) were kept in a locked box in the home office of the researcher. The CD audio, signed consent forms and transcripts will be kept in a locked office of the thesis supervisor for a period of fifteen years as requested by the research committee of the participating hospital.

CHAPTER 4 - STUDY FINDINGS

The findings of this study comprise the shared experiences of caring for adult patients who die in the ED, as described by eleven nurses who work in the ED of a multi-site academic health science center in a major Canadian city. This chapter begins with an overview of the study findings, and an outline of the themes and categories. The major results of the study are presented in relation to the study's objectives which were: to describe the experiences of nurses when caring for adults who die in the ED, to improve our understanding of the care nurses provide and to describe factors that facilitate and factors that challenge the care nurses provide to adults who die in the ED. The factors identified that facilitate and challenge nurses are interwoven within the themes. Direct quotes from the participants are used throughout the findings to support the categories that have been developed. To protect their anonymity, the participants are identified by alphabetical order from A to K.

4.1 An Overview of the Findings

The results of interviews conducted with eleven ER nurses who have experienced caring for dying patients in the ED revealed three major themes: *"it is not a nice place to die"*, *"I see the grief"*, and *"needing to know you've done your best"*. These themes are derived from the words used by the participants. The over-riding message behind these themes is that an ED is not an ideal place to die, but ER nurses attempt to make an unfortunate situation better for dying patients and their family members.

The first theme, *"it is not a nice place to die"*, describes how the ED is a very intense, fast-paced and busy environment. Participants shared stories of the competing demands that are ever present in EDs and the challenges of not having enough time to establish relationships or to complete interventions that are not deemed essential. These competing demands and lack of time cause ER nurses to feel pulled in all directions and torn between providing care that is necessary versus care that they desired to provide to patients at the end of life.

The second theme, *"I see the grief"*, describes the ER nurses' experience of bearing witness to intense and raw grief, peering into the intimate lives of strangers in a sad and often tragic moment, and being able to see beyond that moment and knowing what this event means to the suddenly bereaved. In bearing witness to the grief of others, participants shared stories of how they may or may not be able to control their own emotions, of feeling helpless in their lack of ability to fix a situation, and how bearing witness to such intense grief makes them focus on being thankful for what they may have (such as life, love, and family). Participants also shared heartfelt stories about tragic situations that challenged them professionally, but have given them new insight to their own lives and how they cope with witnessing and participating in death in the workplace.

The third and final major theme identified in this study is *"needing to know you've done your best"*. Encapsulated in this theme is how the ER nurse functions when an adult dies in the ED by trying to make the situation better and how (s)he is able to cope with death in the workplace and move forward.

One of the ways the participants try to make the situation better is by creating a better environment; one that is private, quiet and seemingly more peaceful for dying patients and their family members. Through their stories, participants shared the importance of helping and supporting the families through the dying process in both expected and unexpected deaths, and allowing the family to be present with their loved one as much as possible.

Participants shared creative means of ensuring that patients and families were comfortable given the unique challenges of an ED.

Also, included in this final theme, *"needing to know you've done your best"*, is how participants were able to reflect on their experiences in order to grieve effectively, to find meaning and satisfaction within a sad situation, and a reason to continue to practice in the area of emergency nursing. Although very challenging, emergency nursing is also very meaningful and participants create a sense of caring, compassion and camaraderie that becomes a part of their professional existence.

4.2 Outline of the Themes

Theme #1 "It's not a nice place to die"

- Category A-ER is intense
- Category B-Being pulled in all directions
  - Subcategory a) competing demands
    - b) not enough time

Theme #2 "I see the grief"

- Category A-Witnessing grief
- Category B-Peering into people's lives
- Category C-Seeing beyond the moment

Theme #3 "Needing to know you've done your best"

- Category A-Trying to make it better
  - Subcategory a) creating a better environment
    - b) meeting the family where they are
    - c) death with dignity
- Category B-Reflecting back
  - Subcategory a) reviewing the events
    - b) leaving work at work
    - c) moving forward

4.3 Theme 1: "It's not a nice place to die"

Study participants revealed that they strongly felt that the ED was not a nice place to die. This theme has two categories, the first category, *'ER is intense'* describes the participant's descriptions of the environment of the ED. The department is busy and there is a lack of physical space and a lack of time to provide an ideal (calm, quiet, private) environment for dying patients and family members.

The second category, *'being pulled in all directions'*, also identifies two subcategories; *'competing demands'* and *'not enough time'*. This category describes the busy-ness of the ED that leads the nursing staff to feel as though they are being pulled in many different directions and must therefore prioritize care delivery decisions. Nurses described being torn in two ways: physically between patient care and other competing demands, and emotionally between a desire to be at the bedside with the dying patient and his/her family and the need to address other patients and issues.

4.3.1 Emergency is Intense

Study participants consistently described the ED environment as having a large impact in the provision of care for a dying patient. Participants reported that the ED is a seemingly chaotic place where patients of varying levels of illness, injury and/or disease continue to arrive and require a wide range of interventions. Participants described the ED as being cold, busy, noisy, and often filled with strange smells. For a patient, there is often a lack of privacy as the only thing separating them from another patient is a curtain. This lack of privacy makes it difficult not to hear what is going on with the patient in the next bed. The busy and seemingly chaotic environment in an ED greatly contrasts from that which was described by participants as being ideal at the end of one's life, such as a quiet, serene atmosphere that may be more easily provided on an inpatient unit.

"It is just too busy for patients who are dying. It's noisy. And there's too much commotion. It's not an ideal atmosphere"-participant D.

"W*ell, you can always have them in a private room. For a family to be there quietly. Sometimes, they pass away in the lying beds of OBS with a curtain around them and family members crying. Nobody is immune to not knowing what's going on behind that curtain"* – participant H.

"on a floor or a more isolated place where you don't have people who are gawking at you, peeking in the rooms trying to find somebody else. Where there is a little privacy and a little more confidentiality" –participant G.

The context of the ED presents some unique challenges and participants felt a need to create an area that is quieter in an attempt to provide the family with more privacy and space. Participants shared stories of challenges and described times in the ED when a patient may be dead or dying and the department is seemingly out of control, making it impossible for nursing staff to provide a quiet, private or spacious spot for patients and their loved ones.

"It's a lot harder when you have somebody who has just taken an overdose down the hallway screaming their head off and cursing and swearing. You try to make it as calming and quiet for the family and family member that's dying" -participant J.

"At times it's just out of control here and you can't control it. You have just no way of providing a quiet, peaceful environment for them" –participant I.

"These poor people who are down here and it's palliative or we've withdrawn treatment and the condition keeps going on and on, it's all drawn out and they're in a loud, noisy environment. That is not a very pleasant place to be saying goodbye to your relatives or someone that you love. I think I would hate it if it was my family member"-participant I.

Regardless of whether the death was expected, or unexpected, participants all agreed that the ED is not a nice place to die.

4.3.2 Being Pulled in all Directions

In addition to describing contextually the environment as being an important part of the reason the ED is not a nice place to die, participants also shared the challenges of the *'competing demands'* (described as the emotional and physical demands being placed on the nurse) and of *'not enough time'* to accomplish all of the tasks that are desirable, causing the nurse to feel as though (s)he is *'being pulled in all directions'*.

"With the high acuity in the department, sometimes you are unable to do that because your workload is so heavy and you're being pulled in all different directions"-participant I.

4.3.2.1 Competing Demands

An ED is a fast-paced environment requiring nursing staff to quickly assess patients and prioritize care delivery. Participants spoke of having a heavy workload and the acuity of patients as being high. Nurses caring for patients who die in the ED described feeling torn between wanting to be at the bedside of a dying patient and having to run off to care for patients who required immediate treatment.

"you can get torn in emergency, you can help that dying person, but still treat the asthmatic but still treat the person in rapid Afib [atrial fibrillation] *or all those other patients that need care and if you have limited resources- like maybe there's only two of you on or three of you on. How can you accomplish all this and still feel like you did the best job you can do? So that's where you have to really prioritize"*-participant A.

Participants agreed that a trauma or a resuscitation event is physically, mentally and emotionally exhausting. A resuscitation code can come into the department at any time and participants describe an ability to perform their nursing tasks in such situations without emotional involvement.

"Because you switch into auto-pilot. You're there to do a job. You can't be emotionally invested at that time. You know that this person is in a bad way, you have to protect them and you go through all of your ATLS (Advanced Trauma Life Support), and your BTLS (Basic TLS). Your protocol, your standards. You go through it like you've been taught, it's been ingrained into your body. You've been so trained for it that your body automatically knows what it's supposed to do. At that point, you're not emotionally

invested but you're physically..there's an adrenal high that you're running on at the same time that sort of picks you up and keeps you going which also leaves you outside of the picture. You don't get too caught up in the moment until afterwards, once the patient dies" -participant J.

Participants admitted that competing demands are a part of the environment that they work in, but that these demands may pull the nurse away from the bedside and cause him/her to feel frustrated and/or guilty about his/her inability to provide the care that (s)he desired.

"You have to try and to justify taking the time away from the other patients and sometimes you can and sometimes you can't. Sometimes you get all over and done and everybody's gone and you think I didn't do that family justice. I didn't spend the time. I didn't explain things"-participant C.

Therefore, the need to care for many patients simultaneously creates a sense of frustration for the nurse who would like to spend more time at the bedside of dying patients and with family members, but (s)he feels torn by having to deal continuously with other presenting emergencies.

4.3.2.2 Not Enough Time

Not having enough time to complete all of the nursing care desired was experienced by all of the nurses in their work in the ED. One participant described the provision of care to be similar to that of a conveyor belt where patients come in, get treated and leave.

"It's more like a conveyor belt the way things are being done now" –participant J.

Participants identified the challenge of not having enough time to talk to family members or establish relationships because the department is too busy and the workload is heavy and continuous. Many participants stated that this may be perceived as uncaring behaviour by the bereaved family, but that in truth, it is related to the volume of people in the department and lack of time.

"I don't have time to talk to family members! I would love to but, wow, it just can't happen. We run twelve hour shifts. Just the few moments you can take, something else suffers because you take that time. It's frustrating" –participant D.

Participants acknowledged the importance of taking time to talk and be with patients and families in meaningful ways, but that often there was barely enough time to get essential tasks completed. Nurses felt frustrated that in the busy environment of the ED, it was not always possible to provide care to dying patients and their families in a way that the nurse desired. Particularly when caring for dead or dying patients, nurses felt that it was important to be present at the bedside (especially if the dying patient has no family), to not rush the grieving family, and to be available to talk to the families and answer questions.

Many participants shared stories of having been able to provide more ideal end-of-life care in other clinical areas where they had worked. Participants felt that in other clinical areas, they were able to spend more time with the family and establish a meaningful sense of rapport.

"Most of my positive experiences have been when I worked in ICU. That was because we had, first of all some one to one ratio, so I had more time to spend with just one patient and the families. We get to know the family and you have more help to explain everything you are doing because you can focus solely on that person on that family. So, you develop more of a rapport versus here it's very difficult to develop a good rapport because you have more than one patient so while you're trying to develop some rapport, it's more of a strained rapport because you have to interrupt saying, 'sorry I have to go' to tend to an emergency; something else is coming through the door. So, you can't develop that nurse-client or that nurse-family relationship quite as well as you could at the ICU and because of that, I think that they see it as..Some people have made comments, like you know, they get the impression it's almost like it's a bother for us to take care of their loved one who is dying. Actually it's not that it is a bother, it's just that we are busy and we can't focus as much as we want to on it. So, it's just more of a controlled atmosphere in intensive care than this" –participant G.

Most of the participants expressed frustration about not being able to provide the end-of-life care that they believed they were capable of providing, or that which they were wanting to provide. Often the situation is hectic, and it is not until after the event and the bereaved family has left, or at the end of the day when the nurse has time to reflect on how (s)he could have made it better if (s)he had had more time.

Overall, the study findings clearly demonstrate that ER nurses who provide care for patients who die in the ED feel that the environment is not ideal. ER nurses are very aware of what they are capable of and have their perception of patient and family needs at the end of life, however, the environment in which they work provides them with many barriers and challenges on a regular basis and leaves a lasting impression that an ED is *'not a nice place to die'*.

4.4 Theme 2: "I see the grief"

The second theme identified in this study describes the participant's experiences of watching people grieve when an unanticipated death occurs. Whether the death was a young accident victim, a terminally ill patient or an elderly person, the grief displayed by the suddenly bereaved is raw and usually intense. This theme is divided into three categories. In the first category, *'witnessing grief'*, participants described how difficult it is to bear witness to people (whom often they have just encountered) grieving.

'Peering into people's lives' is the second category and describes how the death caused participants to reflect on their own vulnerability and to find ways to deal with their own grief. In the third category, *'seeing beyond the moment'*, participants shared their experience of recognizing that the deceased is not just a body, but had an identity such as someone's family member. Participants describe a sense of knowing what this death means to the future for the suddenly bereaved and that this encounter will be a life changing event for them.

4.4.1 Witnessing Grief

As most ED visits are unscheduled and unplanned, when a person dies in the ED the death is unanticipated by the family. When a death is unanticipated, the suddenly bereaved are left with profound grief and exhibit a wide array of intense emotions.

Participants shared stories about what it is like to be present in what is often one of the most vulnerable, intense, heart-felt and saddest times of another individual's life. Often death in the ED occurs quickly and there is no time to establish a rapport or therapeutic relationship with family members. Many times, the first encounter the nurse has with a grieving family is to deliver the bad news of the death of their loved one.

"it just feels like you've been punched in the stomach; all of a sudden the wind is taken out of you" participant J.

Participants shared stories about their experiences and all agreed that the death of a patient was considered to be a part of the job, but dealing with the families after a death was one of the hardest things they have to deal with in their profession.

"taking care of the patients who have died in the ED is.. I don't mind that part of the job. The part of the dying patients in the emerg is the families I find the most difficult to deal with" –participant H.

"It's the empathy I feel for the family that they leave behind. And that's just heart wrenching. That's the only thing that's difficult about it. Just watching the families that are left behind, who are upset. Especially if it's unexpected" –participant F.

Bearing witness to intense grief, as displayed by the suddenly bereaved evoked emotion in the participants. Many described how they cope with any other aspect of the job, but bearing witness to the raw and intense grief of others was one of the most difficult aspects of their work. Most participants admitted that at times it was difficult not to share in the grief and pain of the family, and that they were unable to control their own emotions.

"you see this woman and she is just falling to the floor and uncontrollably crying and devastated and rightfully so. That was the hardest one that I've ever had to deal with because you're there. That's your life right there and you just can't even imagine what she's going through. And at that point, you don't even... you can't say I understand or it'll be okay, because it's not going to be okay and I don't understand and at that time, you just cry with her"-participant I.

Participants all agreed that witnessing the intensity of grief that follows a death in the ED was one of the most difficult and most challenging aspects of their role. Despite not having a previous relationship with the suddenly bereaved, participants felt that bearing witness to their intense grief challenged them to maintain their professional composure and challenged their ability to provide support to that family.

4.4.2 Peering into People's Lives

Participants described a fine line between being emotionally involved and emotionally detached, and the ability to function in their role as ER nurses. Participants spoke of trying to remain distant from the deceased and his/her family members as the realness of the situation evokes strong emotions within everyone involved.

"when you can kind of all of a sudden peer into their life that really hits you. I think that's what makes it easier for me, I try to avoid seeing that sometimes so that it doesn't hit me cause then it's quite tearful" –participant K.

Knowing that death is permanent, and recognizing that life is fragile, held meaning for the participants. They were continuously reflecting upon their own lives and how they know that they are not immune to situations that they witness within the context of the job.

"scared that that could be you tomorrow or somebody you know" –participant A.

"makes me appreciate what I have, try to enjoy what I have while I've got it because it might not be here tomorrow" –participant K.

All of the participants agreed that their own emotions were difficult to conceal when the death is unexpected. The death of a young person or a tragic death is always emotional for everyone involved. The death of an older person, or someone who was expected to die, is not as emotionally provocative as unexpected death.

"Traumatic deaths are always more difficult for families and for the people initially working on them, just because it's unexpected. It's always a shock to the system. A rapid death it's not something that's planned for. It's not something that people are prepared for like cancer" –participant J.

Participants described ways of putting death into perspective as a means of coping. If a patient was older or had been sick for a long time, death was seen as an alternative to suffering. Although all death brings a sense of loss and grief, participants agreed that if a person was older and had had a chance to live their life, then the death was easier to accept.

"if it was a really sick patient you know he's probably better off that he's dead than fighting what's going on" –participant B.

"The situation's always changing. It's always difficult to see someone die and it affects you. What makes it easier for me, is I can rationalize things and look at context, has the family had time to bereave about the impending death, how sudden is it, where was this individual in the life event. And that's what makes it easier for me" –participant K.

Participants all agreed that having insight into the lives of people who experience unanticipated death, both from the perspective of the deceased and of the suddenly bereaved, challenges them in their role as professionals. This unique experience causes them to reflect upon their own lives and create a means of dealing with their own grief by putting death into a context that allows them to remain professional and to move forward.

4.4.3 Seeing Beyond the Moment

'Seeing beyond the moment' is the third category in the theme *'I see the grief'*. This category brings recognition to the nurses' ability to see beyond the moment of a death in the ED, and also brings a sense of knowing what may lie ahead for the future for the suddenly bereaved.

In anticipating the future of the suddenly bereaved, participants described a sense of appreciation for life, as there was no immunity to tragedy or death, and a feeling of vulnerability. Being able to put death into perspective enabled participants to cope with this difficult aspect of the job. Although participants described a need to be somewhat detached from the situation, they also acknowledged their emotions and felt that it was normal and appropriate to have their own emotions. In order to continue to work in this area knowing that a similar situation will occur again, participants acknowledged feeling and displaying their emotions as a normal part of the job.

"It upsets me but yet at the same time I've learned to kind of detach myself from that to maintain my ability to work in this area because there's times when I get home and I'm depressed from the job. If you're not into this job a hundred percent, you're not going to do well. If you don't leave work with emotion, I'm sure it's still a tell-tale thing, you know it's time to leave it. As people say, if you're just numb to the situation. It's normal to feel sad. It's normal to be tearful when you go home in certain situations otherwise you wouldn't be in a caring profession" –participant K.

Two participants spoke of organ donation as a means of providing them comfort in the face of a tragedy. Organ donation is a potentially positive outcome in a bad situation, such as in the death of a young trauma victim, but due to time constraints does not always occur. When a potential donor is not identified and the organs are not retrieved, this leaves the nurses feeling as though they could have done more in the situation.

"Organ donation is another part that also should be part of end of life, but you just don't have the time to deal with that. Or you get pulled away. You end up later on thinking, I didn't do everything I could" –participant C.

On the other hand, in the face of tragedy, when organ donation does occur, something very positive can come out of a very bad situation.

"she ended up being a donor. So we got something that she donated and that was part of the end of life thing, that was something some good was going to come out of this bad, bad situation"-participant C.

Several participants felt that after lengthy resuscitation efforts in a traumatic event, death can be a better alternative to what could have been. Having previously been through successful trauma resuscitations gave participants insight that often just because a person is saved from dying doesn't mean that their lives will return to their pre-injury state. Participants shared stories of knowing what some of the alternatives to death could be, such as keeping a person alive on machines, and admitted that they sometimes found solace in the fact that the person died and was spared a life of anguish.

"I was relieved that we did try. We did do everything that we could possibly do. Relieved that this young girl was still beautiful and she was going to die this way that she was gone and she was her memory would be preserved as to what she was and not left in a bed for twenty years to wither away on a bunch of tubes on a machine" –participant A.

Death in an ED is not always a negative event. Death can be seen as a blessing, especially when it is expected such as in a patient who has been very sick and perhaps dying from disease at home. Often in expected death, patients are dying at home and an unanticipated acute crisis, such as increased pain, shortness of breath, or loss of consciousness, brings him/her in and (s)he dies in the ED. In supporting patients and family members through death in situations like this, the participants perceived that death could also provide some relief to a family.

"Sometimes you see families who, they've been sick for so long and you know they're just riddled with cancer. It's like mets everywhere. And, the family's exhausted. The patient's exhausted. And you know, sometimes when they do die finally, everybody's just like 'Ah , thank god'. Finally they've gone, so those ones, you feel a bit more positive because you feel like everybody can move on now" –participant F.

Overall, watching people grieve in a vulnerable moment, such as a death in the ED, is professionally challenging for ER nurses. These nurses bear witness to the severity of the grief without having developed a rapport with family members know that the death is a life-changing event for the suddenly bereaved. The nurses in this study revealed that they reflect upon their own vulnerability and need to develop a means of coping with this aspect of their job.

4.5 Theme 3: "Needing to know you've done your best"

This third and final theme describes how participants deal with death in the ED. Participants agreed that at the end of the day, despite the events throughout the shift, they needed to know that they had done their best in all circumstances. Caring for dying patients in ER is described as difficult, challenging and stressful, but yet the participants admit to loving their job.

4.5.1 Trying to make it better

The first category in the final theme is *'trying to make it better'*. This category describes how participants will go above and beyond to try to make the situation of caring for a dying patient better. In trying to make it better, nurses will attempt to manipulate the physical environment in order to create a better place for dying patients and their families.

Participants do their best to work with the family and ensure that their needs are met and, despite all the chaos that may be present, ensure that their patient dies with dignity.

Within the category *'trying to make it better'*, are three subcategories: *'creating a better environment', ' meeting the family where they are',* and *'death with dignity'.* Participants describe trying to make a bad situation better by doing their best to create a nice atmosphere in less than ideal conditions, and ensuring that the patient dies comfortably, without pain and/or suffering and with loved ones nearby. As death in ER is often sudden, and is usually unanticipated, family members are in varying levels of the grieving process (which can range from shock to a level of acceptance). Participants describe the importance of caring for these family members and of meeting the family where they are in this grieving process.

4.5.1.1 Creating a Better Environment

Participants all agreed that the ED is not a nice place to die, and that an imperative part of caring for a dead or dying patient and the suddenly bereaved was to try to create a better environment. The ED is busy and chaotic and all participants agreed that they would go above and beyond to try to create a place that is both private and quiet for the patient and family. Sadly, this is not always possible due to circumstances beyond the control of the nurses, and their frustration at not being able to control the environment was voiced. The following quotes illustrate what these nurses would like to do in order to help make the environment more comfortable for dying patients and their families.

"you try your best to make the room as quiet as you can or put them some place that's more private for them but at times it's just out of control here and you can't control it. You just have no way of providing a quiet peaceful environment for them. I mean you do the

best that you can, but circumstances always come where you get patches or traumas and you're shuffling people around. You just try and do the best you can and that's another thing with not having beds to transfer people to if we had private rooms that you could take these people to and let them be with their family. Because that's all they want to be is with their family and you don't have that resource around here. I think it's sad"-participant I.

"We try and give them their own spot, away from the hub-bub, away from the noise, away from the clatter and chatter. You just basically try and move them to a spot where there's the least amount of traffic and that's not always easy" –participant J.

The environment of the ED presents challenges that are beyond the control of the nurse. According to the participants, in addition to the constant influx of patients, two of the hardest aspects of the environment to try to control are the large number of people present, and the constant lack of privacy for patients. Due to the uncontrollable environmental factors, ER nurses try to get dying patients out of the department and to an in-patient unit as quickly as they can in order to provide the patient with a more ideal, more controlled place to die.

"Most times expected are your DNR patients or whatever that were not getting a room. Probably the biggest problem is lack of privacy for these people. Emergency is a big open space so it's kind of hard to keep it private for the family members and all that too. So, usually we try and get them out as quickly as we can to give them some privacy" –participant E.

Participants shared an idealistic view of having a quiet, peaceful place for a person to die. The uncontrollable environment of the ED does not create such an atmosphere. Participants felt that the creation of an idealistic environment to die was a very important component of end-of-life care and they were willing to do anything to re-create the environment.

4.5.1.2 Meeting the Family Where They Are

Although the importance of family was interwoven throughout the descriptions of the nurses' experiences, ultimately, the nurses recognize that the most challenging aspect in caring for dead or dying patients in the ED is dealing with the family. In trying to create a better environment, the participants spoke about the family as an integral part of the event and how, as nurses, they did their best to accommodate the individual needs of the family in any situation.

When a person dies in the ED, participants felt that it is important not to rush family members out, but to allow them as much time as they needed at the bedside of their loved one. Given the busy-ness of the ED, this was often a challenge as there is an ongoing need to free up a bed for the next person being admitted.

"the family needs to have closure time. I don't rush them off if we need the bed obviously because somebody who's alive needs treating then find a place find somewhere that they can have a few minutes with that person before they go because they need that bit of closure. Meeting them later on in a funeral home doesn't always work, you know" – participant A.

Participants spoke of caring for both the deceased and the family members as if they were their own family. Empathy was an important value for these nurses as it was apparent throughout all interviews that participants felt that in caring for others it was important to be aware of how you would like to be cared for, and to deliver your care in that same manner.

"I think the most important thing is to have the ability to empathize with them to put yourself in their position. Yes they're crying and weeping and you go back to the desk and you know, Geez, I wish they would give it up, but that's part of the process. That's what they have to do. What would you do if we were in that position? If that was your father lying there. What would you do?" –participant C.

"When we've had someone die or their family, you have to figure out how you felt and how you would want to be treated. You put yourself in their shoes" –participant F.

Despite the many challenges participants shared in their stories participants all agreed that dealing with family is one of the hardest aspects of this situation.

"family is the worst for me. I can deal with that dying patient but it's the family that get to me" –participant A.

Dealing with family can be the most stressful aspect of caring for patients who die in the ED because of the family's expectations of care. The focus of emergency medicine is the restoration of health and too often families present with an unrealistic expectation of the prognosis of their loved one. These expectations challenge staff who are trying to be with the family and provide them with support, but yet have other matters within the department that also require their time and presence.

"as well as family's perceptions of, what are their expectations of care. Some families still don't seem to understand what DNR truly means and trying to explain that to them sometimes comes across...like especially if it's somebody who is in their nineties and death appears imminent. I hate using the word appear but 'appears imminent' from our perspective, but the family says, 'No I've changed my mind, I don't want the DNR' so that takes a whole new road in which we have to try and delicately explain to them what this means for the patient and that kind of stuff. The other thing, of course, is just what's going on in the department itself and family dynamics" –participant G.

Communication is a vital component in caring for patients who die in the ED. Participants agreed that although end-of-life conversations are very difficult to initiate or partake in, it is essential that these conversations be direct and honest. Families are experiencing a state of crisis and it is important that they have a complete understanding of the situation, know that everything is being done, or was done for their loved one and that all of their questions have been answered. Participants felt that this was an essential part of the family's acceptance of the death of their loved one.

"you have to be so honest with them, you can't beat around the bush. You have to tell them flat out that I have some awful news for you. Take them aside, somewhere and be very honest with them and tell them that this is what's happened. We did everything we

could. That there can be no question in their mind that anything was left out or that there was any avenue unexplored that would have helped in the situation" –participant C.

"I think that the big thing is the family's acceptance of the outcome" –participant B.

Families are all different and each one poses a unique situation. In meeting the family where they are in their acceptance of the death of their loved one, participants agreed that part of their role was to prepare the family for the death whenever possible. Participants shared stories of having minutes, not hours or days, to engage in a conversation with the family about the inevitable death of their loved one. Others described situations when the dying process occurred over a longer period of time. The important factor for nurses was that the family members were able to prepare themselves for the patient's death and not the length of time before a patient actually died.

"If we were able to, I guess for us, prepare them for the death and that they know it's coming. That makes it a little easier I guess" –participant E.

"You basically tell them what's going to happen. You can't tell them exactly when, but that way they know and that way, they're not surprised in two hours when their family member stops breathing or if their heart stops. They know it's coming. They know to say their good-byes. They know to call in any other family they need to call. And you know, family appreciate that" –participant J.

"In those situations, I find it more rewarding to have the family there and explain to them what we're doing for them, the reality of the situation and telling them what I can do for them, here is the eventual outcome, but in the meantime this is what I can do for them and when the family accepts that, it's very rewarding" –participant K.

The opportunity for the family to say good-bye to their loved one while (s)he was still alive was viewed as an important part of caring for patients who die in the ED. This opportunity to say goodbye was not always possible for reasons such as the person arrived with no vital signs, or family members had not yet arrived because the death occurred quickly or that the family had not yet been notified. When families were not able to say good-bye, participants described feeling frustrated, sad and sometimes guilty that they were unable to keep the patient alive long enough for the family to have that opportunity.

"It's almost more of a guilt that you weren't able to save this patient. That you weren't able to keep them alive so that they were able to say goodbye. It's always important for somebody to be able to say goodbye to a family member before they know they're dead" –participant J.

Giving families the opportunity to be at the bedside and say good-bye provided participants with a sense that they did their job well, and the feeling that they were able to provide that family some comfort in a sad situation.

"It gives you a certain satisfaction that you've managed to allow that family member, or family to come and say goodbye to that family member. Because it's emotionally

gratifying. It makes you feel better because they're able to have that closure" –participant J.

The participating hospital has a policy and orientation education program on family presence, which allows for family members to be at the bedside of their loved one during critical and tragic moments. It was apparent among all participants that this policy has been well integrated into the end-of-life care they provide in the ED. Participants agreed that having family members at the bedside made the acceptance of the death easier for the family as it began the grieving process and also provided the nurses with some comfort.

"the most positive for me is incorporating the family into the code situation, the resuscitation part. For the family member, when we involve them, and let them watch; bring them right into the bedside, see that we are helping them, we are doing what we know best and they see the effort that we are putting in. The most positive is when the family has seen that, they have accepted the death and they've come to us afterwards and said, 'you guys did a good job, thank you'. It makes it better too when you incorporate the family in those situations because then they can have a better understanding and I do get a reward from that" –participant K.

"I think it's easier to accept if you have a process in place where the family can see what's going on. Especially if you're running a code and if the family is there, they're more accepting of it." –participant B.

4.5.1.3 Death with dignity

Participants all agreed that when a patient dies or is dying it is essential that their dignity be preserved. One important element in death with dignity, as described by participants, was providing patients and family members a quiet, peaceful place to be together. Equally important was ensuring that patients were made comfortable through the provision of analgesia and sedatives as needed, and if possible, awake enough to say good-bye. Ensuring the patient's comfort was equated with making the family comfortable.

"You're taking care of the patient, to make them comfortable and you're making them comfortable to make the family comfortable. And that's the big thing, you don't want them to suffer, but you don't want the family to see them suffer" –participant J.

There are times when the team decides that the patient's illness or injuries are too severe to reverse and a decision is made to stop aggressive life-saving interventions and to provide only comfort measures until the patient dies. At this time, participants advocated to ensure that patient comfort was a priority. Part of making the patient comfortable was to make sure that (s)he was free of pain and not suffering with undesirable side effects like shortness of breath.

"And if I can't return them to health then they're going to have a dignified death no matter what I have to do. And I will go to ends, I'll turn rocks over to get somebody to order analgesic, to get sedation, to order the things I need to make sure that that person is comfortable" –participant C.

Despite the challenges presented by the environment that participants worked in, all participants agreed that a priority of end-of-life care was to ensure that the patient was kept comfortable and died with dignity. Participants felt that their family members were comforted when they were able to ensure that the patient was comfortable and their dignity was preserved. Feeling that both the patient and the family were comfortable created a sense of knowing for the nurse that his/her job was done well.

4.5.2 Reflecting Back

The second category in this theme, *'reflecting back'*, completes the study findings with the participant's description of how they cope with this difficult aspect of their work. In coping with caring for dying patients and their families, participants describe a need to review the process with the team and engage in self-reflection. Participants agreed that, at times, their job is challenging and that dealing with tragic events like death will continue to be a part of their role as nurses and changes them personally and professionally. Participants shared stories about the importance of *'leaving work at work'* and *'moving forward'*. Participants shared a passion for the profession and a sense of camaraderie.

4.5.2.1 Reviewing the Events

All of the participants felt that reviewing the events following a death was an essential part of the process of caring for patients who died in the ED. Reviewing the events was described by participants as a way of talking about the events surrounding the death in order to better understand what happened, and to learn from the event. It was also used as a means of validating that each team member did his/her best and helped to put closure upon the situation.

Participants felt that after an unsuccessful resuscitation and when time permitted, that if, as a team, they had the ability to talk about the events from a learning perspective and acknowledged what worked and what did not, how severe the injuries really were and what they should change or do differently in a similar situation, gave them an educational perspective of the event and enhanced their clinical competence.

"it's interesting, sometimes, depending on who the trauma team leader is. Sometimes we'll actually sit back and review things. And take it as an educational purpose. We kind of take it as a learning experience and just try to determine what we could have done differently. After the trauma code's over usually you're pooped, really just exhausted. I like it when we go over stuff and just figure out what we could change or do better. What caused it" –participant F.

Participants all agreed that within the team there existed a sense of camaraderie that was difficult for anyone outside that team to relate to or to understand. Caring for patients who died in the ED was an experience that was different from anything else. They found it was often difficult for a non-ER nurse to understand this unique experience. Participants relied on their peers to support them in difficult situations, and also comforted their peers when the roles were reversed. It was through this sharing of experiences and supporting each other in difficult times that a unique bond between team members was created.

"I know they're there to support me if I need to step away for a second or if we need to talk about it afterwards. Just knowing that I am not alone that I am not dealing with this by myself, that there are other people around. It is comforting to me" –participant D.

"Everyone around here is pretty good. When things like that happen, we usually talk about it afterwards and, I don't think we mean to talk about it, but we debrief each other. I think, by us talking about what happened and sharing experiences, or hearing nurses who have been here longer, and they usually tell you stories that happened years and years ago. It makes you understand that you're not alone in the way that you feel" –participant I.

Participants described another important aspect of reviewing the events as a period of self-reflection. Participants shared stories of how they learned to care for patients who died in the ED and to cope with death through a process of reflecting upon their experiences. They relived the events of the experience and reviewed what went well, what did not and what they could change about their own practice if a similar situation was to occur again. Some of the ways that they were able to cope with death was coming to terms with how they personally felt about death, being able to walk away at the end of a shift feeling as though they were able to help the family through the process, and having their work validated by means such as the family saying thank-you.

"It was hard at first. I think I've come to, I had to really decide how I felt about death personally before I was okay with caring for those people; but the first few really hit me kind of hard. Within myself, I guess when I really decided that heaven existed and that's probably where people went. That's where I thought people went. That was comforting-that death wasn't the end" –participant D.

"I've had people come, and that's the best thing is when you hear the family member say thank-you for what you've done. Thank-you for your help you've made this a lot easier than it could have been and that's a big thing" -participant J.

"you know they've thanked you and they are very appreciative of the work that you've done and I think that helps makes you feel that your effort wasn't wasted" –participant K.

Although not a regular part of caring for adult patients who die in the ED, having the time and the ability to review the events as a team was perceived by ER nurses as an important part of the process. Reviewing the events allowed nurses to share experience and offer support to each other. It was an important part of caring for patients who died in the ED as it validated the challenges of the role and helped nurses put closure on what was often a tragic situation.

4.5.2.2 Leaving Work at Work

All of the study participants spoke of the importance of leaving their work at work and of having an established ritual that allowed them to do so. It was these rituals that helped participants to unwind and to put things into perspective. Many of the study participants had significant others who were in the health care field and who created an informal support structure for them.

"I'm very lucky. My [spouse] is a nurse. I have an hour's drive that I have time to mull it over and I can discuss it with her, (s)he understands" –participant C.

"My loved one is in a profession that's similar to mine. I always have someone I can talk to at home that understands" –participant I.

Some of the participants shared established rituals such as sitting in front of the TV to unwind, having a glass of wine, going to the gym or going to church. Many participants spoke of the drive home as the key component in leaving their work at work.

"That's it, drive home. My 30 minute drive home is enough for me to unwind, listen to music-LOUD! Do whatever. That 30 minutes allows me to leave my work at work" – participant J.

"My drive home is usually the window down, to think about the day, don't take it home kind of time. That's when I do my thinking and I leave it in the car; leave it at work" –participant I.

Although the ritual was different between participants, all participants described a regularly established routine that allowed them some time alone to reflect on their day and put things into perspective. The study clearly indicated that having this time was an essential component in their ability to cope with regular events such as death, and to not bring their workplace issues into their personal lives.

4.5.2.3 Moving Forward

Caring for patients who died in the ED was a frequently occurring event for ER nurses. Participants shared stories of having to deal with their own emotions while providing care to people facing difficult, tragic life moments.

Participants shared the challenges in caring for patients and families during this difficult time, and acknowledged that they also felt strong emotions that they sometimes were unable to control. However, they recognized that they could not burden themselves with long-term stress or grief, but needed instead to be able to feel that they had done their best in the situation and to move forward.

"it's something that is going to happen and I can't burden myself with the long term guilt that I shouldn't be carrying the emotional feelings of stress that the family does. This is my job at the same time and my job is to facilitate this and if this is to happen then good I did a good job" –participant A.

Participants accepted that people do die and that being a care provider to an individual at the end of their life will continue to be a part of their job. Although participants in this study were committed to ensuring a patient have a peaceful death, they felt that it was also an important aspect of their job to be able to support families in the best manner that they could.

"Even though the person died you get the satisfaction of saying, 'I helped that family get through it'. You know what that means. And that's important. It's important for you, it's important for the family, it's important for the whole thing. One, they leave with a better opinion, better outlook. Two, you feel better and more confident about what you've done. It's just a whole better experience. You don't have to dwell on it, you don't think about it after, you don't think about maybe I could have done that a little better"-participant J.

Most of the study participants expressed a love or a passion for their work as an ER nurse.

"I love my job. I love my career" –participant C.

"I want to continue in my job" –participant K.

An essential part of moving forward was having the ability to come back to their work. Participants expressed how they were able to keep coming back to work despite the challenges they faced.

"It's the dedication. It's the people that I work with. Actually I think that's probably it's the people I work with. I come to work for the people I work with. I don't come to work for the patients I am going to see or the potential patients I am going to see. I go to work because I am part of a team. I don't go because I'm just that individual going to work, I have to go there because if I don't, then they're left short one person. And if they're short one person, then there's one less person to count on if things go bad" –participant J.

At the end of the day, participants agreed that the fact that patient died despite their best efforts was not important, but what was important was that they needed to know that they had done their best in the situation.

"I guess what you have to do is feel in your own gut that you did what you could given the situation" –participant C.

"If you've done as much as you can possibly can, you always feel better" –participant J.

"You feel the need to be told, 'Hey, you did your best'" –participant K.

In knowing that they have done their best, given the circumstances of the situation (how busy the department was, how many staff were able to help, how many other patients were requiring care, the events surrounding the death, how the family coped with the situation), participants were able to find meaning and satisfaction in their work. Through this meaning and satisfaction, participants expressed a love for their chosen career and a desire to keep coming back.

4.6 Additional Findings

Male Emergency Room Nurses

Of the eleven participants recruited for this study, 45.5% (n=5) were males (21.6% of the staff of site A and 11.8% of the staff of site B were male). Generally, participants in nursing research have been predominantly female, possibly because of the higher ratio of female nurses to male nurses within the profession.

When the thesis committee noted that a larger than expected number of male ER nurses requested to participate in the study, the research team decided to ask the male participants why they chose to participate in this particular study. Most of the male participants stated that they were drawn to the study because of the topic as described on the poster (Appendix D). At the end of the interview, they all responded that they felt that the interview process was *"very therapeutic"* and saw it as a form of debriefing. One said that death in the ED was very real and not many people recognized its significance and impact on their lives. Another participant had been involved in a particularly stressful situation and felt that *"no one cared"*; at the end of the interview he was reminded of the availability of an Employee Assistance Program (EAP) and he declined. He stated that he actually felt much better telling his story, thanked the interviewer for listening and expressed a desire for more story-telling opportunities.

One male participant said that, unlike his female colleagues, he did not like to sit in the staff room and relive every moment of a sad situation, but that as a human being, he feels the sadness and loss and also had a story to tell. Similar to the other male participants, he was grateful for the interview as a forum to share his stories and felt that the interview process was therapeutic.

Another participant shared how his view of death in an ED changed after getting married and having children. Once he had the responsibility of a child, he felt that in seeing young patients die, who may not have had the same opportunities as he himself, he had become very emotional. He said, *"we are professionals and we have a job to do, but we are still human and we still hurt"*.

The interview transcripts reflected that men spoke of experiencing the same emotions as their female counterparts but made a conscious effort to hide these emotions from others. Male participants shared stories of having to *"turn away"* or *"step back"* from a family so no one could see his tears, whereas female participants shared stories of *"being tearful"* and of *"crying at the bedside"*. The transcripts also indicated that in sharing stories about their experiences, the men paused more, as though an attempt to gather their composure, when telling of a particularly difficult death.

4.7 Summary of Findings

The purpose of this chapter was to discuss the findings and to relate them to the four objectives of the study. The first objective was to describe the nursing experience when caring for adults who die in the ED. An interpretive approach to data analysis resulted in the identification of three major themes: *It's not a nice place to die*, *I see the grief*, and *needing to know you've done your best.* The over-riding message was that, although challenging, when caring for patients who died in the ED, ER nurses did their best to make a bad situation better. Teamwork was identified as a major contributing factor to nurses' ability to work in this environment.

The second objective was to improve our understanding of the care nurses provided to adults who died in the ED. Nurses in this study provided thick descriptions of providing family and patient centered care without the benefit of a previous relationship in an environment that was challenging and often chaotic. Regardless of whether the death was expected or unexpected, preservation of patient dignity and caring for the family were identified as two very important components of care that nurses provided at the end of life.

The third and fourth objectives were to describe factors that facilitated and/or challenged nurses when caring for adults who die in the ED. These factors were interwoven throughout the themes and were identified as age of the patient, family acceptance, the environment, and teamwork.

The findings of this study suggested that ER nurses were committed to holistic end-of-life care and caring for both patients and family members. Although the environment of an ED is not an ideal place to care for dead or dying patients and their family members, nurses worked together as a team to make the best out of the situation.

CHAPTER 5: DISCUSSION OF FINDINGS AND IMPLICATIONS FOR PRACTICE, EDUCATION AND RESEARCH

This chapter includes a discussion of the findings related to the purpose and the objectives of the study. The purpose of the study was to improve our understanding of the experience of emergency room (ER) nurses when caring for adults who die in the emergency department (ED). The four research objectives as defined at the onset of the study were: 1) to describe this nursing experience, 2) to improve our understanding of the care these nurses provide, 3) to describe factors that facilitate this nursing care, and, 4) to describe factors that challenge this nursing care. Implications of the findings of the study for practice, education, research and the role of the Advanced Practice Nurse (APN) will also be highlighted in this chapter.

5.1 Introduction

What was unique about death in an ED was that whether or not the patient was terminally ill and expected to die, or whether the death was unexpected and sudden, the event was unanticipated by family members. Participants in this study shared stories about their experiences in both situations and provided actual nursing care, which ranged from full resuscitation (which could last for hours) to being present so that someone did not have to die alone. All participants agreed that the biggest challenges they faced related to the context of the environment and caring for suddenly bereaved family members.

5.2 Death in the Emergency Department

The ED has been described as an area with high-stress, high-anxiety, fast-pace, and unpredictable events requiring nurses to care for patients who arrived suddenly with often unexpected illness and/or injuries (Chan, 2004; Heaston, Beckstand, Bond & Palmer, 2006). However, not all patients arrive with acute illness and/or injury.

Participants in this study acknowledged that sometimes people with advanced age and/or disease came into the ED and family might have unrealistic expectations for care. Many patients with terminal illness and their families have activated the Emergency Medical Services (EMS) when they panicked as a result of the escalating manifestation of symptoms, and might be seeking life-saving or life-prolonging treatments (Chan, 2004; ENA, 2005).

In this study, these unrealistic expectations challenged the nurses as they felt that they did not have enough time to be able to bring the family to an acceptance of the impending death or to guide them through a decision making process which considered the implications of attempting futile resuscitation efforts.

Although death in an ED can be expected or unexpected (Campbell & Zalenski, 2006), it is almost always unanticipated by families. Tye (1996) suggested that sudden bereavement was one of the most traumatic crises that an individual can experience. Wright (1991), as cited in Saines 1997a, suggests that when witnessing sudden bereavement, ER nurses are part of an event that cannot be equaled to any other life event in its ability to impose emotional pain and distress on another individual. ER nurses are frequently faced with the challenge of caring for individuals in the immediate aftermath of this stressful event.

Studies have indicated that witnessing acute grief regardless of how the death occurred in the ED environment is one of the most difficult tasks in which a nurse must engage (Campbell & Zalenski, 2006; Helps, 1997; Saines, 1997b; Schoolfield, 1992). The suddenly bereaved feel a multitude of emotions: disbelief, helplessness, shock, frustration, fear, stress, bewilderment, sadness and anger (Campbell & Zalenski, 2006; Schoolfield, 1992). Often, without the privilege of having a pre-existing relationship, ER nurses are the ones to provide care to the suddenly bereaved during their immediate grief reaction.

5.3 The Environment

The ED environment was described by participants as being one of their biggest challenges in caring for patients who die in the ED. This challenge was related to factors that were beyond the control of the staff, such as the physical layout of the department and the continuous arrival of patients requiring nursing care. The nurses described feeling constantly in demand and not having enough time to focus on specific activities such as being able to provide dying patients one-on-one nursing care, but rather having to run from patient to patient throughout their shifts.

The Emergency Department

Participants in this study often spoke about the intensity of this environment and described it as *'too busy'*, *'noisy'*, *'smelly'*, *'out of control'* and *'chaotic'*. Participants also spoke about the lack of privacy for dying patients and their families and shared feelings of frustration and sadness related to the challenges of trying to create a *'more ideal'* or a *'nicer'* place for these patients and family members. In studies by Heaston et al. (2006) and Olsen, Buenefe and Falco (1998) the lack of privacy and the busy-ness of the environment was described as being challenging when caring for suddenly bereaved family members.

Heaston et al. (2006) contend that ED designs do not allow for a private, quiet area for families to grieve, and this design flaw is perceived as one of the biggest obstacles to providing end-of-life care in an ED. Nurses in Heaston et al.'s study found it necessary to *sacrifice* a room in benefit of the dying patient and his/her family but found that this sacrifice compounded the problem of increased patient volume, workload, and lack of physical space, and that these three factors also increased the potential for other deaths in the ED.

Olsen et al. (1998) support the findings of this current study and describe the ED as a cold and uncaring place for suddenly bereaved families to mourn. Environmental barriers such as the busy ED setting, the lack of a previous relationship, the constant need to attend to other patients, the lack of space to grieve privately, and the lack of immediately available clergy or social support staff to assist in the death notification and grieving process impede the ability of the nurse to assist families in the grieving process.

In addition to environmental barriers, the literature suggests that ER nurses feel a sense of failure, guilt, incompetence and/or defeat when a patient dies (Campbell & Zalenski, 2006; Levy, 2001). It was also suggested that ER nurses felt that death in an ED was often preventable due to advances in technology and medicine (Chan, 2004; Heaston et al., 2006). The participants of this study did not express feelings of guilt, failure, defeat or incompetence, but rather frustration in not being able to care for the dying patient in a manner that they desired. The inability to provide this care was compromised because of the uncontrollable challenges that the environment presented.

Manipulating the Environment

Because of the constant chaos, the noise, the lack of privacy and the busy-ness, participants in this study felt a need to manipulate the environment in the ED. The environment that they felt was more ideal at the end of life was described as *'quiet'*, *'private'* and *'away from the hub-bub'* of the ED. It was not clear in this study why the nurses felt that it was so important to be able to provide this type of environment to patients and their families. All participants identified their inability to control the environment as a major source of frustration. It could be suggested that the participants felt that the provision of an ideal environment to die was a means of providing patient comfort.

Attempting to manipulate the environment was a priority for participants of this current study. The nurses gave many examples of how they tried to make changes in the environment to provide both the patient and the family a *'nicer'* place. Some of their efforts included moving other patients, tidying the area, dimming the lights, and moving the patient to a quiet or larger area.

These findings are supported by Hawley (2000) who observed comforting strategies provided by nurses in the ED and found that although it was hypothesized that nurses in this fast-paced environment do not have time to comfort patients, comfort was actually provided in many ways and often simultaneously with other nursing care. These observed comforting strategies were categorized as either direct comfort, such as those provided directly to the patient, or indirect comfort, such as manipulation of the environment for the patient dying in the ED, for example, trying to find a quiet place in the ED or dimming the lights to minimize the gruesomeness of the situation.

5.4 A 'Good Death'

Nurses in this study agreed that one of the most important outcomes in caring for dying patients was the experience of a 'good death' as perceived by the patient and the family. A 'good death' was one in which there was nursing involvement, the patient and family were prepared for the death, had a sense of closure, beliefs, values and last wishes were honored, and the patient was able to die pain-free, peacefully and with dignity (Kehl, 2006; Sienhauser, Clipp, McNeilly et al., 2000). Findings by Saines (1997b) demonstrated that sudden death in an ED often failed to meet any of those criteria. When ER nurses did not have the opportunity to positively influence the quality of their patients' deaths, this led to distress for the nurse involved in their care. This current study supported the work of Saines (1997b).

Preserving Patient Dignity

Participants in this study all agreed that despite the circumstances surrounding the death of a person, it was very important to preserve the patient's dignity. Preservation of patient dignity included trying to create a quiet, peaceful place so that the dying person could be with their loved ones, and received, as necessary, treatment interventions that promoted patient comfort, such as the use of analgesia and sedation. In preserving patient dignity, nurses felt that they had comforted the family and it also provided them with a sense of satisfaction in their role.

Even if a patient arrived deceased, the nurses continued to preserve patient dignity by attempting to create a peaceful environment for family members to be present, and trying to clean the body as much as they could. The inability to maintain the patient's dignity was identified as a source of frustration for participants in this study. This finding was supported by Socorro et al. (2001) who also found that ER nurses reacted very negatively when the dignity of a dying patient and his/her family was not respected. For example, in Socorro et al.'s study, one nurse described the situation where a family had been brought into a messy resuscitation room as being a *'horrible'* experience.

Griffin-Heslin (2005) suggested that dignity is fundamental to the provision of nursing care, but that sometimes there were unavoidable factors that affect the maintenance of dignity, such as in a busy ED, and that this might result in the perception of unsatisfactory care both from the perspective of the bereaved and from that of the nurses.

Despite attempts by ER nurses to preserve the dignity of patients, factors such as the nursing shortage, the demands on the nurse and the environment may be beyond their control.

5.5 Caring for Patients Who Die in the Emergency Department

Participants of this study described ways of caring for dying patients that were congruent with needs that have been identified as important for end-of-life care. Some of these needs included: communicating clearly with family members about a patient's condition and poor prognosis and obtaining a Do-Not-Resuscitate (DNR) order, managing symptoms, allowing family to be present, and encouraging them to say good-bye. These needs have been identified in the literature (Heaston et al., 2006; Hopkinson et al., 2005; Mangurten et al., 2005; Matincheck, 2006; Olsen et al., 1998; Tye, 1993). These findings demonstrated that participants felt confident about being able to identify the needs of the patient and family. However, the nurses expressed a sense of frustration at not having ample time to deliver this emotionally supportive care in a desired manner due to competing demands. All of the participants in this study spoke of the *'competing demands'* of the continuous heavy workloads and having to care for many patients and families. These demands pulled them away from the bedside of a dying patient, caused them to rush the family out of the department soon after the patient had died, did not allow them to support the family in a manner that was desired by the nurse, and, after the patient died, required them to resume nursing care with other patients.

Socorro et al. (2001) described a similar situation whereby nurses, after saying goodbye to the bereaved family, were required to immediately return to other patients. The involved nurses felt a bond with the departing family but due to the demands of other patients, had to postpone dealing with their own emotional feelings, which subsequently led to an unsatisfactory closure of the events for them. Unsatisfactory closure of events such as dealing with unexpected death in the ED could lead to occupational stress, burnout, dissatisfaction in the role and decrease in quality of care to patients (Helps, 1997).

According to Campbell and Zalenski (2006) and Schoolfield (1992), the needs of a dying patient and his/her family include: having one-on-one nursing care, constant contact with one or two people and not being left alone for extended periods of time unless specifically requested. However, all of the participants in this current study spoke of not having enough time to stay with a dying patient and his/her family which they perceived as an essential component of their nursing care.

5.6 Caring for Suddenly Bereaved Family Members

Study participants agreed that one of the most important aspects of caring for dying patients was caring for the family. This was also one of the most challenging aspects of their role as they attempted to meet the family where they were in their trajectory of grief and emotions and bring them to a level of understanding and acceptance of the death in a very short period of time.

Nurses in this study specifically described the care they provided to the suddenly bereaved as the hardest aspect of providing care to patients who were dying or have died in the ED. Findings by Saines (1997b) emphasized that ER nurses felt a sense of emotional turbulence and emotional empathy in witnessing the intense grief of the suddenly bereaved as the nurses realized the effects of the death on the lives of the suddenly bereaved family members. Nurses must not only be able to deal with their feelings of frustration, stress and sadness, but they must be able to provide professional, competent care to the family of the deceased (Schoolfield, 1992).

Participants in this study admitted that when a death was tragic or particularly sad, they shared in the family's grief and pain and were oftentimes unable to control their own emotions. It was apparent in this study that ER nurses experienced their own grief when caring for patients who died in the ED. Many of the participants acknowledged that maintaining their composure during tragic moments was very difficult. Interestingly, several of the female participants in this study acknowledged *'crying at the bedside,* while several of their male counterparts admitted to *'having to turn away from the family'* to *'regain their composure'*. According to McQueen (2004), it is now considered acceptable for nurses to show their emotions as they empathize with patients and families as it is a way of showing their humanity, however, there is clearly also a need for them to manage their emotions if they are to offer help and support.

In a quantitative study, conducted by Tye (1992), about the perceptions of the needs of suddenly bereaved family members in an ED, results suggest that sudden bereavement is widely recognized as being one of the most traumatic crises an individual can experience and that the time immediately surrounding the death of a loved one is crucial to determining the family's ability to accept the death. Spending this time supporting the family facilitates their grieving process. Death in an ED presents a crisis state for the family and during their brief stay in the ED they are often unable to formulate coping strategies and subsequently need the support of caring individuals such as the nurse to help guide them through the reality of the death. In a study about sudden death in the ED, Saines (1997b) suggested that compassionate care of the suddenly bereaved is of great importance in building the foundation for their recovery.

Concern for Family

Although the goal of care in emergency medicine is focused on saving lives, nurses are taught to see beyond medical interventions and to provide holistic health care. A holistic approach to end-of-life care implies that the nurse considers the physical, emotional, social, economic, ethical, and spiritual needs of the patient and his/her family members (Dobratz, 2005). Marrone and Fogg (2006) suggest that the family is part of the patient and that holistic care acknowledges this, especially during tragic events. The unpredictable nature, busy workload, life-saving culture of the emergency environment, and lack of physical and material resources to care for bereaved families makes the provision of holistic care difficult (Chan, 2004; Heaston et al., 2006; Saines, 1997; Socorro, Tolson & Flemming, 2001).

Schoolfield (1992) stated that death in an ED is a frequent event and is potentially stressful for the ED nursing staff. They emphasized that when patients die in the ED, the patient requires more time and resources than other patients, and the need to care for their families is essential. Schoolfield also suggested that caring for the family included: allowing them to be close to their loved one as quickly and as often as possible, establishing communication and contact with as few people as possible, access to a private room with a telephone, comfort measures such as coffee, tissue, water, and blankets, an understanding that expressing their grief is acceptable, and help in choosing a funeral home. This support is crucial and will assist the family in their grieving process.

An article by Morse (1992) that explained the usefulness of comfort in an ED, suggested that although ER nurses were focused on patient care, in moments of crisis, such as death in an ED, the nurses were very concerned about caring for the family. One of the examples given in Morse's article was that while the nurses were busy providing full resuscitation efforts (including cardiopulmonary resuscitation [CPR]), one of the nurses questioned her colleagues, *"Where is the family?"*.

Participants in this current study expanded on their concern for the family and tried to identify specific, individual needs of each grieving family in an attempt to *'meet them where they are'* in the grieving process. Despite the chaos and busy-ness of the ED, participants were able to recognize the grief being experienced by the suddenly bereaved.

Participants described the many ways that a family reacted to a death regardless of whether the death was sudden and unexpected, or if their loved one had a terminal illness or advancing age and the death was somewhat expected. Some of the ways family members reacted to the death involved expressions of acceptance, anger, and/or denial. Participants found their role challenging when the suddenly bereaved did not recognize the graveness of the situation and felt that it was important, both for themselves and for the family members, to help the family reach a level of understanding of the severity of the event and acceptance that their loved one had died. Participants found meaning and satisfaction in their role when they were able to prepare the family for a death and bring the family to a level of acceptance of the death that could enable that family to move forward in their grieving process. As one participant said, *'when the family accepts that* [the death], *it is very rewarding'*.

Saying Good-bye

Nurses in this study also felt that being able to give families the opportunity to say goodbye to their loved one while (s)he was still alive was very rewarding and gave them a sense of having done their job well. These nurses would do whatever they could to provide families with this opportunity and were sensitive to the needs of the family.

They spoke of the importance of having family members present as much as possible. This facilitates the opportunity to have a family member there while the patient is still alive and lets the family see that everything possible is being done for their loved one. It was evident through the narratives of the participants that having family present during critical or tragic moments was a regular part of the care that they provided. Having the family present gave the nurses a sense that the family appreciated their efforts and were better able to accept the outcome (death) after having witnessed the care provided to their loved one by the team. Being appreciated and feeling that the family was accepting of the death was important for the participants, as it gave them satisfaction in their role in knowing that they had done their job well.

The importance of providing families with the opportunity to be with a dying patient is supported by testimonials of people who experienced the death of a loved one in an ED and reported that having been given the ability to say goodbye and be with their loved one while they were still 'alive' provided them with acceptance and closure (Andrews, 2004; Mangurten et al., 2005; Matincheck, 2006; Vanderbeek, 2000). Marrone and Fogg (2005) suggested that giving family members the opportunity to say good-bye can reduce family members' feelings of helplessness, guilt, panic and anxiety which subsequently helps them through their grieving process. Campbell and Zalenski (2006) suggest that families want to be close to their dying loved one as it promotes cohesion, allows for closure and may also soothe the patient as (s)he dies.

Comfort

Study participants spoke of doing their best in attempting to make the situation better for the family. All participants spoke of reflecting back on these events, and all agreed that when they felt they had done their best despite all of the challenges they had encountered, the family was *'cared for'* or *'comforted'*. It was through this ability to care for and comfort a suddenly bereaved family that nurses found satisfaction and meaning in their professional role.

Results of studies that examined death in the EDs, indicate that many nurses do not feel adequately prepared to deliver end-of-life care to dying patients and to provide supportive care to the suddenly bereaved (Chan, 2004; Socorro et al., 2001; Tye, 1996). However, participants in this study felt prepared to deliver appropriate and adequate end-of-life care, but desired to provide a more comforting environment.

Findings of a study on the perceptions of nurse comforting strategies as perceived by patients in an ED by Hawley (2000) revealed that patients recalled that nurses made it a point to include family in their care and not only to focus on the needs of the patients. They specifically attended to the emotional and informational needs of the family members. This recognition and attention to the family members' needs was identified by patients as being comforting.

Communication

Heaston et al. (2006) described supportive behaviors in providing end-of-life care as; communication with family, availability of support staff, and the family's acceptance that the patient was dead/dying. Socorro et al. (2000) found that ER nurses felt positive about their role in caring for the patient when (s)he had explained things clearly to the family, and encouraged and supported the suddenly bereaved.

Nurses in this study felt very strongly that they should provide care to their own patients and families in a manner that they would want themselves or their loved ones to be cared for. According to Green (2006), communication skills for compassionate end-of-life care include communicating with empathy. Empathy is important because it allows the nurse to gain an emotional appreciation of another person's feelings and lets the nurse understand the person's experience from inside his/her own frame of reference. Even in the short time frame that nurses had to interact with and care for dying patients and their families, participants described providing very compassionate care.

Often in the ED, the first encounter between a nurse and a family may be to deliver news that their loved one has been critically injured, is very ill, or has died. Participants in this study spoke of the difficulty in communicating with families, whom they have often just met, in sad circumstances. Communication was identified in the literature as being one of the most important supportive behaviors in the nurse-patient-family relationship (Hawley, 2000; Heaston et al., 2006; Levetown, 2004; Kelly, 2005) but most nurses have found that one of the most difficult aspects of delivering bad news in the ED was that they often did not know what to say, or how to say it effectively (Crossno, 2004; Kelly, 2005; Levetown; 2004, William, O'Brien, Laughton & Jelinek, 2000).

Participants of this current study felt that one of the most difficult conversations to partake in was delivering *"bad news"* to unsuspecting family members. 'Bad news' is defined by Brixley (2003) as any news that drastically and negatively alters the receiver's view of his/her life. When delivering bad news, it is important that the process involve open, honest and direct communication as this establishes a foundation of trust and understanding between the team, the family and the patient. The manner in which the news is shared may be a significant predictor of the receiver's response and partial truths, false or misleading information may cause the receiver increased anxiety and lack of trust in the health care team (Brixley, 2003).

In life-threatening situations, open, honest and regular communication between the ED staff and the family members was identified by participants in this study as being a vital component in caring for families experiencing crisis such as the death of a loved one. Levy (2001) supports the finding that constant, open and honest communication with families is one of the most important skills required by nurses when families are faced with the death of their loved one. Participants in this current study also felt that although end-of-life conversations with family members were difficult to initiate or to partake in, it was essential that this conversation happened and that the information relayed was direct, clear and honest.

5.7 Seeing Beyond

Participants described having the ability to see beyond the moments spent in the ED and to anticipate the impact that the death would have on the suddenly bereaved. In envisioning what potentially lay ahead for the suddenly bereaved, participants described an appreciation *'for what I have'* and also feeling vulnerable as they knew that they were not immune to possibly being involved in events similar to those they witnessed as part of their job. Vulnerability is an ever present aspect of being human, and in the ED, the recognition that saving lives is not always possible can precipitate feelings of helplessness as the rescuers themselves could just as easily be in need of rescue (Malone, 2000).

Findings of an ethnographic study by Malone (1992) conducted in two inner-city American hospital EDs found that feelings of vulnerability existed amongst ER nurses witnessing death. The feeling of vulnerability was described as a sense of knowing that the deceased could have been themselves or a loved one. In addition to feeling vulnerable, Malone described the ED as creating a zone of helplessness for ER nurses because their ability to control and predict the future breaks down, and causes them to realize that something unanticipated could just as easily happen to them.

Acceptance

Participants in this study were also able to put death into perspective and felt that sometimes death could be a positive outcome. Death could be viewed as a means to end the suffering of a terminally ill cancer patient, or a *'blessing'* as in the situation of a young person with irreversible head trauma and massive internal injuries. Death was described as a better alternative than spending a lifetime *'hooked up to machines...to wither away'*. However, participants in this study all agreed that the tragic death of a young person was the most emotionally, mentally and physically draining aspect of their job. When a person died with advanced age or disease, participants felt that the death was *'easier to accept'*.

As the majority of literature on death in an ED is focused on sudden, tragic death, the over-riding message is that dealing with death in an ED is one of the most stressful aspects of emergency nursing. Viewing death as a positive outcome appears to be a unique finding in this study. This finding may in part be explained because the nurses also described situations when people came in to the ED and died for reasons other than tragedy and acute illness.

5.8 Reflecting Upon the Events

Participants in this study spoke of the importance of spending a few minutes reflecting on the events surrounding a death, especially one that occurred due to an unexpected or a traumatic event. Reviewing the events occurred on three levels; 1) reviewing the event as a learning opportunity; 2) reviewing the event from a team perspective as a way of evaluating how the team worked together and how they were able to support each other during difficult or stressful times; and 3) as a personal reflection.

A Learning Opportunity

Participants described how spending time reviewing the events surrounding the death in an attempt to better understand what happened, and to learn from those events was a means of validating their role as professionals, and enabled them to put closure on the situation. Participants expressed a sense of frustration and bitterness when the department was too busy to be able to afford them a few minutes to review events. One participant felt that *'no one understands what we go through'* and another said that *'it feels like no one cares'*.

Morrissey (2005) contends that staff who work in an ED regularly face traumatic situations and systems are not always in place to help them to express their responses to these situations or to provide them with support. In fact, they have no time to reflect on the situation, but must move on to the next person(s) requiring their care. This lack of time to reflect formally on critical incidents, and the need for time to recover emotionally before dealing with another death, leads nurses to deal with their reactions in a more informal manner, such as during meal breaks. This support is often insufficient and may subsequently lead to long-term stress and burnout (Morrissey, 2005; Saines, 1997b).

Helps (1997) suggested that ER nurses need regular debriefing sessions after traumatic incidents. Saines (1997b) found that having an opportunity to review the events of a traumatic situation gave nurses an opportunity to learn from the experience and also reduced their anxiety.

Part of a Team

Participants spoke of feeling a unique bond with other members of their team. They described the importance of being part of a team and of supporting each other. Participants agreed that it was the team that helped them cope with difficult times and being in an environment where *'everyone understands'* the stress of what they cope with within their role and the need to *'step away'* from a difficult moment. Participants spoke of a unique camaraderie that was part of their role and as one participant said *'we take care of ourselves, we take care of each other'.*

Several studies support the importance of teamwork as it has been shown to lower the risk of high levels of occupational stress and burnout and contributes to a healthy work environment (Borrill, West, Shapiro & Rees, 2000; Boykin et al., 2004; Helps, 1997; Kelly, 2005; Parsons, Cornett & Burns, 2005; Zwarenstein, Reeves & Perrier, 2005). Findings also indicate that team cohesion and interpersonal relationships were listed by ER nurses as both a source of stress and a source of satisfaction (Helps, 1997; Kelly, 2005; Parsons, Batres & Golightly-Jenkins, 2006).

In this study, due to the busy-ness of the ED, the nurses noted that there was not always time to review the events as a learning experience or from a team perspective. Several participants said that when time did not permit these conversations to occur, they went home *'feeling depressed'*, *'unappreciated'* or *'inadequate'.*

McQueen (2004) suggests that the nature of the therapeutic relationship and the emotional intensity in providing care to patients who die in the ED carries the risk of burnout for the health care staff. Therefore, it is vital that all team members in the ED have a good working relationship and have the ability to recognize each other's stress in order to increase occupational satisfaction, deliver quality patient care, and to prevent burnout.

Self-Reflection

In reviewing the events, participants spoke of a time of self-reflection and described how they learned to cope with the issue of death in the ED through their experiences. Participants said things like *'the first few hit me really hard'* but that they were able to learn more effective ways of dealing with the grieving families and with their own feelings surrounding the event, such as leaving work after a stressful event and *'feeling depressed'*, needing some time to *'wind down'* or seeking solace *'in the chapel'*.

Another important aspect of coping with frequent deaths was that these ER nurses described a process of examining how they felt about death on a personal level. These nurses spoke of a need to establish their own philosophy about death in order to be able to provide care for patients and family members in these situations. It developed from personal and/or professional experiences, and/or may have a religious basis, and involved self-reflection into their meaning in life. Nurses in this study reflected upon death and in particular, when death was tragic, felt that as humans they were not immune to the situations they witnessed. Personal beliefs included things like being able to find comfort in feeling that the person had *'lived a life'*. One nurse expressed finding comfort in feeling that '*heaven existed'*, and another said (s)he felt that *'death wasn't the end'*.

Schoolfield (1992) supported the finding that nurses have a need to develop an understanding of their own feelings about death before they deliver the care that needs to be provided to the suddenly bereaved in the short time frame allowed in the ED. By having an understanding of their own feelings about death, nurses are able to put the stress of the events aside and interact with the family in a professional way.

Worden (1991) as cited in Saines (1997b) suggested that sharing in the experience of death can touch the lives of professionals in three ways: 1) the death may cause the individual to recall previous losses, 2) the death may increase the awareness of the potential that they are not immune to the events that they witness and, 3) witnessing death of others is a reminder of their own mortality. These three findings were also supported by this current study. All participants spoke of how caring for patients who die in the ED caused them to reflect upon their personal losses, such as the death of a family member or close friend; being aware that they themselves (or a loved one) could be the next person to die in the ED; and was a constant reminder that one day they too, would die.

Study participants also spoke of finding comfort in the sense of knowing that they had done their best in supporting the suddenly bereaved family in a difficult time, and of feeling *'appreciated'* by these family members. Participants felt that this appreciation for their hard work was often validated by the family *'saying thank-you'* or saying *'you've made this easier for me than it could have been'*.

Reviewing the event and feeling appreciated by family members allowed participants in this study to feel validated in their professional role. Feeling validated and appreciated provided participants with a sense of closure on a particularly difficult aspect of their job.

5.9 Caring for Self

Participants spoke of the importance of being able to separate their work life from their personal life and as several participants stated, *'leave work at work'*. All participants shared their rituals or routines for *'unwinding'* and *'not bringing it home'*. Although the rituals differed across participants, they all felt leaving their work behind was a critical component of emotional well-being and their ability to continue to work as an ER nurse.

Emotional Well-Being

Campbell (2007) suggested that emergency nursing is a very demanding high-stress job and requires that ER nurses be in excellent physical and emotional health. The demands that are placed on an individual working in the ED can induce unhealthy amounts of stress and should be managed in a proactive and positive manner. Stress that is not managed properly can lead to burnout, may cause nurses to lose their capacity to care, withdraw from the bedside or leave the profession (AACCN, 2006; Boykin et al., 2004; Helps, 1997).

Campbell (2007) acknowledges that nurses need to discover a stress-reducing modality that works best for them and to practice this modality on a regular basis. Some of the suggested tactics include exercise, meditation, laughter, music, touch (massage) and guided imagery. These suggestions were being implemented in the lives of the study participants. They spoke of stress reducing strategies such as *'listening to loud music', 'the long drive home', 'going to the gym', 'watching TV', 'going to church',* and/or calling a friend or relative (who was usually in the health care profession).

Participants identified *"leaving work at work"* as a key component of the category *'reflecting back'* and vital to maintaining mental and emotional health. This was also a necessary part of their job and a key part of their ability to be able to continue to work in the ED. This finding was supported by Campbell (2007) who suggested that ER nurses should adopt a healthy lifestyle both on and off the job in order to prevent stress and burnout among this vulnerable population.

Although dealing with adult patients who die in the ED is a very stressful and often emotional event, participants agreed that they could not *'burden'* themselves with long term guilt or stress. What participants needed to know was that they had done their best despite the circumstances and were able to move on. Participants were *'dedicated'* to their profession, admitted to *'loving'* their job and felt that they were able *'to make a difference'* in their role, not only in caring for patients who die and their families, but in their daily work.

Staying in the ED

In a study by Peterson (1996), ER nurses said they were attracted to working in the ED because of the 'adrenaline rush' it gave them. Contrary to this finding, participants in this study did not speak of the 'adrenaline rush' as the reason they continue to work in the ED. Their ability to continue to work, despite having dealt with some very difficult challenges, was based upon their commitment to their profession and to their team. When participants were asked what brought them back to this environment day after day, they all agreed that making a difference, knowing they had done their best and being part of a team were the keys to job satisfaction.

Feelings of peer support and cohesiveness, described as *'being part of the team,* appeared to contribute to a high level of job satisfaction for nurses in this study and for their ability to continue working in this area. According to the Canadian Health Services Research Foundation [CHSRF] (2006), a system that supports effective teamwork can improve the quality of patient care, enhance patient safety and reduce workload issues that cause burnout in healthcare professionals. Effective teamwork can significantly increase job satisfaction and retention, and improve patient satisfaction (Borrill, West, Shapiro & Rees, 2000; Zwarenstein, Reeves & Perrier, 2005).

The importance that these participants attached to teamwork is supported by a study by Parsons and Cornett (2005), where teamwork was identified as one of the major components of a healthy ED workplace. The specific team behaviors that were identified included demonstrating a positive attitude, supporting one another and offering to help without being asked. The results of Parson and Cornett's study also revealed that dealing with frequent deaths can have profound implications on the emotional health of nurses. It was identified that there is a need to develop healthy workplace initiatives that promote stress reduction and overall health of employees. Although this study focused on ER nurses, developing healthy workplace initiatives would be beneficial to all hospital employees.

According to ENA (2003), due to the heavy workloads, and nursing shortage, ER nurses are at an increased risk for job dissatisfaction, burnout, and leaving the profession. It is imperative that nursing management in organizations value and encourage the practice of redistributing workloads, ensuring that a team member has a much needed time-out. It is also important that the team has a few minutes to review the events following a death that has involved resuscitation efforts, which may be essential in preventing feelings of dissatisfaction and burnout among ER nurses.

Nurses in this study emphasized that having the opportunity to provide one-on-one nursing care is the ideal when caring for the dying patient. This was not always possible due to the demands on the unit, leaving participants feeling frustrated over their inability to provide care in a manner that they desired. The literature also supported having a delegated one-on-one nurse. Currently, when a nurse assumes this role, other things *'suffer'* because there are not enough nurses. Understaffing is an issue throughout nursing. Therefore, it is important for management to recognize that nurses are doing their best with what they have, emphasize the importance of teamwork, acknowledge the challenges nurses face and acknowledge their efforts. As several participants said, *'you just want to feel valued', 'you just want a simple thanks'*.

5.10 Summary of the Discussion of Findings

The current study's findings have contributed new knowledge to the understanding of the experience of ER nurses caring for adults who die in the ED. The participants shared detailed stories of caring for dead or dying patients and their family members long after the event was over. This suggested that the experience of caring for dying patients was not limited to their professional role, but carried over into their personal lives.

The overriding message of this experience was that caring for adults who died in the ED was a difficult and challenging aspect of their nursing role. Factors that contributed to the difficulty were: the busy environment, having to care for family members (whom they had often just met) experiencing a very tragic moment in their lives, and the lack of time to care for dying patients in a desired manner. Despite these challenges, it was clear that ER nurses in this study were committed to providing holistic end-of-life care and were able to find meaning and satisfaction in their professional role.

5.11 Implications for Nursing Practice, Education, and Research

This section will include implications of the study findings as they relate to nursing practice, education, and research in emergency nursing.

5.11.1 Implications for Nursing Practice

Emergency Room Design

Findings from this study clearly identified the environment as being one of the most challenging aspects of caring for patients who die in the ED. In designing or re-designing future EDs, it would be beneficial to dying patients and their families, the suddenly bereaved and staff to create an area that is private, quiet, large enough to accommodate multiple family members at the bedside and away from the *'hub-bub'* of the department.

This setting would enable nurses to care for them in a manner that was described as *'ideal'* by participants in this study. A private setting allows the family members to grieve openly, be with their dying relative and not be subjected to the chaos that may be occurring within the ED. This type of environment would meet the commitment to a client-centered relationship and facilitate a compassionate and caring approach to care delivery.

Participants in this study also suggested that when a dying patient is admitted in the ED, that it be a priority to transfer that patient to a more comfortable in-patient unit. A priority transfer requires that both the sending department and the receiving department work together to facilitate this. It is important to recognize that transferring a dying patient is not about workload, but it is congruent with compassionate patient care.

End-of-life Care Education

The sample demographics revealed that none of the participants had formal end-of-life care training or education other than some nationally recognized advanced life-saving or trauma skill courses and the required training program provided by the organization for having family present during critical and/or tragic moments. The manner in which participants provided care to patients who died in the ED and their family was based mainly upon their experiences. It was apparent in this study that ER nurses were able to provide compassionate, holistic, and patient-family centered care to adults who died in the ED and their bereaved family members, despite not having formal training in end-of-life care. Participants recognized end-of-life needs such as *'privacy'*, *'peace'*, *'analgesia'*, *'sedation'*, *'family members at the bedside'*, *'dignity'*, and *'acceptance'*.

It is important that novice ER nurses be mentored with experienced ER nurses in order to learn skills to care for dying patients and their family members. Educational programs in end-of-life care would also be beneficial as one of the benefits of formal education is that it can give participants equal skills creating an environment that delivers safe and competent care.

Olsen et al. (1998) suggested that in addition to traditional teaching methods (paper based materials) death education can involve teaching methods such as videotapes where learners can watch actors portray a realistic recreation of a death in the ED, and participate in role playing opportunities. Role-playing opportunities with simulated cases allows the learner to have an opportunity to learn how to develop humanistic and interpersonal skills needed to approach families after the death of a patient.

Therefore, one recommendation from the current study is a need to integrate formalized education programs for ED staff about end-of-life interventions such as decision-making skills, grief training, communication strategies, maintaining patient comfort through symptom management and emotional support for families (Peden, Tayler, & Brenneis, 2005). This process may be facilitated through the incorporation of end-of-life care pathways and through end-of-life care education programs for all members of the team.

At the end of the interview, many of the participants asked the interviewer what intervention this study would recommend to their departments as they all felt that they could benefit from training on how to care for dying patients. Some participants expressed that this education/training would be highly beneficial if done with all members of the team, including physicians. In addition to wanting more education on end-of-life care strategies, participants expressed a need for more support when a patient is dying or has died.

This support could be provided to the ED through processes such as having extra staff to provide care to stable patients when a nurse was busy with a dying patient and family members; having social work and/or pastoral care readily available at all hours and not just during regular business hours; and having administrators acknowledge their concerns when dealing with difficult situations. Participants gave some examples of ways in which administration could acknowledge the difficult work that the ER nurses do through means such as: expressing appreciation for the work of the ER nurses and through facilitating a quick transfer to a quiet, private room on an inpatient unit so that the dying patient can have a peaceful place to die.

Family at the Bedside

Although the participating hospital has a program that encourages having family present during critical and/or tragic moments, nurses in this study felt that when a patient was dead or dying having the family at the bedside was an important aspect of their care and was also beneficial to nursing staff. The benefits for participants of this study were identified as perceiving that the family recognized *'we are helping them'*, *'we are doing what we do best'*, and *'we did everything we could'* and subsequently feeling as though they helped the family accept the death. One study participant said having the family present is *'one of the most positive'* aspects of caring for patients who die in the ED because it validates her role.

Although limited to tragic and traumatic deaths, findings from previous studies (MacLean, Guzzetta, White et al., 2003; Mangurten et al., 2005; Matincheck, 2006) suggest that having family members stay with dead or dying patients is also beneficial for the family members. However, according to MacLean et al. (2003), a lack of a formal process places ER nurses in a difficult position when confronted with the request of a patient's family member to be at the bedside. Consequently, it is important for organizations to develop a formal policy and process on family presence. Having a formal process in place, as demonstrated in this study, allows for consistent, safe and caring practices for the patient, the patient's family and staff.

The results of this study illustrate the possible benefits of how a formalized educational program, such as the one that these study participants received on having family members at a patient's bedside can become ingrained in nursing practice and transfer beyond the resuscitation room to all areas of the ED where a patient may die.

Interdisciplinary Support

In sharing their experiences, participants spoke of how other professionals, primarily social workers and chaplains, who were part of the emergency team, helped them care for patients and families in the ED because these professionals did not have the immediate workload demands that the nurses had. They were able to spend more time offering explanations, answering questions, finding resources and supporting the emotional needs of the patient and family members.

One of the challenges identified by participants was that often these support people were needed immediately but were not readily available beyond normal working hours (Mon-Fri, 8am-4pm) and consequently the role that these other disciplines could provide to the family were provided by the nurse. Staffing patterns were also reduced after hours, which subsequently increased the workload of the nurse and impacted his/her ability to provide time caring for the dying patient and supporting grieving family members.

There was limited mention of the role of the physician in providing end-of-life care to patients or of caring for family members. It was perceived by participants that in the context of the ED, the priority for physicians was to focus on the physiological stability of other patients.

Effective collaborative teamwork improves quality of care (CHSRF, 2006) and therefore, consideration must be given to the composition of the members of the ED team and how to provide a culture that enhances patient and family-centered care. A suggestion is for EDs to have teams that include professionals from all of the health care disciplines, a chaplain and the support staff. When end-of-life care educational programs are offered, it should be made available to all members of the team as caring for dying patients and their family members in an ED requires a collaborative approach.

5.11.2 Implications for Nursing Education

Communication Techniques

Participants in this study often found it difficult to communicate bad news to family members. They were concerned about not being able to say the right thing or '*make it better*' because when someone dies, especially tragically, nothing anyone says is going to make the situation better. Communicating bad news and/or communicating with the suddenly bereaved could occur either in person or over the phone. A supportive educational intervention could include teaching health care staff, including nurses, how to communicate bad news and how to talk to suddenly bereaved individuals in an effective and concise manner. Education about communication strategies would also be helpful for ER nurses, such as: strategies for building rapport in a brief time period, helping patients/families make decisions, and facilitating debriefing sessions for individuals and/or the health care team.

5.11.3 Implications for Nursing Research

Male Emergency Room Nurses

It was apparent in this study that there was an over-representation of male participants. Conducting further research to determine if this was a normal occurrence relating to the clinical area and/or the topic of study or if it occurred by chance would provide the profession with knowledge about male ER nurses and/or males as study participants. Based on the findings of this study, it appeared that men coped differently than women in stressful situations, such as death in ER. More research in the area of how men cope with their emotions, specifically when caring for dying patients in EDs, whether or not there were differences in care delivery, and attitudes towards end-of-life care based upon gender would add new knowledge in this important area.

The Family's Perspective

There is a need to learn more about the perspective of the family involved in an ED death. Participants from this study reflected on their observations of family responses to a loved one dying in the ED. However, there is a notable absence in the literature of families' personal experiences of having a loved one die in the ED. There are statements threaded throughout the literature that suggest that families may feel uncared for (Boykin et el., 2004) or may perceive nurses as too busy to communicate with them (Kelly, 2005). While these perceptions may be related to the busy environment of the ED, there is a lack of research-based evidence to support these statements.

5.12 The Role of the Advanced Practice Nurse (APN)

According to the Canadian Nurses Association [CNA] (2008), an Advanced Practice Nurse (APN) is a graduate prepared registered nurse who has in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, communities and populations. The five core competencies that define the practice of the APN include: 1) expert clinician; 2) educator; 3) researcher; 4) consultation; 5) leader (CNA, 2002; Hamric, Spross & Hanson; 2005). The role of an ER APN is to enhance the development of nursing knowledge and skills in meeting the needs of clients requiring emergency care. This section will focus on the role of the APN in the context of caring for patients who die in EDs in relation to the implications of the findings of this study.

5.12.1 Expert Clinician

The expert clinical practice of the ER APN consists of both direct and indirect patient care. (S)he could provide direct care to the complex patients in the ED or provide indirect clinical care such as providing support and mentorship to staff nurses who care for patients in the ED.

Staff Support

The results of this study clearly show that ER nurses deal with death and traumatic events on a regular basis, however, systems are not always in place to help them express or work through their personal responses to these situations. ENA (2002) suggests that ED management should make debriefing of critical incidents available as needed to help nurses and other providers who care for dying patients cope with the potentially high stress situations. The APN is in a position to facilitate a supportive environment so that nurses can have the opportunity to share their reactions to distressing events. Having the time and the opportunity to share their feelings is crucial to the health and potentially the retention of ER nurses (Hanna & Romana, 2007). This staff support could be facilitated by the APN through organized debriefing sessions with the individual nurses or with the entire team (including the external providers; fire department, police and paramedics).

Patient and Family Advocate

According to Hamric et al. (2005), end-of-life care is an area that would benefit from the expanded skills, attentive planning and coordinating efforts an APN provides. When a patient is near death, many decisions between the family and the health care team need to be coordinated to ensure continuity of care and a peaceful death. Although in an ED there is not much time to coordinate these decisions, many of the issues surrounding end-of-life care remain the same: pain control, management of distressing symptoms, plans for withholding or initiating life support measures, and a need for psychological and spiritual support for both the patient and the family (Gazelle, 2001; Hirai, Miyashita, Morita, Sanjo, & Uchitomi, 2006).

The APN has the ability to be an integral part of helping the family through the initiation of difficult discussions, assisting them with the decision making process, providing explanations about what is happening, and ensuring that their loved one is kept comfortable. The APN is also in a position where (s)he can put programs into place that can help staff develop skills to help families in this situation.

5.12.2 Educator

As an educator, the ER APN can develop, plan and implement teaching resources about end-of-life care for staff and families. Some of these teaching strategies can include self-learning modules, journal clubs, workshops and continuing education days. For example, a workshop on how to deliver bad news would be beneficial to ER nurses. As an educator, an APN can assist in the development of some end-of-life critical care pathways, provide skill training in areas such as decision-making skills, communication techniques, crisis management strategies, and stress reducing strategies that may enhance staff development in end-of-life care for all team members.

5.12.3 Researcher

The APN has a role to support evidence-based practice in emergency care. Being involved in original research and supporting research being done in emergency care can be an integral part of the role of the APN.

Research Activities

Some of the research activities that the APN could be involved in include being a member of internal research committees and promoting research with colleagues. The

APN has as role to ensure that research has a practical application for the nurses at the bedside. Promotion of research activities with colleagues could include activities such as participating in research studies similar to this one, and activities such as lunch and learn sessions, nursing grand grounds, and/or filling a binder with current 'hot topics' and research articles relevant to interesting situations that happened in the ED. Having current research easily accessible in the staff room could allow staff the benefit of reading articles during a meal break.

ENA (2002) states that ER nurses should be involved in research to gain a better understanding of end-of-life issues and to develop interventions for end-of-life care in the ED. An example of the research that could be undertaken by the APN is to explore the impact of a patient's death on the interdisciplinary members of the health care team (nurses, doctors and support staff) in different hospital settings (major trauma center, community, teaching). How that death affects the role nurses play within the interdisciplinary team, and specifically, their present and potential contribution towards providing expertise and support for the team caring for dying patients in the emergency room could also be examined. An understanding of these experiences may provide the basis for the further development of nursing and interdisciplinary interventions that improve the delivery of end-of-life care.

5.12.4 Consultant

According to Hamric et al. (2005), the role of the consultant is to enhance patient care and/or improve skills and confidence of the consultee. The consultant may or may not see the patient directly.

Formal and Informal Consultation

As end-of-life care in the ED is a stressful and challenging aspect of providing nursing care the APN may be asked to provide an informal consultation generated by nurses at the bedside regarding patient-care issues. The APN could be viewed as a resource person and could be consulted by other nurses, managers, support staff, other professionals and/or external groups to provide suggestions regarding clinical as well as professional practice issues that will enhance patient care and/or nurse skills. This information may be used to develop or recommend changes in policies and procedures, medical directives and clinical pathways for emergency nursing in end-of-life care.

The APN may also facilitate processes that encourage family members to be present with their dead or dying relative, support family members and bereavement follow-up programs. An APN of a large center, such as the participating hospital, could be a consultant to smaller, more rural, hospitals to support nurses dealing with death in the ED.

Ethical Decision Making

Often when a patient is critically injured or dying of advanced age or disease, the family may be asked to make some difficult decisions regarding the use of life sustaining or supportive measures. The APN is in a unique position to coordinate complex care issues and facilitate communication with both the family and the team regarding decisions that would be made in the best interest of the patient.

As family members are in crisis, they may be unable to comprehend the severity of the situation and the APN may provide an unbiased point of view that can redirect the focus of care on what the patient's needs are and perhaps what his/her wishes may have been. The APN is in a unique position to develop a program to build capacity for ER nurses to assist families in making difficult decisions, and provide tools that may enhance this skill.

5.12.5 Leader

The most common leadership roles an APN may be expected to play are those of advocate, mentor, group leader, and change agent (Hamric et al., 2005).

Sharing and Networking

A unique leadership role of the APN could be to develop a network of interested practitioners and stakeholders in his/her region to share ideas and strategies for improving end-of-life care in EDs. (S)he could plan networking meetings through the coordination of agendas, finding a geographically suitable venue for meetings, and creating and maintaining a membership list. Meetings could be face-to-face, teleconferenced, and/or web-casted. The benefits to sharing knowledge and networking with other professionals could enhance patient care, improve staff satisfaction, and support nursing initiatives.

5.13 Study Limitations

This study explored the experience of ER nurses who have cared for patients who have died in the ED. The study's findings may not be applicable to the experience of every ER nurse or even every ER nurse working at the participating hospital.

All of the participants worked in a large multi-site urban teaching hospital and their experiences may not reflect those of ER nurses who have had similar experiences in a rural setting. For example, urban versus rural differences could reflect the availability of a trauma team and an emergency physician versus a family physician, or no in-house physician, readily available operating rooms versus having to transfer patients out of the facility, available technology and other resource factors that have not been captured in this study.

Another limitation of the study is that the only those participants who were interested in participating in the research study and/or were interested in the research study topic participated in this study and consequently only their experiences and views were represented.

A final limitation is the relationship between the researcher and the participants. In knowing that the researcher was an ER nurse, this relationship could have impacted the depth of the discussions and the details of the stories that were shared by the participants.

5.14 Conclusion

This study's findings contribute new knowledge for understanding the experience of being an ER nurse and caring for patients who die in the ED. By virtue of their role and close contact with patients, ER nurses are in a unique position to influence end-of-life care. Findings from this study will help to improve our understanding of the care ER nurses provide and identify factors that facilitate and/or hinder end-of-life care delivery. As well, the study demonstrated through three major interrelated themes (*"It is not a nice place to die"*, *"I see the grief"* and *"Needing to know you've done your best")* how end-of-life care is more than an individual interaction between a patient and a nurse, but includes activities that create a context and structure to describe the experience of providing end-of-life care in the ED. These themes cannot be examined in isolation; rather together, they create a story of the experience of ER nurses who care for adult patients who die in the ED. The complexity of nursing practices to facilitate end-of-life care has been illustrated, but so have the opportunities for personal and professional growth that nurses experience in the context of providing end-of-life care. For the eleven participants of this study, the experience of caring for patients who died in the ED extended beyond the patient and included caring for the entire family in a compassionate manner, and highlighted the importance of being part of a team. This experience was not limited to their professional role, but also gave them the opportunity to grow as individuals.

Although ideally everyone should die in a quiet, peaceful environment, people will continue to die in the midst of the chaos of an ED. The results of this study demonstrated that despite the realities of the ED, ER nurses were able to be therapeutic, deliver compassionate end-of-life care, support family members during a difficult time, be part of a team, and find meaning and satisfaction in their role within this challenging environment. Compassionate end-of-life care is a well-described social ideal and there is a need to develop comprehensive ED infrastructures and supportive mechanisms that will help all nurses deliver appropriate and holistic end-of-life care to both patients and their family members.

While the nursing community continues to identify factors that contribute to quality of end-of-life care, the impact of ER nurses on end-of-life practice must be recognized. This research adds new knowledge to the profession and provides a foundation for future inquiry. The knowledge generated from this study can be used to improve end-of-life service delivery and outcomes for patients and families experiencing death in the ED.

REFERENCES

American Association of Critical Care Nurses. (2006, January). *Moral Distress* (AACN Public Policy). Aliso Viejo, CA: Author.

Andrews, R. (2004). Family presence during a failed trauma resuscitation attempt of a 15-year-old boy: Lessons learned. *Journal of Emergency Nursing*, 30, 556-558.

Aronson, J. (1994). A pragmatic view of thematic analysis. *The Qualitative Report*, 2 (1). Retrieved May 20, 2006 from http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html

Bassler, P. C. (1999). The impact of education on nurses' beliefs regarding family presence in a resuscitation room. *Journal for Nurses in Staff Development*, 15(30), 126-131.

Borrill, C., West, M. A., Shapiro, D., & Rees, A. (2000). Team working and effectiveness in health care. *British Journal of Health Care,* 6(8), 364-371.

Boykin, A., Bulfin, S., Bladwin, J., & Southern, R. (2004). Transforming care in the emergency department. *Topics in Emergency Medicine*, 26(4) 331-336.

Brixey, L. (2003, January/February). The difficult task of delivering bad news. *American Academy of Ambulatory Care Nursing,* 3-5.

Burns, N. & Grove, S. K. (2007). *Understanding nursing research* (4th ed.). St. Louis, MO: Saunders.

Campbell, P. M. (2007). Self-care for the caregiver. In K. S. Oman & J. Koziol-McCain (Eds.)., *Emergency nursing secrets* (pp. 61-66). Edinburgh: Elsevier Mosby.

Campbell, M. & Zalenski, R. (2006). The emergency department. In B. R. Ferrell & N. Coyle (Eds.), *Textbook of palliative care* (pp.861-869). New York: Oxford University Press.

Canadian Emergency Physicians Association. (1998). Canadian Triage and Acuity Scale (CTAS) Available http://www.caep.ca/template.asp?id=B795164082374289BBD9C1C2BF4B8D32

Canadian Emergency Physicians Association & National Emergency Nurses Association. (2006). *Joint statement on emergency department overcrowding.* Retrieved November 15, 2006 from Canadian Emergency Physicians Association website: http://www.caep.ca/

Canadian Health Services Research. (2006). *Teamwork in healthcare: Promoting effective teamwork in healthcare in Canada.* Ottawa, Ontario: Author.

Canadian Institute for Health Information. (2001). *Health care in Canada 2001: A second annual report.* Ottawa, Ontario: Author.

Canadian Institute for Health Information. (2006). Quickstats. Retrieved March 16, 2006 from http://qstat.cihi.ca/discoverer4i/viewer?eul=QSEUL&qp_Fiscal~20Year=2003 &qp_Fiscal~20Year=2004&ac=qpublic1~40cihidb04.cihi.ca&db=cihidb04.cihi.ca& wsk=14&nlsl=en- ca&wbk=HP15&pg=1&us=qpublic1&_po=10000011101111 111111011 &_act=Apply~20Parameters

Canadian Nurses Association. (2003, October). Ethical distress in health care environments. *Ethics in practice for Registered Nurses.* Ottawa, Ontario: Author.

Canadian Nurses Association. (2008). *Advanced Nursing Practice: A national framework.* Available from CNA website http://www.cna-aiic.ca/CNA/documents/pdf/publications /ANP_National_Framework_e.pdf

Chan, G. K. (2004). End-of-life models and emergency department care. *Academic Emergency Medicine*, 11(1), 79-86.

Ciccarello, G. P. (2003). Strategies to improve end-of-life care in the intensive care unit. *Dimensions of Critical Care*, 22(5) 216-222.

Crossno, R. J. (2004). Dying in the emergency department: What emergency physicians should know palliative medicine. *Topics in Emergency Medicine*, 26(1), 19-28.

Davies, J. B. (1997). Grieving after a sudden death: Impact of the initial intervention. *Accident and Emergency Nursing*, 5, 181-184.

Dobratz, M. C. (2005). Gently into the light: A call for the critical analysis of end-of-life outcomes. *Advances in Nursing* Science, 28(2), 116-126.

Emergency Nurses Association. (2003, June). *Staffing and productivity in the emergency care setting* (6th ed.). Des Plaines, IL: Author.

Emergency Nurses Association. (2003, July). *Resuscitative decisions* (8th ed.). Des Plaines, IL: Author.

Emergency Nurses Association. (2004, February). *Role of the emergency nurse in tissue and organ donation* (9th ed.). Des Plaines, IL: Author.

Emergency Nurses Association. (2005, March). *End-of-life care on the emergency department* (2nd ed.). Des Plaines, IL: Author.

Emergency Nurses Association. (2005, October). *Family presence at the bedside during invasive procedures and cardiopulmonary resuscitation* (5th ed.). Des Plaines, IL: Author.

Furman, J. (2000). Taking a holistic approach to the dying time. Nursing2000, 30(6), 45-49.

Gazelle, G. (2001). A good death: Not just an abstract concept. *Journal of Clinical Oncology,* 19, 917-918.

Green, A. (2006). A person-centered approach to palliative care nursing. *Journal of Hospice and Palliative Care* Nursing, 8(5), 294-301.

Griffin-Heslin, V. L. (2005). An analysis of the concept dignity. *Accident and Emergency Nursing*, 13, 251-257.

Gutierrez, K. M. (2005). Critical care nurses' perceptions of responses to moral distress. *Dimensions of Critical Care*, 24(5), 229-241.

Hamric, A. B., Spross, J. A., & Hanson, C. M. (2005). *Advanced practice nursing: An integrative approach* (3rd ed.). St. Louis, MO: Elsevier Saunders.

Hanna, D. R., Romana, M. (2007, August). Debriefing after a crisis. *Nursing Management*, 39-47.

Hawley, M. P. (2000). Nurse comforting strategies. *Clinical Nursing Research*, 9(4), 441-459.

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

Helps, S. (1997). Experiences of stress in accident and emergency nurses. *Accident and Emergency Nursing*, 5, 48-53.

Hirai, K., Miyashita, M., Morita, T., Sanjo, M., & Uchitomi, Y. (2006). Good death in Japanese cancer care: A qualitative study. *Journal of Pain and Symptom Management,* 31(2), 140-147.

Hobgood, C., Villani, J., & Quattlebaum, R. (2005). Impact of emergency department volume on registered nurse time at the bedside. *Annals of Emergency Medicine, 46,* 481-489.

Hochschild, A. R. (2003). *The managed heart.* Los Angeles: The University of California Press.

Hopkinson, J. B., Hallett, C. E., & Luker, K. A. (2005). Everyday death: How do nurses cope with caring for dying people in hospital? *International Journal of Nursing Studies*, 42, 125-133.

Huryk, L. (2006). Is it really an emergency? When nonurgent cases overwhelm the ED. *American Journal of Nursing*, 106(1), 69-72.

Kehl, K. A. (2006). Moving toward peace: A analysis of the concept of a good death. *American Journal of Hospice and Palliative Medicine*, 23(4), 277-286.

Kelly, A. E. (2005). Relationships in emergency care. *Topics in Emergency Medicine*, 27(3) 192-197.

Knapp, J. & Mulligan-Smith, D. (2005). Technical report: Death of a child in the emergency department. *Pediatrics*, 115, 1432-1437.

Knoll, S. M. & Johnson, J. L. (2000). Uncertainty and expectations: Taking care of a cardiac surgery patient at home. *Journal of Cardiovascular Nursing*, 14(3) 64-75.

Levetown, M. (2004). Breaking bad news in the emergency departments: When seconds count. *Topics in Emergency Medicine*, 26(1), 35-43.

Levy, M. M. (2001). End-of-life care in intensive care unit: Can we do better? *Critical Care Medicine*, 29(2), N56-N61.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Lofland, J., & Lofland, L. H. (1984). *Analyzing social settings.* Belmont, CA: Wadsworth

Publishing Company, Inc.

Long, T. & Johnson, M. (2000). Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing*, 4, 30-37.

MacLean, S. L., Guzzette, C. E., White, C., Fontaine, D., Eichhorn, D. J., Meyers, T.A., & Desy, P. (2003). Family presence during cardiopulmonary resuscitation and invasive procedures: Practices of critical care and emergency nurses. *Journal of Emergency Nursing*, 29(3), 208-221.

Malone, R. E. (2000). Dimensions of vulnerability in emergency nurses' narratives. *Advances in Nursing Science*, 23 (1), 1-11.

Mangurten, J. A., Scott, S. H., Guzzetta, C. E., Sperry, J. S., Vinson, L.A., Hicks, B. A., Watts, D. G., & Scott, S. M. (2005). Family presence: Making room. *American Journal Nursing*, 105(5), 40-48.

Marino, P. A. (1998). The effects of cumulative grief in the nurse. *Journal of IV Nursing*, 21(2), 101-104.

Marrone, L. & Fogg, C. (2005). Family presence during resuscitation. *Nursing2005*, 35(8), 21-22.

Mason, J. (1998). *Qualitative researching*. Thousand Oaks, CA: Sage.

Matincheck, T. (2006). Nurses' beliefs and practices of family presence during cardiopulmonary resuscitation and invasive procedures. *Topics in Emergency Medicine*, 28(2), 144-148.

McQueen, A. (2004). Emotional intelligence in nursing work. *Journal of Advanced Nursing*, 47(1), 101-108.

Meltzer, L. S., & Huckabay, L. M. (2004). Critical care nurses' perceptions of futile care and its effect on burnout. *American Journal of Critical Care*, 13(3), 202-208.

Milne, J. & Oberle, K. (2005). Enhancing rigor in qualitative description. *The Journal of Wound, Ostomy and Continence Nursing*, 32, 413-420.

Morrissey, J. (2005). Staff support after trauma in A&E. *Emergency Nurse*, 13(6), 8-10.

Morse, J. M. (1992). Comfort: The refocusing of nursing care. *Clinical Nursing Research*, 1(1), 91-106.

Morse, J. M. & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.

Nairn, S. (2004). Emergency care and narrative knowledge. *Journal of Advanced Nursing*, 48(1), 59-67.

Olsen, J. C., Buenefe, M. L., Falco, W. D. (1998). Death in the Emergency Department. *Annals of Emergency Medicine,* 31(6), 758-765.

Parsons, M. L., Batres, C., & Golightly-Jenkins, C. (2006). Innovations in management: Establishing team behavioral norms for a healthy workplace. *Topics in Emergency Medicine*, 28(2), 113-119.

Parsons, M. L., Cornett, P. A., & Burns, A. L. (2005). A healthy emergency department workplace: The staff describe it. *Topics in Emergency Medicine*, 27(3), 198-205.

Pattison, N. (2004). Integration of critical care and palliative care at the end of life. *British Journal of Nursing*, 13(3) 132-138.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.

Payne, S. A., Dean, S. J., & Kalus, C. (1998). A comparative study of death anxiety in hospice and emergency nurses. *Journal of Advanced Nursing*, 28, 700-706.

Peden, J., Taylor, C., Brenneis, C. (2005). End of life care: Every nurse's business. *Alberta RN*, 61(6), 8-9.

Peterson, L. (1996). *The lived experience of practicing emergency department nurses.* (Master's Thesis, University of Alaska Anchorage, 1996). Proquest, AAT 1381184.

Polit, D. F. & Beck, C.T. (2004). *Nursing research: Principles and methods* (7th ed.). Philadelphia: J.B. Lippincott.

Polit, D. F. & Hungler, B. P. (1995). *Nursing research: Principles and methods* (5th ed.). Philadelphia: J.B. Lippincott.

Saines, J. C. (1997a). Phenomenon of sudden death: Part 1. *Accident and Emergency Nursing*, 5, 164-171.

Saines, J.C. (1997b). Phenomenon of sudden death: Part 2. *Accident and Emergency Nursing*,5, 205-209.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health*, 23, 334-330.

Schoolfield, M. (1992). Difficult situations in the emergency department: A nursing perspective. *Topics in Emergency Medicine*, 14(2) 29-44.

Sienhauser, K.E., Clipp, E. C., McNeilly, M., Christakis, N. A., McIntyre, L. M., & Tulsky, J. A. (2000). In search of a good death: Observations of patients, families and providers. *Annals of Internal Medicine*, 132, 825-832.

Socorro, L. L., Tolson, D., & Fleming, V. (2001). Exploring Spanish emergency nurses' lived experience of the care provided to suddenly bereaved families. *Journal of Advanced Nursing* 35, 562-750.

Streubert Speziale, H. J. & Carpenter, D.R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative* (4th ed.). Philadelphia: Lippincott.

Taylor, S. J. & Bogden, R. (1984). *Introduction to qualitative research methods: The search for meanings.* (2nd ed), Chichester: John Wiley and Sons.

Thorne, S., Reimer Kirkham, S. & MacDonald-Emes, J. (1997). Interpretive description: A non-categorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health*, 20(2), 169-177.

Thorne, S., Reimer Kirkham, S. & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods*, 3(1), 1-21.

Thomas, D. R. (2003). *A general inductive approach for qualitative data analysis.* University of Auckland, New Zealand, School of Population Heath.

Tye, C. C. (1992). Qualified nurses' perceptions of the needs of suddenly bereaved family members in the accident and emergency department. *Journal of Advanced Nursing*, 18, 948-956.

Tye, C. C. (1996). Sudden bereavement in the accident and emergency: The development and evaluation of a short educational course for qualified nurses. *Accident and Emergency Nursing*, 4, 88-93.

Vanclarbeck, J. (2000). Til death do us part. *American Journal of Nursing*, 100(2), 44.

Webster, G. & Baylis, F. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-232). Hagerstown, MD: University Publishing Group.

Williams, A.G., O'Brien, D.L., Laughton, K. J., & Jelinek, G. A. (2000). Improving services to bereaved relatives in the emergency department: Making healthcare more human. *The Medical Journal of Australia*, 173, 480-483.

Wright, B. (1997). Editorial. *Accident and Emergency Nursing*, 5, 177.

Wright, B. (2003). Excitement vs burnout. *Accident and Emergency Nursing*, 11, 1.

Zwarenstein, M., Reeves, S., & Perrier, L. (2005). Effectiveness of pre-licensure interprofessional education and post-licensure collaborative intervention. *Journal of Interprofessional Care*, 19 (supplement 1), 148-165.

APPENDIX A - SEARCH TERMS

Summary of search strategies

Common databases, CINAHL, PUBMED, PsychLIT, and Cochrane were used.

The following terms were searched alone and in combination with one another:
-death

-emergency departments

-Emotions

-emergency nurses

-Critical care nurses

-nurse-client relationships in ER

-sudden death

-qualitative studies and sudden death

-unexpected death

-empathy

-emotional labor (keeping terms empathy, emotions, theory, burnout and nursing practice)

-moral distress

-traumatic bereavement

<u>An example of a search:</u>
Database CINAHL, term emotions, yielded 2023 articles, add term ER nurses and 0 articles were found;
Add sudden death to emotions and 6 articles found -none were relevant
The same search in PubMed yielded 221 articles, although most of them encompassed the helping role of the nurse with bereaved families, there were some (~20)useful articles found.

A variety of articles were selectively reviewed

APPENDIX B - LETTERS OF SUPPORT

The Ottawa Hospital | L'Hôpital d'Ottawa

Sept. 13, 2006

Dr. R. Saginur
Chair of OHREB
Ottawa Hospital, Civic Campus
751 Parkdale Ave
Suite 106
Ottawa, Ontario
K1Y 1J7

Dear Dr. Saginur,

Please accept this letter in support of Kerry-Anne Hogan's Masters of Science in Nursing thesis entitled "Caring for adult patients who die in emergency departments: Reflections of emergency room nurses". The CIHR Palliative Care Research Strategic Training Program is currently funding this thesis project and I believe that this is a worthy study to be conducted at the Ottawa Hospital. Kerry-Anne is working under the supervision of Dr. F. Fothergill-Bourbonnais, Dr. S. Brajtman both of the University of Ottawa, Dr. K. Wilson of the Rehab Centre and S.Philips APN at the Ottawa Hospital.

Sincerely,

John Trickett RN BScN
Clinical Manager
Emergency - Civic Campus, Ottawa Hospital
613 798 5555 (Ext 13069)
Pager 792 0336
Fax 761 4936

The Ottawa Hospital | L'Hôpital d'Ottawa

Sept. 13, 2006

Dr. R. Saginur
Chair of OHREB
Ottawa Hospital, Civic Campus
751 Parkdale Ave
Suite 106
Ottawa, Ontario
K1Y 1J7

Dear Dr. Saginur,

Please accept this letter in support of Kerry-Anne Hogan's Masters of Science in Nursing thesis entitled "Caring for adult patients who die in emergency departments: Reflections of emergency room nurses". The CIHR Palliative Care Research Strategic Training Program is currently funding this thesis project and I believe that this is a worthy study to be conducted at the Ottawa Hospital. Kerry-Anne is working under the supervision of Dr. F. Fothergill-Bourbonnais, Dr. S. Brajtman both of the University of Ottawa, Dr. K. Wilson of the Rehab Centre and S.Philips APN at the Ottawa Hospital.

Sincerely,

AnnMarie DiMillo
Clinical Manager. Gestionnaire clinique
Emergency Department,General Campus
Ottawa Hospital
phone: 737-8186
pager: 719-1601

APPENDIX C - PARTICIPANT INTERVIEW QUESTIONS

-Can you tell me what it is like to care for someone who dies in the emergency department?

-What are some of the most memorable situations that you have encountered in caring for someone who dies in the emergency department? Can you tell me about them?

- What are some of the most difficult situations that you have encountered in caring for someone who dies in the emergency department? Can you tell me about them?

-What are some factors that facilitate caring for someone who dies in the emergency department?

-What are some factors that hinder caring for someone who dies in the emergency department?

-Can you describe a death that you continue to think about long after it has occurred?

-Why do you continue to think about this death?

-Is caring for someone who dies in the emergency department stressful? If yes, can you tell me why? (what factors make it stressful)

-Is there anything you'd like to add about your experience in caring for someone who dies in the emergency department?

APPENDIX D - POSTER

The Ottawa Hospital | L'Hôpital d'Ottawa

Are you an Emergency Room Nurse?

uOttawa

Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières
University of Ottawa
Faculty of Health Sciences
School of Nursing

Have you cared for patients who have died in the ER?

Would you be willing to share your stories?

I am a Master's of Nursing student at the University of Ottawa and I am interested in *your* experience in caring for patients who have died in the ER.

I am looking for 10 - 15 nurses willing to meet with me for a 30-60 minute audio-recorded interview.

If you are interested, please contact me: Kerry-Anne Hogan at to arrange an interview to be held at a location and time that is convenient for you. This research study has been approved by the Ottawa Hospital and the University of Ottawa Research Ethics Boards.

☐ *Civic Campus Civic*
1053 av. Carling Avenue
Ottawa, Ontario K1Y 4E9

☐ *General Campus Général*
501 chemin Smyth Road
Ottawa, Ontario K1H 8L6

☐ *Riverside Campus Riverside*
1967 prom. Riverside Drive
Ottawa, Ontario K1H 7W9

APPENDIX E - STUDY PARTICIPANT INFORMATION LETTER

uOttawa

Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières

University of Ottawa
Faculty of Health Sciences
School of Nursing

Dear emergency room nurse,

My name is Kerry-Anne Hogan and I am a graduate student at the University of Ottawa and an emergency room nurse with more than 10 years of experience. I am asking for your assistance to partake in a research study about the experience of the emergency room nurse when caring for adults who die in the emergency department. The study data will be used to complete my MScN thesis. The criteria for the study include English-speaking, currently employed as a registered nurse in the emergency department at the Ottawa Hospital (either campus), have experience caring for an adult patient who has died in your department, and willing to talk about that experience during a 30-60 minute audio recorded interview.

Participation is completely voluntary and will be kept confidential. At no time will anyone other than the research team be aware of your participation.

Should you wish to participate in this study, the interview will take place at a time and location convenient to you. To arrange an interview time, please contact me at or at home

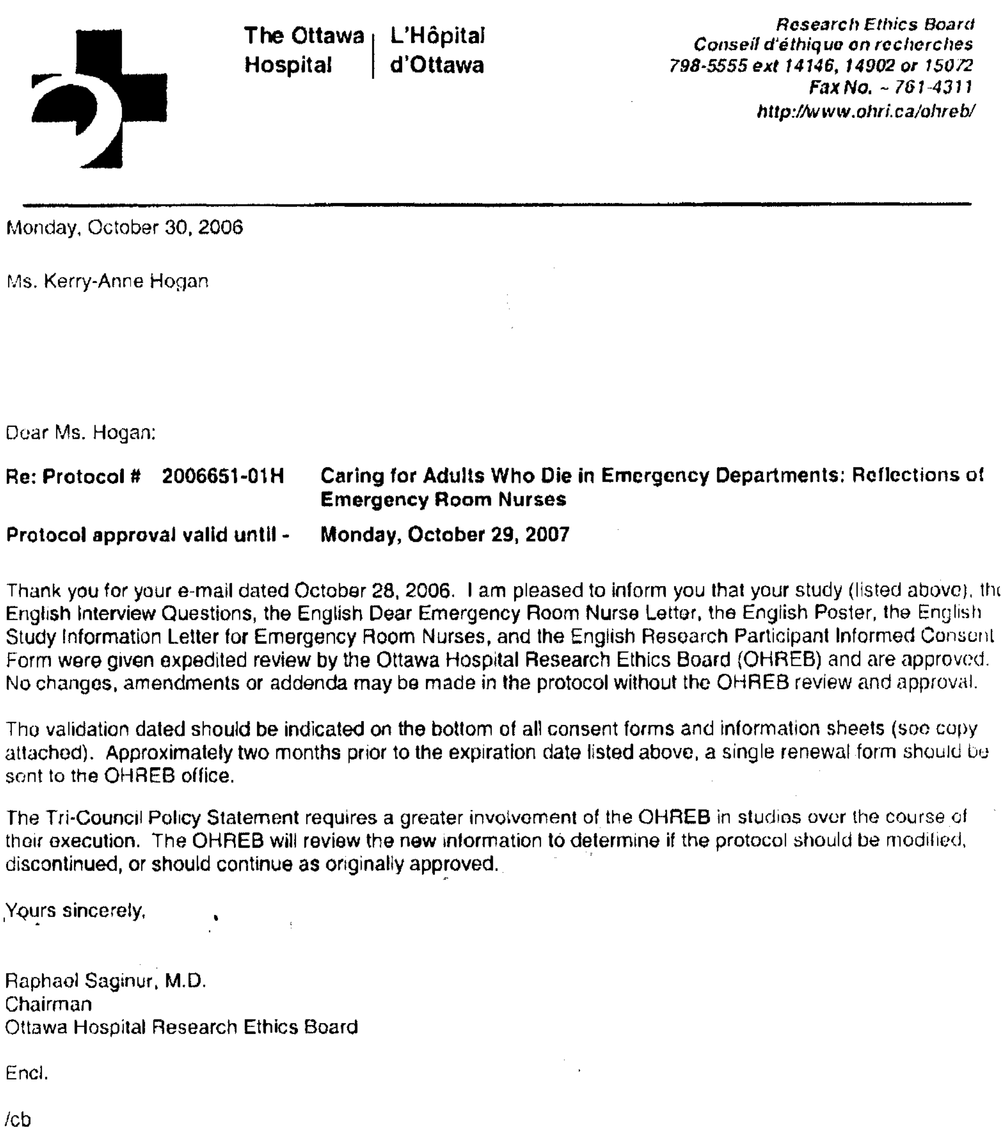
I thank you in advance for your interest.

Sincerely,

Kerry-Anne Hogan RN BN ENC(C) MScN Candidate
Queensway Carleton Hospital Emergency Department
Ottawa University School of Nursing
CIHR Palliative Care Research Strategic Training Program Fellow

☎ 613 562 [illegible]
✉ 613 562 5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

APPENDIX F - PARTICIPATING HOSPITAL ETHICS BOARD APPROVAL



The Ottawa Hospital | **L'Hôpital d'Ottawa**

Research Ethics Board
Conseil d'éthique en recherches
798-5555 ext 14146, 14902 or 15072
Fax No. - 761-4311
http://www.ohri.ca/ohreb/

Monday, October 30, 2006

Ms. Kerry-Anne Hogan

Dear Ms. Hogan:

Re: Protocol # 2006651-01H **Caring for Adults Who Die in Emergency Departments: Reflections of Emergency Room Nurses**

Protocol approval valid until - Monday, October 29, 2007

Thank you for your e-mail dated October 28, 2006. I am pleased to inform you that your study (listed above), the English Interview Questions, the English Dear Emergency Room Nurse Letter, the English Poster, the English Study Information Letter for Emergency Room Nurses, and the English Research Participant Informed Consent Form were given expedited review by the Ottawa Hospital Research Ethics Board (OHREB) and are approved. No changes, amendments or addenda may be made in the protocol without the OHREB review and approval.

The validation dated should be indicated on the bottom of all consent forms and information sheets (see copy attached). Approximately two months prior to the expiration date listed above, a single renewal form should be sent to the OHREB office.

The Tri-Council Policy Statement requires a greater involvement of the OHREB in studies over the course of their execution. The OHREB will review the new information to determine if the protocol should be modified, discontinued, or should continue as originally approved.

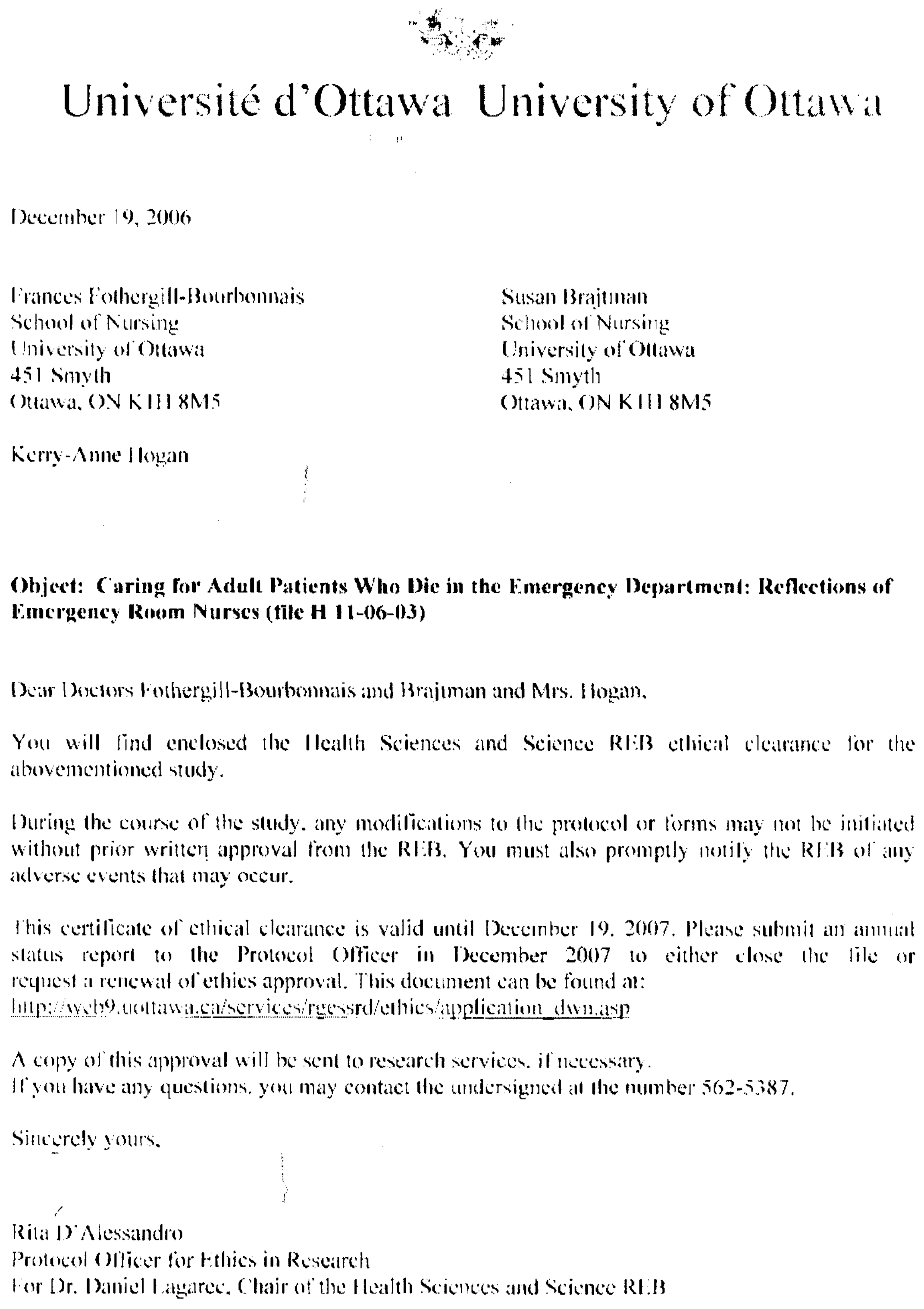
Yours sincerely,

Raphael Saginur, M.D.
Chairman
Ottawa Hospital Research Ethics Board

Encl.

/cb

APPENDIX G - UNIVERSITY OF OTTAWA ETHICAL APPROVAL



Université d'Ottawa University of Ottawa

December 19, 2006

Frances Fothergill-Bourbonnais
School of Nursing
University of Ottawa
451 Smyth
Ottawa, ON K1H 8M5

Susan Brajtman
School of Nursing
University of Ottawa
451 Smyth
Ottawa, ON K1H 8M5

Kerry-Anne Hogan

Object: Caring for Adult Patients Who Die in the Emergency Department: Reflections of Emergency Room Nurses (file H 11-06-03)

Dear Doctors Fothergill-Bourbonnais and Brajtman and Mrs. Hogan,

You will find enclosed the Health Sciences and Science REB ethical clearance for the abovementioned study.

During the course of the study, any modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

This certificate of ethical clearance is valid until December 19, 2007. Please submit an annual status report to the Protocol Officer in December 2007 to either close the file or request a renewal of ethics approval. This document can be found at: http://web9.uottawa.ca/services/rgessrd/ethics/application_dwn.asp

A copy of this approval will be sent to research services, if necessary.
If you have any questions, you may contact the undersigned at the number 562-5387.

Sincerely yours,

Rita D'Alessandro
Protocol Officer for Ethics in Research
For Dr. Daniel Lagarec, Chair of the Health Sciences and Science REB

Université d'Ottawa University of Ottawa

December 19, 2006

Frances Fothergill-Bourbonnais
School of Nursing
University of Ottawa
451 Smyth
Ottawa, ON K1H 8M5

Susan Brajtman
School of Nursing
University of Ottawa
451 Smyth
Ottawa, ON K1H 8M5

Kerry-Anne Hogan

Object: Caring for Adult Patients Who Die in the Emergency Department: Reflections of Emergency Room Nurses (file H 11-06-03)

Dear Doctors Fothergill-Bourbonnais and Brajtman and Mrs. Hogan,

You will find enclosed the Health Sciences and Science REB ethical clearance for the abovementioned study.

During the course of the study, any modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

This certificate of ethical clearance is valid until December 19, 2007. Please submit an annual status report to the Protocol Officer in December 2007 to either close the file or request a renewal of ethics approval. This document can be found at:
http://web9.uottawa.ca/services/rgessrd/ethics/application_dwn.asp

A copy of this approval will be sent to research services, if necessary.
If you have any questions, you may contact the undersigned at the number 562-5387.

Sincerely yours,

Rita D'Alessandro
Protocol Officer for Ethics in Research
For Dr. Daniel Lagarec, Chair of the Health Sciences and Science REB

Université d'Ottawa University of Ottawa

HEALTH SCIENCES AND SCIENCE RESEARCH ETHICS BOARD

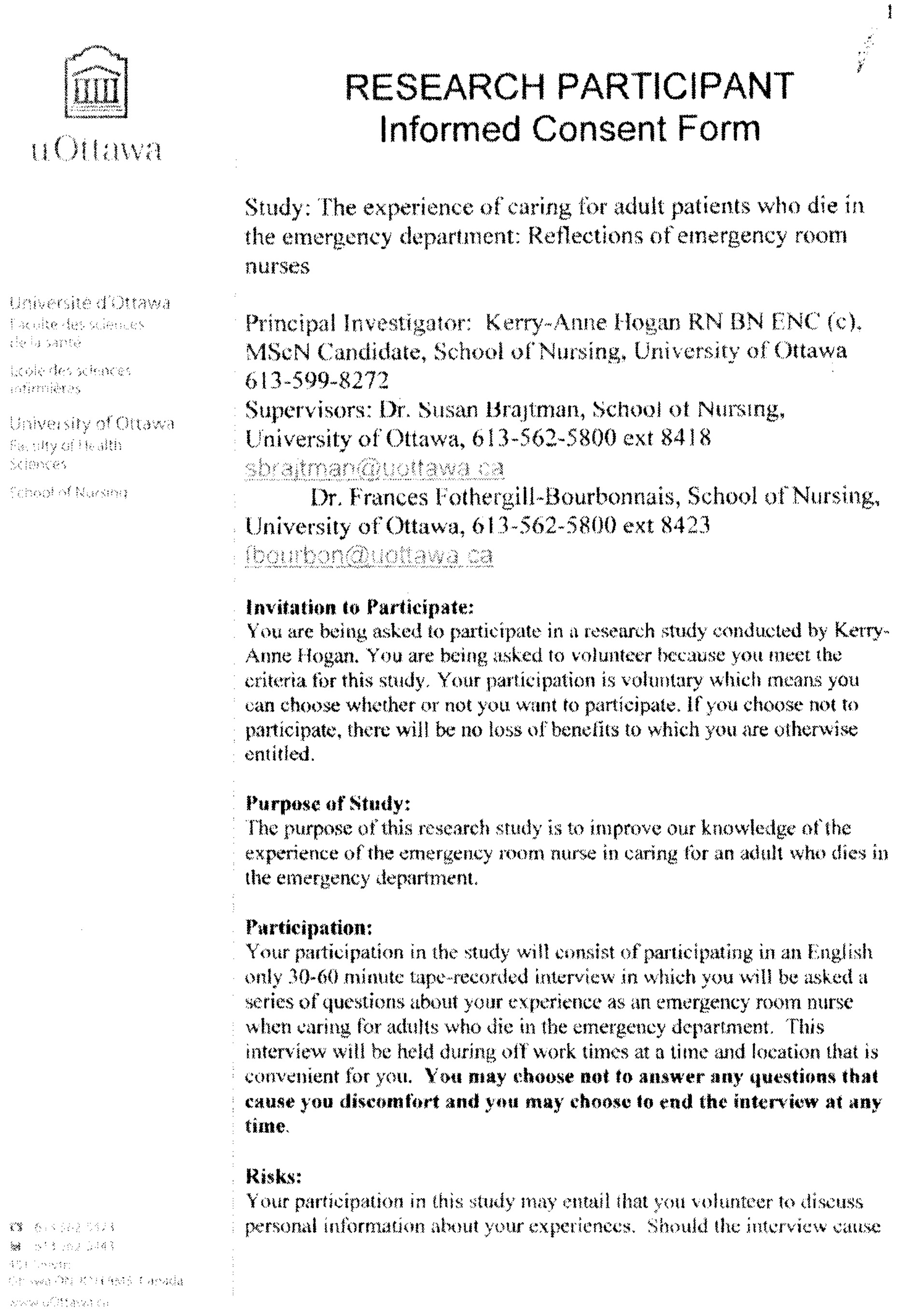
CERTIFICATE OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Health Sciences and Science Research Ethics Board has examined the application for ethical approval of the research project entitled **Caring for Adult Patients Who Die in the Emergency Department: Reflections of Emergency Room Nurses (file H 11-06-03)** submitted by Kerry-Anne Hogan and supervised by Frances Fothergill-Bourbonnais and Susan Brajtman of the School of Nursing. The Board found that this research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave it a Category 1a (approval). This certification is valid one year from the date indicated below.

Rita D'Alessandro
Protocol Officer for Ethics in Research
For Dr. Daniel Lagarec, Chair of the
Health Sciences and Science REB

December 19, 2006
Date

APPENDIX H - STUDY PARTICIPANT CONSENT (ENGLISH)



1

uOttawa

RESEARCH PARTICIPANT
Informed Consent Form

Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières
University of Ottawa
Faculty of Health Sciences
School of Nursing

Study: The experience of caring for adult patients who die in the emergency department: Reflections of emergency room nurses

Principal Investigator: Kerry-Anne Hogan RN BN ENC (c), MScN Candidate, School of Nursing, University of Ottawa 613-599-8272
Supervisors: Dr. Susan Brajtman, School of Nursing, University of Ottawa, 613-562-5800 ext 8418
sbrajtman@uottawa.ca
Dr. Frances Fothergill-Bourbonnais, School of Nursing, University of Ottawa, 613-562-5800 ext 8423
fbourbon@uottawa.ca

Invitation to Participate:
You are being asked to participate in a research study conducted by Kerry-Anne Hogan. You are being asked to volunteer because you meet the criteria for this study. Your participation is voluntary which means you can choose whether or not you want to participate. If you choose not to participate, there will be no loss of benefits to which you are otherwise entitled.

Purpose of Study:
The purpose of this research study is to improve our knowledge of the experience of the emergency room nurse in caring for an adult who dies in the emergency department.

Participation:
Your participation in the study will consist of participating in an English only 30-60 minute tape-recorded interview in which you will be asked a series of questions about your experience as an emergency room nurse when caring for adults who die in the emergency department. This interview will be held during off work times at a time and location that is convenient for you. **You may choose not to answer any questions that cause you discomfort and you may choose to end the interview at any time.**

Risks:
Your participation in this study may entail that you volunteer to discuss personal information about your experiences. Should the interview cause

☎ 613 562 5423
613 562 5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

you emotional upset you may exercise your right to end the interview. If desired, you may personally contact your occupational health department and Employee Assistance Program for professional counselling. You may choose to contact them yourself for professional, free and confidential counselling at 1-800-387-4765 (English) or 1-800-361-5676 (French).

Benefits:

Although you will not receive any direct benefit from your participation in this research, you will receive $20.00 to cover your expenses (time, parking and gas).

The information collected during this interview will be used for the MScN thesis of Kerry-Anne Hogan to advance the profession's understanding of what it means to care for patients who die in the emergency department.

Confidentiality and anonymity:

The interview will be tape-recorded to enhance accuracy. Later, when the interview is transcribed, your name will not be attached to the transcript; your interview will be recorded as a number, ie informant #1. This number is used to protect your identity in any transcripts of the interview. This informed consent form, with your real name, will not be matched with the data, and your participation will be kept confidential. The study results will also be published. There is the possibility of using direct quotes from participants in the actual study results. No personal identifying information will appear in any presentations or publications. Please initial below your preference in regards to the possibility of direct quotation of your interview data:

I agree to be quoted but all personally identifying information shall be removed and the contents of the quote shall not be revelatory of my identity.______

I do not wish to be quoted at all.______

Conservation of Data:

The interview tapes, transcribed interviews and other documentation will be secured in a locked filing cabinet in the office of the thesis supervisor (Dr S. Brajtman). The interview tapes themselves will be destroyed and the documents shredded 15 years after completion of this study.

The individuals who have access to this data are the research committee and include:

Dr. Susan Brajtman, School of Nursing, University of Ottawa
Dr. Frances Fothergill-Bourbonnais, School of Nursing, University of Ottawa
Dr. Keith Wilson, Psychologist, Rehabilitation Centre
Susan Phillips, APN Geriatrics, The Ottawa Hospital

Voluntary Participation:

When you sign this form, you are agreeing to take part in this research study. This means that you have read the 3 page consent form, your questions have been answered, and you have decided to volunteer. As previously stated, you may choose to withdraw at any time. If you choose to withdraw prior to completion of the interview, the tape will be deleted immediately and no data will be collected.

Acceptance:

I ________________________________have received assurance from the researcher that the information I will share will remain confidential. The contents from the tape-recorded interviews will be used only for Kerry-Anne Hogan's Masters of Nursing thesis and my confidentiality will be protected as my name will not be attached to the interview transcript.

I have read and understood this consent. I have had all my questions answered. I can choose to end the interview at any time without having to give an explanation to the interviewer and there will be no impact on my employment.

I ______________________________ voluntarily agree to participate in the above research study conducted by Kerry-Anne Hogan of the School of Nursing, Faculty of Post-Graduate Studies at the University of Ottawa under the supervision of Dr S. Brajtman and Dr. F. Fothergill-Bourbonnais.

Kerry-Anne Hogan will be returning to the emergency department and sharing the findings of this study to all interested staff members. None of the participants will be identified during this presentation.

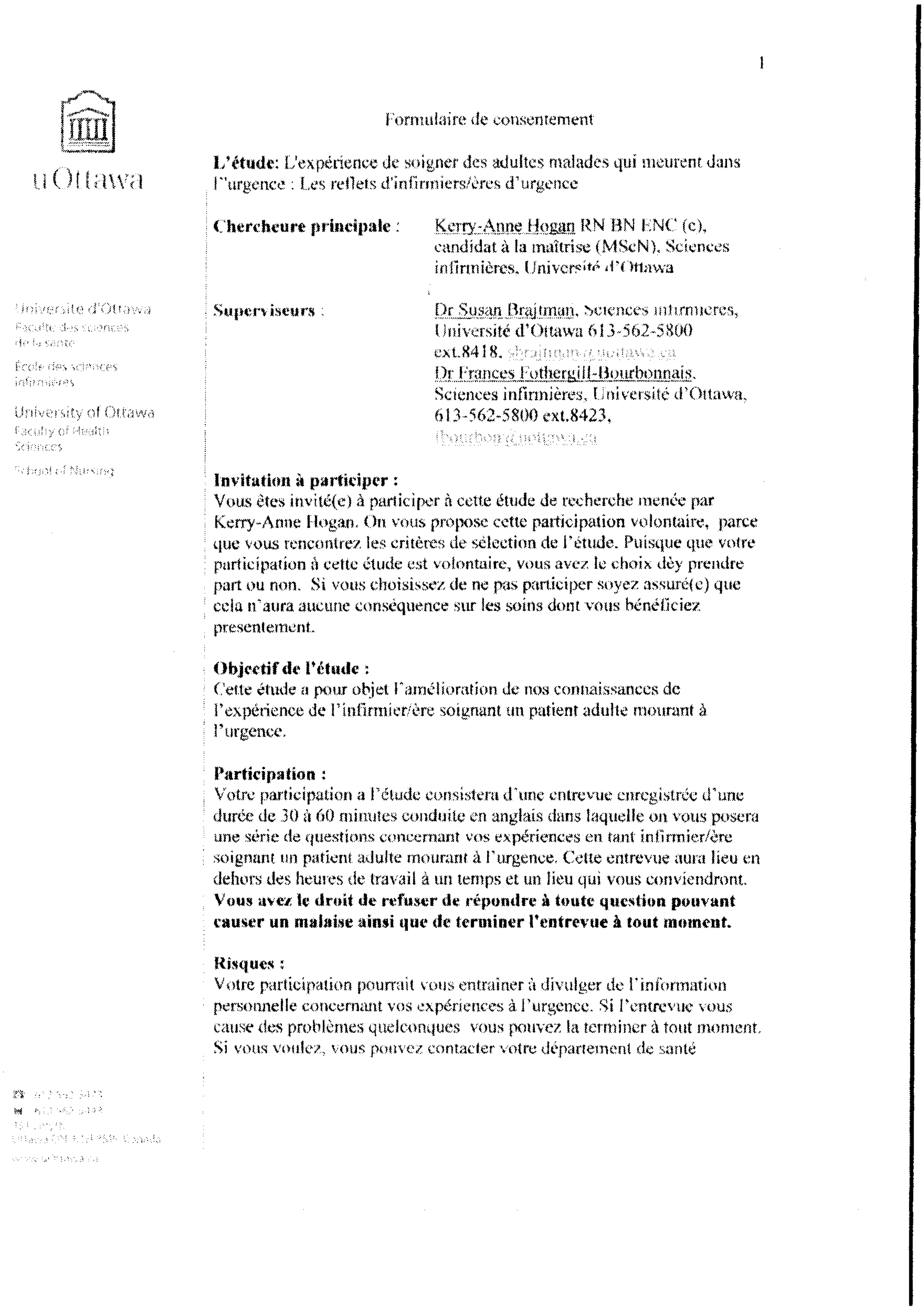
If I have any questions regarding the ethical conduct of this study, I may contact Rita D'Alessandro, the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON, K1N 6N5, 613-562-5841 or ethics@uottawa.ca. and/or the Chairman of the Ottawa Hospital Research Ethics Board at 613-798-5555.ext. 14902.

There are two copies of the consent form, one of which is mine to keep.

Researcher's signature______________________
Date ________________

Participant's signature________________________
Date____________________

APPENDIX I - STUDY PARTICIPANT CONSENT (FRENCH)



uOttawa

Universite d'Ottawa
Faculte des sciences
de la sante

École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences

School of Nursing

Formulaire de consentement

L'étude: L'expérience de soigner des adultes malades qui meurent dans l'urgence : Les reflets d'infirmiers/ères d'urgence

Chercheure principale :	Kerry-Anne Hogan RN BN ENC (c), candidat à la maîtrise (MScN), Sciences infirmières, Université d'Ottawa
Superviseurs :	Dr Susan Brajtman, Sciences infirmieres, Université d'Ottawa 613-562-5800 ext.8418, sbrajtman@uottawa.ca Dr Frances Fothergill-Bourbonnais, Sciences infirmières, Université d'Ottawa, 613-562-5800 ext.8423, fbourbon@uottawa.ca

Invitation à participer :
Vous êtes invité(e) à participer à cette étude de recherche menée par Kerry-Anne Hogan. On vous propose cette participation volontaire, parce que vous rencontrez les critères de sélection de l'étude. Puisque que votre participation à cette étude est volontaire, vous avez le choix dèy prendre part ou non. Si vous choisissez de ne pas participer soyez assuré(e) que cela n'aura aucune conséquence sur les soins dont vous bénéficiez presentement.

Objectif de l'étude :
Cette étude a pour objet l'amélioration de nos connaissances de l'expérience de l'infirmier/ère soignant un patient adulte mourant à l'urgence.

Participation :
Votre participation a l'étude consistera d'une entrevue enregistrée d'une durée de 30 à 60 minutes conduite en anglais dans laquelle on vous posera une série de questions concernant vos expériences en tant infirmier/ère soignant un patient adulte mourant à l'urgence. Cette entrevue aura lieu en dehors des heures de travail à un temps et un lieu qui vous conviendront. **Vous avez le droit de refuser de répondre à toute question pouvant causer un malaise ainsi que de terminer l'entrevue à tout moment.**

Risques :
Votre participation pourrait vous entrainer à divulger de l'information personnelle concernant vos expériences à l'urgence. Si l'entrevue vous cause des problèmes quelconques vous pouvez la terminer à tout moment. Si vous voulez, vous pouvez contacter votre département de santé

☎ [illegible]
✉ [illegible]
[illegible]

professionnelle ainsi que le programme d'assistance aux employé(e)s pour de l'assistance psychologique. Vous pouvez contacter le service professionnel vous-même gratuitement, et en toute confidentialité au 1-800-387-4765 (Anglais) ou 1-800-361-5676 (Français).

Avantages :
Bien que vous ne bénéficierez pas d'avantages directs suite à votre participation à l'étude, vous recevrez néanmoins $20.00 pour couvrir les dépenses encourues (temps, stationnement, essence).
L'information retenue pendant cette entrevue sera utilisée pour la thèse de la MScN de Kerry-Anne Hogan avec l'intention de faire avancer la compréhension professionnelle de ce que cela signifie réellement que de prendre soin de patients adultes mourant à l'urgence.

Confidentialité et anonymat :
L'entretien sera enregistrée pour améliorer la précision. Plus tard, lorsque l'entretien sera transcrit, votre nom ne sera pas attaché à la transcription ; votre entretien sera enregistré avec un numéro, ie indicateur #1. Ce numéro protége votre identité dans les transcriptions de l'entretien. Cette formulaire de consentement, avec votre nom, ne sera pas lié avec les données, et votre participation sera confidentielle. Les résultats de l'étude seront publiés. Il y a la possibilité d'utiliser des citations directes des participants. Des informations distinctives et identifiantes ne seront pas utilisées dans des présentations ou des publications. S'il vous plaît cocher ci-dessous votre préférence concernant les citations directes de votre entretien :

Je consens à être cité(e) sachant que toute information personnellement distinctive sera enlevée et que le contenu des citations ne seront pas révélateurs de mon identité. ___

Je souhaite ne pas d'être cité. ___

Conservation des données :
Les cassettes, transcriptions et toute documentation seront fermer dans un classeur mis sous clé dans le bureau de la directrice de la thèse (Dr S. Brajtman). Les cassettes seront détruites et les documents seront déchiquetés 15 ans après la conclusion de cette étude.
Les individus qui ont accès aux données forment le comité et sont :
Dr Susan Brajtman, Sciences infirmières, Université d'Ottawa
Dr Frances Fothergill-Bourbonnais, Sciences infirmières, Université d'Ottawa
Dr Keith Wilson, Psychologue, Centre de réadaptation
Susan Phillips, APN gériatrie, L'hôpital d'Ottawa

Participation volontaire :
En signant cette formulaire vous consentez à participer à cette étude. Ceci veut dire que vous avez lu les 3 pages du formulaire de consentement, que vos questions ont bien été répondues et que vous avez décidé de participer sur une base entièrement volontaire. Tel qu'indiqué plus haut, vous pouvez vous retirer de l'étude à tout moment. Si vous

choisissez de vous retirer avant la fin de l'entrevue la cassette sera effacée immédiatement et aucune donnée ne sera conservée.

Acceptation :
Je ______________________________, ai maintenant l'assurance de la part du chercheur que l'information que je divulgue restera confidentielle. Les contenus de l'entrevue enregistrée sera utilisé seulement pour la thèse de la maîtrise des sciences infirmières de Kerry-Anne Hogan, et ma confidentialité sera protégée étant donné que mon nom ne sera pas lié à la transcription de l'entretien.

J'ai lu et compris le présent formulaire de consentement. Toutes mes questions ont bien été répondues. Je peux choisir de terminer l'entretien à tout moment sans donner d'explication à l'interviewer et sans conséquence à mon emploi.

Je ______________________________ consentis volontairement de participer à l'étude mentionnée ci-dessus menée par Kerry-Anne Hogan de l'École des sciences infirmières, de la Faculté d'études poste-diplômée à l'Université d'Ottawa sous la direction de Dr S. Brajtman et Dr F. Fothergill-Bourbonnais.

Kerry-Anne Hogan retournera à l'urgence et offrira les résultats de cette étude aux pesonnel(le)s intéressées. Aucun(e) participant(e) sera identifié pendant cette présentation.

Si j'ai des questions en ce qui concerne la conduite éthique de cette étude, je peux contacter Rita D'Alessandro, l'Officier de Protocole pour l'Ethique dans la Recherche, Université d'Ottawa, Tabaret Hall, 550 rue Cumberland, salle 159, Ottawa, ON, 613-562-5841 ou ethics@uottawa.ca. Je peux aussi contacter le Président du Conseil d'Ethique de Recherche de l'Hôpital d'Ottawa à 613-798-5555 ext.14902.

Il y a deux copies de cette formulaire de consentement, une desquelles est la mienne.

Signature du/de la chercheur(e) ____________________ Date ______________

Signature du/de la participant(e) ____________________ Date ______________