Expert Nurse Behaviours in Care of the Dying Adult

in the Emergency Department (ED)

By

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ABSTRACT

Emergency departments (EDs) are most often thought to be places where resuscitative and life-saving interventions occur. Often overlooked is the fact that EDs are also places where dying patients receive end of life care. Emergency nurses assume the care of dying patients on a regular basis and are thus in a key position to meet the needs of dying patients and their families. Research focused on identifying expert nurse behaviours in the provision of care of the dying patient has been conducted on an adult palliative care inpatient unit, an adult intensive care unit, the community, adult and pediatric medical units, and in a personal care home setting. Those studies have provided beginning empirical evidence regarding the nature of expert care of the dying in those particular settings. However, little is known in the nature of expert nurse behaviours in care of the dying adult in the ED setting. To address this gap in literature, a descriptive exploratory study was conducted with registered nurse experts (n = 6) in two EDs within an urban setting in Western Canada. Analysis of the participant interviews resulted in the identification of five nurse behaviours deemed as being essential in the provision of nursing care of the dying adult patient in the ED. These behaviours included: 1) providing comfort; 2) honouring the personhood of the patient; 3) responding to the family; 4) responding after the death of the patient; and 5) responding to colleagues. Expert nurse behaviours identified in this study provide an empirical foundation to guide nurses working in the ED in the care of dying patients and their families.

Table of Contents

List of Tables

List of Figures

Chapter One: Statement of the Problem

Introduction

This chapter provides a statement of the problem for the study and a description of its overarching purpose. The five research questions driving the project are identified. The assumptions underpinning the study are stated, and terms relevant to the study are defined. The chapter concludes with an explanation of the study's significance.

Statement of the Problem

Death is a common occurrence in the emergency department (ED); causes of death in the ED are varied and may include sudden death related to trauma or illness, acute exacerbation of a chronic condition, and progression of advanced disease (Chan, 2004). Because of their sustained contact with patients, nurses working in the ED have an important role to play in providing end of life care (Emergency Nurses Association, 2005). In order to provide such care, nurses must be knowledgeable about, and feel comfortable with, caring for dying patients and their families. However, the literature suggests many nurses do not receive adequate education in care of the dying as part of their basic training , and thus feel ill equipped to provide such care (Beckstrand, Callister, & Kirchhoff, 2006; Ferrell, Virani, Grant, Coyne, & Uman, 2000). Moreover, research suggests nurses' abilities to provide quality end of life care in the ED are hampered by time pressures, heavy workloads, and space constraints that preclude opportunities for patient and family privacy (Heaston, Beckstrand, Bond, & Palmer, 2006).

Research examining the nature of expert nursing practice in care of the dying has been conducted, resulting in the identification of behaviours that nurse experts in palliative care (Degner, Gow & Thompson, 1991), adult intensive care (McClement & Degner, 1995), adult medical units (Harbeck, 1995), pediatric units (Hawkins, 1995), the community (Helwar, 1994), and personal care homes (Wowchuk, 2004) deem essential in providing quality end of life care in

those respective settings. To date, however, no research has been conducted examining expert

nursing behaviours in care of the dying in the ED. Thus, our understanding of the nature of

expert nursing practice is incomplete. To address this gap in the literature, the focus of this

qualitative study was to explicate and describe the critical nursing behaviours commensurate

with expert end of life nursing care in the ED. For the purpose of this study, the focus was on

end of life care provided to patients for whom a decision had been made to provide palliative

care measures by the healthcare team and the family, and whose deaths were expected within

hours or days. Such patients included those who were already enrolled in a palliative care

program, as well as individuals who presented to the ED with a life threatening condition for

whom comfort care as opposed to curative intent had been decided.

Purpose of the Study

The purpose of the study was to understand and describe the critical behaviours identified

by expert emergency nurses in care of the dying adult patient in the emergency department. The

following research questions were addressed:

1. What are the behaviours that emergency nurses in the emergency department deemed
    "expert" in care of the dying by their colleagues, describe as having a positive influence
    on the care of the dying adult in the emergency department setting?

2. What are the behaviours that emergency nurses deemed "expert" in care of the dying by
    their colleagues, describe as having a negative influence on the care of the dying adult in
    the emergency department setting?

3. How do the behaviours identified by the emergency nurses in this study compare with the
    seven categories of nursing behaviours identified by Degner, Gow, and Thompson's
    (1991) study?

4. What factors do expert emergency nurses identify as facilitating their ability to provide

    optimal care to the dying adult in the emergency department setting?

5. What factors do expert emergency nurses identify as constraining their ability to provide

    optimal care to the dying adult in the emergency department?

Assumptions Underlying the Study

The following assumptions underlie this study:

1. There are patients for whom curative treatment is not appropriate (Campbell & Zalenski,

    2006).

2. The unit of care in the ED includes the dying patient and his/her family (Coyle, 2006).

3. All Canadians have the right to quality end of life care (Standing Senate Committee,

    2000).

4. Family members are at risk emotionally and physically during bereavement (Corless,

    2006). The type of care that their dying relative receives in the ED may contribute to or

    moderate this risk.

5. Emergency nurses play an important role in the care of dying adults and their families in

    the emergency department (ENA, 2005).

6. Emotional investment on the part of nursing staff is essential when providing effective

    end of life care (Vachon, 2006).

7. Expert nurses are able to reflect on their experiences in care of the dying (Benner, 1984).

8. Nurses may lack confidence and feel ill equipped to provide end of life care (Beckstrand

    et al., 2006; Ferrell et al., 2000).

Definition of Terms

In this study, terminology was used in the following context:

Emergency Department (ED) – Department located within a hospital which provides services 24 hours per day, 7 days per week. The program mandate is responsible for the assessment, diagnosis, and treatment of all emergency and urgent health care needs; may include less-urgent or non-urgent care, along with outpatient services when other primary care services are unavailable or accessible (retrieved November 5, 2011 from Winnipeg Regional Health Authority, n.d.).

ED healthcare team – Includes physicians, registered nurses, licensed practical nurses, psychiatric nurses, support staff, home care nurses, social workers, occupational therapists, physical therapists, and respiratory therapists (retrieved November 5, 2011 from Winnipeg Regional Health Authority, n.d.).

End of Life Care – Care provided to patients for whom a decision has been made to provide palliative care measures, and whose *death is expected within hours or days*.

Expert Nurse – A nurse who no longer relies on an analytic process to understand a situation, but rather has an intuitive grasp of a situation which allows the situation to be understood quickly without the wasteful consideration of a large range of unfruitful possible problem solutions (Benner, 1984).

Family – Includes persons bound by biology or legal ties but extends to include individuals with whom the patient defines being a "close other" or who function in a "familistic" way such as nurturing, intimacy, economic, social, and psychological support in times of need, support in illness, and companionship (Berry & Griffie, 2006).

Palliative Care –

"...improves the quality of life of patients and families who face life-threatening illness,

by providing pain and symptom relief, spiritual and psychosocial support from diagnosis

to the end of life and bereavement. Palliative care provides relief from pain and other

distressing symptoms; affirms life and regards dying as a normal process; intends neither

to hasten or postpone death; integrates the psychological and spiritual aspects of patient

care; offers a support system to help patients live as actively as possible until death;

offers a support system to help the family cope during the patients illness and in their

own bereavement; uses a team approach to address the needs of patients and their

families, including bereavement counselling, if indicated; will enhance quality of life, and

may also positively influence the course of illness; is applicable early in the course of

illness, in conjunction with other therapies that are intended to prolong life, such as

chemotherapy or radiation therapy, and includes those investigations needed to better

understand and manage distressing clinical complications (World Health Organization,

2002, p. 84)."

Registered Nurse - A person who has successfully completed an approved education program

and who is registered as a registered nurse under the Manitoba Registered Nurses Act (2001)

(retrieved November 5, 2011 from College of Registered Nurses of Manitoba).

Significance of the Study

The purpose of this descriptive exploratory study was to identify the essential nursing

behaviours that expert nurses utilize when providing quality end of life care for dying adults in

the ED. The findings from this study broaden our current understanding of expert nursing care

of the dying by identifying nursing behaviours integral to the care of palliative patients in the ED

setting. As such, this study builds upon and extends the work started by Degner, Gow, and

Thompson (1991) aimed at developing a model of expert nursing practice in care of the dying.

Study findings also provide the basis for educational programs in end of life care in the ED,

directions for practice, and the identification of future areas of research that are needed regarding

the care of palliative patients in ED settings.

Summary

This chapter has outlined the statement of the problem as regards the need to study the

nature of expert nursing behaviours in care of the dying adult patient in the ED. The overall

purpose of the study has been identified, and research questions driving the study have been

presented. Assumptions underlying the study and definitions of terms as they relate to the

project have been provided. The significance of the study has also been discussed. The next

chapter will provide a review of the literature relevant to the study.

Chapter Two: Literature Review

Introduction

This chapter presents the literature review that informed this study. Consistent with qualitative research approaches, the review of the literature was not meant to be exhaustive. Rather, select bodies of literature having relevance to care of the dying patient in the emergency department (ED) were identified, critically analyzed, and synthesized. Five areas of literature were reviewed: i) the concept of end of life care and its relationship to the concept of palliative care; ii) the environment of the ED and its implications for end of life care; iii) emergency nurses' attitudes toward death; iv) empirical work identifying nursing behaviours in care of the dying; and v) dimensions of quality end of life care. Literature regarding the nature of expert practice will be discussed in Chapter 3 in correlation with the study's theoretical frameworks.

The Concept of End of Life Care and its Relationship to Palliative Care

Each person has a unique and often unknown timeframe for the period defined as their "end of life." There is a lack of consensus in the literature regarding a definition of when end of life, and thus the provision of end of life care, begins. The lack of conceptual clarity results in ambiguity and confusion in research examining end of life care. In some instances, end of life care is thought to begin or coincide with decisions being made regarding the withholding or withdrawing of treatment (Kirchhoff & Faas, 2007). In other instances, definitions of end of life care are based on prognostication. Using a prognostication approach, end of life is equated with an expected survival of six months (Heyland et al., 2005) to one year (Wilson et al., 2008). While prognostic approaches to identifying the final stages of illness may help clinicians make resource allocation decisions (e.g., determining which patients can be enrolled on a palliative care program), prognostication is not an exact science, particularly in patients with chronic illnesses, such as end stage heart and pulmonary disease (Chan, 2004). Not surprisingly, the

National Institutes for Health (NIH) (2004) recommend that end of life should not be defined by

a specific timeframe unless there is evidence to support prognostication. Rather, end of life care

may be thought of as encompassing the following components:

> (1) the presence of a chronic disease(s) or symptoms or functional impairments that
>
> persist but may also fluctuate; and (2) the symptoms or impairments resulting from the
>
> underlying irreversible disease require formal (paid, professional) or informal (unpaid)
>
> care and can lead to death (NIH, 2004, p.5)

However, limiting end of life care to focus only on symptomatology detracts from the provision

of end of life care in a holistic manner, thereby increasing the potential risk for needs to go

unmet by patients not experiencing symptoms.

In the position statement, *Providing Nursing Care at the End of Life,* the Canadian

Nurses' Association (CNA) (2008) utilized a definition of end of life put forward by Lunney,

Foley, Smith, and Gelband (2003). Lunney et al. (2003) defined end of life as the "period of

time during which an individual copes with declining health from an ultimately terminal illness –

from a serious though perhaps chronic illness or from the frailties associated with advanced age

even if death is not clearly imminent" (p.22). This broader definition encourages nurses to

initiate discussions regarding end of life earlier in the illness trajectory. Addressing issues

related to end of life care provides an opportunity to implement goals of care that encompass a

more holistic approach which includes the patient, family, and health professionals.

Due to the lack of conceptual clarity, the terms 'end of life care' and 'palliative care' are

frequently used interchangeably (Chan, 2006). Unlike end of life care, however, palliative care

has been well defined by the World Health Organization (WHO):

Palliative care improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement. Palliative care provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patients illness and in their own bereavement; uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated; will enhance quality of life, and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications. (WHO, 2002, p. 84)

There has been a recent shift to incorporate the principles of palliative care into clinical practice for all patients, regardless of the presence of a life-limiting disease (Chan, 2006). Given the uncertainty of prognostication of end of life, it is appropriate to utilize these principles within the ED setting (Chan, 2006). The incorporation of palliative care principles may provide emergency nurses with a holistic framework in which to facilitate the provision of quality end of life nursing care to the dying patient.

Emergency Department Environment and Implications for End of Life Care

Within Canada, hospitals continue to be the most common location where death occurs. In a quantitative study assessing location of deaths within Canada, 66% of deaths occurring during the period of 1994 to 2004 occurred in a hospital setting (Wilson et al., 2009). EDs are

traditionally thought to be places where resuscitation and life-saving treatments are

implemented; not as places where end of life care is provided (Chan, 2006). However, death

occurs in the ED and the culture and environment of the ED may contribute to the quality of end

of life nursing care provided. The goal of an ED is to evaluate, treat, admit or discharge patients.

EDs are thus places of transition and patients are not intended to stay for prolonged periods of

time (Chan, 2004). Alongside the transitional nature of an ED, emergency healthcare providers

also care for patients who present to the department with a wide gamut of entrance complaints

that may range from minor lacerations to cardiac arrests. A report presented by the Canadian

Institute of Health Information (CIHI) highlights the variations of patient acuity level seen in

emergency departments. A summary of ED visits during 2009-2010 identified that of the 5.8

million ED visits reported to a national registry using the Canadian Triage and Acuity Scale,

39.9% of visits were triaged as urgent and 38.1% of visits were triaged as less urgent. The

remainder of visits were distributed amongst resuscitative, emergent, and non-urgent acuity

levels (CIHI, 2011). As a result of the 24 hours/day, 7days/week accessibility of emergency care

settings, the ED is often the gateway to the healthcare system whether for hospital admission or

support services outside of the hospital.

Despite the notion that the ED is a place to receive curative treatment, it is not

uncommon for dying patients to visit the ED (Barbera, Paszat, & Chartier, 2006; Lawson, Burge,

McIntyre, Field, & Maxwell, 2008). Patients with a known terminal illness and their families

seek care from emergency staff for a variety of reasons that may include symptom management

and caregivers' inability to cope at home (Marco & Schears, 2006; Schears, 1999).

Inaccessibility to other care providers outside of regular business hours contributes to the usage

of the ED by patients with terminal illnesses (Lawson et al., 2008). Unfortunately, these patients

may need to endure wait times which may be physically and emotionally taxing for them.

The ED can be a surreal setting where patients are subjected to unfamiliar sounds and

smells while lying on uncomfortable stretchers for extended periods of time (Schears, 1999).

Emergency nurses have identified the poor physical design of EDs as an obstacle in providing

end of life care due to the lack of privacy permitted for the dying patient and his/her family

(Heaston et al., 2006).

A study conducted with a random sample of 169 emergency nurses in the United States

found ED nurses perceived an increased workload to be an obstacle in providing end of life care

(Heaston et al., 2006). The fast pace of an ED may also limit the development of relationships

with patients and families which is necessary in providing quality end of life care (Chan, 2004).

Building a trusting relationships and continuity of care are challenged by shift work and frequent

relocation of patients within the ED (Bailey, Murphy, & Porock, 2011a; Clarke, 2008). Patients

are often moved within the department to facilitate throughput of emergency patients as their

conditions stabilize or deteriorate (Bailey et al., 2011a). The constant movement of patients

creates ongoing fluctuations in nurse-to-patient ratios and lack of continuity for both patients and

nurses who care from them (Bailey et al, 2011a.).

Providing quality end of life care requires health professionals to identify the needs of the

dying patient and their family, establish goals of care, and address any concerns. A therapeutic

relationship between health professionals and the patient and their family must exist in order for

this to occur, and the literature documents that the relationship between the nurse and patient is

the cornerstone of effective palliative care nursing (Dhalin & Giansiracusa, 2006). Ideally, this

relationship is built over a period of time and in a private setting with little chance of

interruption. Nurses also need to be able to communicate effectively with patients and families

in order to develop therapeutic relationships as such communication yields important and

valuable information that can help inform the care that is provided (Dhalin & Giansiracusa,

2006). Unfortunately, dying patients who present to the ED are often unknown to the emergency

staff and, therefore, no previously established relationship exists. The limited information that

clinicians have about the patient speaks to the need for therapeutic relationships to be developed

quickly between the patient, family members, and healthcare team (Bailey, Murphy, & Porock,

2011b). Campbell and Zalenski (2006) thus recommend emergency nurses ask a few additional

questions to assist in recognizing and addressing the needs of terminally ill patients and their

families. However, these recommendations require evaluation in clinical practice to determine if

this additional information is beneficial and contributes to improving end of life care in the ED.

Along with the initial nursing assessment data, these authors suggest that nurses also

assess the patient and family awareness of the presence of an incurable illness; determine patient

preferences for care and determine how rapidly these treatment goals can be established; identify

what can be done to relieve distressing symptoms; and determine what can be done to ease the

family's distress and how to meet their needs (Campell & Zalenski, 2006). The ability to listen

and gather information, along with being sensitive while providing essential information, is

necessary for a successful relationship to develop between the nurse and the patient and their

family (Dahlin & Giansiracusa, 2006).

Overcrowding of EDs is a concern across Canada. A Canadian survey of 158 ED

directors found 62% of participants reported overcrowding of their departments to be a problem

within the previous year (Bond et al., 2007). Lack of available acute care beds results in acutely

ill and dying patients remaining within the ED instead of being admitted. These patients utilize

resources and space within the ED thereby blocking access for new patients who also require

care. Negative impacts of departmental overcrowding identified in the study included: increased

stress among nurses, increased ED wait times, and boarding admitted patients in the department

while waiting for beds (Bond et al., 2007). Overcrowding decreases patient privacy, decreases

access to timely treatment, and increases nurses' workload which limits time available at

patients' bedsides. These barriers created from overcrowding thus challenge nurses' abilities to

provide high quality end of life care.

Emergency Nurses' Attitudes towards Death

Studies examining nurses' attitudes towards death and caring for dying patients have

been conducted; however, few have examined the attitudes of emergency nurses. One study

conducted by Payne and colleagues (Payne, Dean, & Kalus, 1998) surveyed 23 hospice nurses

and 20 accident and emergency (A & E) nurses in the United Kingdom to compare the levels of

death anxiety between the two groups. Payne et al. (1998) found one quarter of A & E nurses

were less accepting of, and had a greater fear of death compared with hospice nurses. This

finding is of concern as research has found that nurses with a greater fear of death have less

positive attitudes toward caring for dying patients (Rooda, Clements, & Jordan, 1999). A

potential explanation for these differences advanced by the authors was that hospice nurses

indicated they purposely chose to work with dying patients, which suggests a low death anxiety

and a high acceptance of death (Payne et al., 1998). In comparison, A & E nurses indicated they

chose to work in the ED because of the variety of patients seen, procedures done, and the

adrenalin rush and excitement of the department. There was no indication of interest in working

with dying patients, despite the awareness that death occurs frequently in the ED. Thus, A & E

nurses appear to be faced with caring for dying patients as a consequence of their job, rather than

choosing to work with such patients on a regular basis (Payne et al., 1998).

Emergency nurses' attitudes toward the provision of end of life care is influenced by the

emotional impact that death and dying has on an emergency nurse (Bailey et al., 2011b). A

qualitative study conducted with emergency staff (n = 10), patients with terminal illnesses (n =

6), and relatives who accompanied a patient on the ED visit (n = 7) explored how emergency

nurses manage the emotional impact of death and dying (Bailey et al., 2011b). Although

inclusion criteria of the study were not reported, patients were diagnosed with various illnesses

including cancer, heart failure, and multiple sclerosis, and they presented to the ED for a variety

of reasons including dyspnea, pain, falls, overdose, and deterioration (Bailey et al., 2011b).

Nurses, who had personal death anxieties, feared saying or doing something wrong for the dying

patient or bereaved family, or felt unprepared, were unable to develop a nurse-patient

relationship that provided the level of support required by the patient (Bailey et al., 2011b).

Nurses with poor coping mechanisms in response to these fears often withdrew themselves from

the bedside as soon as possible and allowed other members of the healthcare team to care for the

patient and family (Bailey et al., 2011b).

The importance ED nurses place on technical aspects of nursing is another factor that has

been identified in the literature as affecting nurses' attitudes towards providing patient care. A

convenience sample of 156 accident and emergency (A&E) nurses in the United Kingdom

(U.K.) were surveyed to identify their perceptions of caring (Walsh & Dolan, 1999). In

comparison with data from a similar study of 1430 general nurses' perceptions of caring within

the U.K., A & E nurses placed slightly greater importance on technical aspects of care, such as

explaining a clinical procedure to a patient, and less importance on sitting with a patient and

getting to know them as a person. These differences were partially attributed to the greater

numbers of ambulatory patients and high rate of patient turnover in EDs which provided nurses

with less opportunity to have contact with patients (Walsh & Dolan, 1999). Technical skills

provided by nurses frequently include pain and symptom management and monitoring the

effectiveness of these interventions. Providing pain and symptom management are nursing skills

that align with the WHO palliative care definition (WHO, 2002); however, these skills are one of

many elements which contribute to the provision of quality end of life nursing care. The risk in

placing a greater emphasis on technical versus psychosocial aspects of care in dying patients is

that it precludes nurses from being able to provide a holistic approach to care which incorporates

a person's priorities, values, and choices as recommended by the Canadian Nurses Association

(CNA, 2008).

Circumstances surrounding a patient's end of life care, whether the death is due to trauma

or a terminal illness, have been found to influence the amount of attention and level of care

patients receive from healthcare providers. Results of a three-phased ethnographic study

exploring end of life care in the ED in regards to how care is delivered to dying and deceased

patients and bereaved family members identified two trajectories of end of life care in the ED -

the *spectacular* and the *subtacular* (Bailey et al., 2011c). The study included a variety of data

sources including informal field interviews, researcher observation, and formal interviews with

ED healthcare providers, including nurses (n = 11), physicians (n = 2), and technicians (n = 2).

Interviews were also conducted with patients diagnosed with a terminal illness who had visited

an ED at least once in the last 6 months (n = 7), and with family members who had accompanied

patients (n = 7).

Deaths occurring along the spectacular trajectory involve sudden loss of life – often due to trauma. These deaths are resource intensive and may include care providers from a variety of disciplines and specialties (Bailey et al., 2011c). Even after death, discussions of these situations and retelling of events frequently continue on in conversations amongst staff members. In contrast, deaths occurring along the subtacular trajectory do not consume the same amount or the same type of resources, and these types of deaths do not elicit the heroic responses that are frequently depicted in society in regards to the activity that occurs in the ED. Bailey et al. (2011c) identified that healthcare providers' attention was less intense toward patients associated with subtacular trajectory of end of life care. For example, study observations noted that continuous nursing care and support was provided to patients located in the resuscitation room, whereas, patients receiving comfort measures were infrequently checked upon and were relocated to areas of the ED that patients perceived and experienced as being "stuck in the corner and left there" (Bailey et al., 2011c, p.366). Health care provider participants fearful of death and dying reported distancing themselves from dying patients and avoiding the development of relationships with patients and families. Overall, Bailey et al. (2011c) identified that the needs of patients associated with the subtacular trajectory of end of life were neglected compared with those patients experiencing end of life care along the spectacular trajectory. Further research using a larger random sample of nurse participants is required to confirm if the attitudes and behaviours presented in Bailey et al.'s (2011c) study are supported and able to be generalized.

Empirical Work Identifying Nursing Behaviours in Care of the Dying

Little research has been conducted examining emergency nurses' behaviours in providing quality end of life nursing care. A notable exception is the study conducted by Heaston and colleagues (2006) who surveyed 169 emergency nurses in the United States to rank

predetermined obstacles and supportive behaviours when providing end of life care. Supportive

behaviours were related to issues of communication, making the patient's death easier for the

family, availability of staff support, and the family accepting the fact that the patient was dying

(Heaston et al., 2006). Communication behaviours perceived to be helpful included good

communication between the physician and nurse, physicians communicating with the family

after the patient's death, and having one family member designated to be the primary point of

contact (Heaston et al., 2006).

Beckstrand and colleagues (Beckstrand, Smith, Heaston, & Bond, 2008) then surveyed

272 emergency nurses to identify their perceptions of the size, frequency, and magnitude of the

obstacles and supportive behaviours identified in the work conducted by Heaston et al (2006).

Allowing family members adequate time to be alone with the body, having good communication

between the physician and nurse caring for the dying patient, and providing a peaceful, dignified

bedside scene for family members after death occurred were supportive behaviours ranked with

the highest scores (Beckstrand et al., 2008). In contrast, having the opportunity to participate in

professional debriefings after traumatic deaths, talking with the patient about his or her feelings

and thoughts about dying, and having enough time to prepare the family for the expected death

of a patient were the supportive behaviours ranked with the lowest scores (Beckstrand et al.,

2008).

While the aforementioned studies provide a starting point from which to understand the

obstacles and supportive behaviours associated with providing end of life care in the ED, the

findings must be viewed in light of their respective limitations. Both studies failed to provide a

definition of the concept of end of life care. No further explanations or descriptions of the

behaviours reported were provided and thus, our understanding of the complete nature of these

supportive behaviours is limited. The small, non-random sample sizes preclude generalizability

of the findings. As well, participants of both studies reported significant number of years as

registered nurses and as emergency nurses. The participants in the study conducted by

Beckstrand et al. (2008) reported participants had a mean of 14.5 years as an ED nurse and

Heaston et al.'s (2006) reported participants had a mean of 15.4 years as an ED nurse. Further

research is needed to confirm if less experienced ED nurses identify and rank obstacles and

supportive behaviours in the same manner.

A series of comparative qualitative studies aimed at explicating expert nursing care of the

dying have been conducted. The types of dying patients involved in these studies includes adult

palliative care inpatients (Degner et al., 1991); adult intensive care patients (McClement &

Degner, 1995); adult medical inpatients (Harbeck, 1995); pediatric medical inpatients (Hawkins,

1995); patients receiving home-based palliative care (Helwar, 1994); and those living in personal

care home settings (Wowchuk, 2004). Common themes related to expert care of the dying

patient in hospital settings identified in these studies included: i) responding during the death

scene; ii) providing comfort; iii) responding to anger; iv) enhancing personal growth; v)

responding to colleagues; vi) enhancing the quality of life during dying; and vii) responding to

the family (Degner et al., 1991; Harbeck, 1995; Hawkins, 1995; Helwar, 1994; McClement &

Degner, 1995; Wowchuk, 2004). A summary of the behaviours identified in each study is

provided in Table A1 (see Appendix J).

The study completed by Beckstrand and colleagues (2008) previously described support

the themes of responding during the death scene, responding to the family, and responding to

colleagues. Although not identified as "expert" nurse behaviours by Beckstrand et al. (2008),

ED nurses perceived that allowing family members adequate time alone with the patient after

death, providing a peaceful and dignified bedside scene, and good communication between nurse

and physician are key behaviours considered to be supportive in the provision of end of life care.

The Canadian Hospice Palliative Care Association (CHPCA) is a national non-profit

organization that advocates for quality end of life and hospice palliative care in Canada. In 2002,

the CHPCA Nursing Standards Committee developed hospice palliative care nursing standards

of practice. These standards are based on an adaptation of the Supportive Care Model developed

by Davies and Oberle (1990) to reflect hospice palliative care nursing practice. The model,

which reflects a supporting nursing role, is comprised of six interwoven dimensions. These

dimensions include: valuing, connecting, empowering, doing for, finding meaning, and

preserving integrity (Davies & Oberle, 1990). Each dimension of the Supportive Care Model has

been adapted into a standard of practice along with recommended nursing behaviours. As

described by the CHPCA nursing standards committee, "valuing" is in an attitude that "believes

in the intrinsic worth of others, the value of life and that death is a natural process" (CHPCA,

2002, p.14). Ensuring access to resources, providing care in a manner that is sensitive to the

diversity of patients and families, and delivering care with awareness of each individual's unique

characteristics and abilities are behaviours that guide nurses within the "valuing" dimension.

"Connecting" involves building therapeutic relationships with patients and families.

Connections are sustained when nurses continue to be available and spend time with family and

give of himself or herself. Connection with families continues during bereavement care;

however, over time, the connection eventually concludes. Strong communication skills, active

listening, providing information in a timely, sensitive, and honest manner are skills that facilitate

the development of a therapeutic connection.

Providing care in a manner that empowers the person and family is the foundation of the nursing standard labelled as "empowering." Assisting the person and family to identify care priorities and to build on their own strengths, along with providing information ranging from disease process, symptom management, and the dying process are a few of the recommended behaviours that nurses engage in as a means to empower patients and families.

The standard of "doing for" involves the provision of nursing care to be administered "based on the best practice and/or evidence-based practices in the following areas: pain and symptom management, coordination of care and advocacy" (CHPCA, 2002, p.18).

Assisting the person and the family to find meaning in their life and their experiences encompasses the standard of "finding meaning." Offering hope, acknowledging and discussing death, and meeting the spiritual needs of the patient and family are nursing behaviours that assist the patient and family in making sense of their situation.

The final nursing standard identified by the CHPCA is "preserving integrity" which encompasses the preservation of the integrity of the nurse, person, and family. Practicing self-care and participating in continuing education and research are behaviours that preserve nurses' integrity. Providing comprehensive and compassionate nursing care, acknowledging grief will be experienced despite the provision of excellent palliative care, integrating palliative care as a health promotion activity, supporting family caregivers to participate in self-care, and recognizing and addressing signs of stress in caregivers to prevent the deterioration of their health status are nursing strategies that contribute to preserving the integrity of the person and family.

The behaviours outlined in the CHPCA nursing standards are congruent with behaviours identified by expert nurses caring for adult palliative care inpatients (Degner et al., 1991); adult

intensive care patients (McClement & Degner, 1995); adult medical inpatients (Harbeck, 1995);

pediatric medical inpatients (Hawkins, 1995); patients receiving home-based palliative care

(Helwar, 1994); and those living in personal care home settings (Wowchuk, 2004). Akin to

behaviours contributing to the standards of "valuing" and "empowering," expert nurses identified

behaviours that sought to enhance the quality of life of patients while dying. Behaviours that

promote the personhood of patients, promote the patient's choice and control, and help patients

do things that are important to them contribute to enhancing a patient's quality of life while

dying (Degner et al., 1991; Harbeck, 1995; Hawkins, 1995).

Expert nurses also identified behaviours that facilitated "connecting" with patients similar

to those identified by the CHPCA standards. Utilizing strong communication skills, actively

listening, and responding to the need for information from both the patient and family members

are behaviours used to connect and develop a rapport with patients and families (Degner et al.,

1991; Harbeck, 1995; Hawkins, 1995; Helwar, 1994; McClement & Degner, 1995; Wowchuk,

2004).

Consistent with the behaviours considered part of the standard "doing for," expert nurses

identified eliminating or reducing both physical pain and psychosocial pain as behaviours that

provide comfort for the patient (Harbeck, 1995; Hawkins, 1995; Helwar, 1994; McClement &

Degner, 1995; Wowchuk, 2004).

Expert nurses engaged in behaviours that responded to the family; these behaviours are

comparable to those described within the "finding meaning" standard. Reducing the potential for

future regret, preparing the family for the death event, and facilitating the transition from

curative to palliation are behaviours used to respond to the family (Degner et al., 1991; Harbeck,

1995; Hawkins, 1995; Helwar, 1994; McClement & Degner, 1995; Wowchuk, 2004).

Demonstrating the nurse had a defined role in care of the dying allowed expert nurses to receive emotional reward and experience personal growth (Degner et al., 1991). Expert nurses did not identify behaviours related to self-care as was identified within the standard "preserving integrity" of the nurse. However, it may be possible that enhancing personal growth may be considered a form of self-care. Behaviours considered to preserve the integrity of the patient and family members, such as providing comprehensive and compassionate nursing care, were weaved amongst the expert nursing behaviours that enhanced the patient's quality of life while dying and behaviours that responded to the family.

Similarities identified by the empirical work examining expert nursing care of the dying in various care settings and standards developed for nurses providing hospice palliative care suggest these key behaviours are essential in care of the dying regardless of the setting and provide a point of comparison for expert nurse behaviours identified by emergency nurses.

Nurses play a key role in providing end of life care; however, not all nurses develop the level of expertise needed to provide end of life care that is supportive to patients and family members (Bailey et al., 2011b). A qualitative study using unstructured observation and semi-structured interviews with emergency staff, patients with terminal illness, and their families (n = 28) reported emergency nurses develop expertise in end of life care through the progression of three stages (Bailey et al., 2011b). The first stage involves the nurse investing one's self into the nurse-patient relationship. Through the use of 'therapeutic self,' nurses were able to know the patient and recognize the individual needs of the patient.

The second stage involves the management of emotional labour. When a nurse believes his or her current emotional status does not coincide with what is expected of the situation, nurses engage in emotional labour as a means to manage or alter their emotional status; Bailey et

al. (2011b) propose that emotional labour is essential as a means for nurses to manage boundaries of intimacy and distance.

The third stage involves the development of emotional intelligence in providing end of life care (Bailey et al., 2011b). Emotional intelligence consists of self-awareness, social awareness, and relationship management. Reflecting on past experiences, understanding one's core values, and identifying strengths and weaknesses in an individual's practice contribute to being self-aware. Being able to self-manage and maintain control in a fast-changing environment also develops an emergency nurse's emotional intelligence. Being socially aware requires the nurse to be able to sense and understand another individual's emotions and react appropriately. The final aspect in the development of emotional intelligence is the ability to manage relationships. Relationship management involves the skill to manage conflict, as well as inspire, motivate, and develop others.

Environmental constraints of the ED, the nurse's willingness to utilize the 'therapeutic self' to develop a nurse-patient relationship, and the nurse's coping mechanisms used to manage his or her anxieties around death impact emergency nurses' progression through the three stages of developing expertise (Bailey et al., 2011b). The behaviours identified by Bailey et al. as being essential in the development of expertise around death and dying in the ED may assist emergency nurses who are seeking to improve the quality of end of life care provided in the emergency setting. However, further research is required to confirm that these behaviours facilitate the development of expertise and thus improve the quality of end of life care of dying patients in the ED.

Dimensions of Quality End of Life Care

In order to identify expert nursing behaviours in end of life care, it is necessary to understand what is meant by quality in end of life care. There has been a shift among health researchers toward conceptualizing, assessing, and measuring the quality of end of life care after significant deficits were identified in care of dying patients (Rosenfeld & Wenger, 2000). The Study to Understand Prognoses and Preferences in Outcomes and Risks of Treatment (SUPPORT) brought to light the need for guidelines, industry standards, and further research related to end of life care (Connors et al., 1995). The SUPPORT study was a two-phased study completed in the United States that involved two years of observational study followed by two years of controlled clinical trials with patients (n=4804) and their physicians (Connors et al., 1995). Study findings identified inadequate assessment of and control of symptoms, lack of communication in regards to prognosis and treatment preferences, limited access to palliative care services, and a lack of alternatives to hospital-based care at the time of death (Field & Cassel, 1997).

Quality in the care of dying patients has been associated with a 'good death.' The Institute of Medicine (IOM) Committee on Care at the End of Life defined a good death as "one that is free from avoidable distress and suffering for patients, families and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural and ethical standards" (Field & Cassel, 1997, p.24). Various frameworks and models of end of life care have been presented within the literature to identify components that are salient indicators of quality of care (Chochinov, Hack, McClement, Kristjanson, & Harlos, 2002; Emanuel & Emanuel, 1998; Rosenfeld & Wenger, 2000; Singer, Martin, & Kelner, 1999; Steinhauser et al., 2000). The supporting or upholding of patient dignity is often considered an essential

component in providing quality end of life care (Thompson & Chochinov, 2008). Though

plagued by definitional ambiguity, over the past decade, empirical work has been completed to

better understand the concept of dignity from the perspective of the dying patient.

Chochinov and colleagues have developed a model of dignity in the terminally ill

(Chochinov et al., 2002). Three categories that contribute to the foundation of the Dignity Model

include: illness-related concerns, dignity conserving repertoire, and social dignity inventory

(Chochinov et al., 2002). Illness-related concerns are comprised of issues related to the illness

that threaten or impact an individual's sense of dignity. Patients' symptom distress and level of

independence are factors contributing to illness-related concerns (Chochinov, 2002).

Dignity-conserving repertoire incorporates psychological and spiritual approaches used

by patients to maintain their sense of dignity (Chochinov, 2002). Dignity-conserving repertoire

consists of dignity-conserving perspectives of the patient and dignity-conserving practices that

can be incorporated to reinforce an individual's sense of dignity (Chochinov, 2002). Dignity-

conserving practices include: continuity of self, role preservation, maintenance of pride,

hopefulness, autonomy/control, generativity/legacy, acceptance, and resilience/fighting spirit.

Living in the moment, maintaining normalcy, and finding spiritual comfort are behaviours

considered to be dignity-conserving practices (Chochinov, 2002).

The final component of dignity-conserving care, social dignity inventory, refers to the

social issues and relationship dynamics that contribute to or detract from an individual's sense of

dignity (Chochinov, 2002). Privacy boundaries, social support, care tenor, burden to others, and

aftermath concerns are subthemes contributing to the social dignity inventory (Chochinov,

2002). Providing dignity-conserving care from the perspective of the dying patient may assist

nurses in the provision of quality end of life care in the ED.

Singer et al. (1999) sought to identify and describe elements of quality end of life care from the patient's perspective. Participants from three patient groups, dialysis patients (n = 48), people with human immunodeficiency virus infection (n = 40), and residents of a long-term care facility (n = 38), were interviewed; study findings identified five domains of quality end of life care: adequate pain and symptom management; avoiding inappropriate prolongation of dying; achieving a sense of control; relieving burden; and strengthening relationships (Singer et al., 1999). As identified by the authors, data used in this study represents secondary analysis of data originally collected for another purpose. Data from patients receiving dialysis and patients with HIV were originally collected to examine advance care planning in these patient populations. Patients residing in long-term care facilities had been originally interviewed to gain understanding of individuals' perspectives of control at the end of life (Singer et al., 1999). Due to the focus of the original studies, findings arising from the secondary data analysis that was conducted may not have captured all the issues related to patients' perceptions of end of life care. Therefore, validation of the study's findings using primary data is required.

Steinhauser and colleagues (2000) examined a good death from the perspective of patients, families, and healthcare providers. Patients with advanced chronic illnesses (n = 340), bereaved family members (n = 332), physicians (n = 486), and other care providers including chaplains (n = 120), hospice volunteers (n = 105), social workers (n = 107), and nurses (n = 97) were surveyed and asked to rate 44 attributes of experience at the end of life. Attributes identified as being important by all the study participants included pain and symptom management, preparation for death, achieving a sense of completion, decisions about treatment preferences, and affirming the whole person (Steinhauser et al., 2000). However, no further explanation of the attributes was provided and is a limitation of the study.

Viewing the death experience as multidimensional, Emanuel and Emanuel (1998) developed a framework that proposed eight modifiable dimensions of end of life care: physical symptoms, social relationships and support, hopes and expectations, psychological and cognitive symptoms, economic demands and care giving needs, and spiritual and existential beliefs. Although the framework synthesizes the dying process, it has not been empirically validated (Chochinov, 2002).

Rosenfeld and Wenger (2000) recognized many common themes amongst the various quality of care models published in the literature and summarized them into eight general quality areas: i) patient self-determination; ii) symptom control; iii) multidimensional quality of life; iv) family well-being; v) satisfaction with care; vi) survival duration; vii) end of life interventions; and viii) resource use and costs. Thus taken as a whole, the literature examining quality end of life care suggests that the provision of such care requires a multidimensional approach which involves the dying patient and their family, interdisciplinary health teams, institutional support, and systemic support. In essence, quality end of life care is the provision of holistic individualized care. The dimensions of quality end of life care identified in the literature provide nurses with a framework to facilitate a good death and provide a point of comparison against which the behaviours identified by nurses in the present study could be compared.

Once the definition of quality end of life care is established, the next challenge is the ability to effectively measure it. Thompson and McClement (2002) propose that current standards of measuring quality care do not adequately measure the quality of end of life care. Traditionally, patient outcome measurements, medical models which focus on patient, practitioner, and systems and patient satisfaction surveys have been used to evaluate the quality of care (Thompson & McClement, 2002). These traditional assessment methods do not capture

the holistic nature of nursing care and therefore it is difficult to accurately evaluate the

contribution of nursing when caring for a dying patient. The authors suggest that it may be more

appropriate to measure the processes of care that patients and families deem relevant and

important, rather than focusing on expected patient outcome (Thompson & McClement, 2002).

Understanding a good death and identifying the key components of quality end of life care will

assist in the development of tools to measure the nursing care currently provided and identify

opportunities for future end of life care to be improved upon. The identification of expert nurse

behaviours in care of the dying patient in the ED may thus contribute to the development of

measures that help to index the nature and impact of nursing care on quality end of life care.

Summary

This chapter reviewed six areas of literature relevant to the proposed study. A review of

the concept of end of life care and its relationship to the concept of palliative care brought

forward the differences in how these terms are defined in the literature and in clinical practice.

The relevance and appropriateness of palliative care principles as regards the provision of end of

life care within the emergency setting was identified. Literature suggests that the environment of

the ED influences the provision of end of life care. The physical design, lack of time and

resources, and transitional nature of the ED were identified as factors that may impact

emergency nurses' ability to provide quality end of life care. Emergency nurses' attitudes

toward death suggest that emergency nurses may be less comfortable in the provision of end of

life nursing care despite the fact that death—both expected and unexpected—is not uncommon

in the ED. Existing empirical work identifying expert nursing behaviours in care of the dying in

a variety of settings provides a foundation to identify similarities and differences in nursing

behaviours in care of the dying identified by expert emergency nurses in this study in

comparison with other care settings. Finally, the dimensions of quality end of life care have been

identified in the literature and provide nurses with a framework to facilitate a 'good death' for

dying patients. These dimensions also provide a point of comparison against which the

behaviours identified by nurse experts in this study can be compared. The next chapter will

provide a description of the theoretical frameworks selected to guide this project.

Chapter Three: Theoretical Framework

Introduction

This chapter will describe and critique the two theoretical frameworks that were used to sensitize the researcher to important concepts and ideas relevant to this study. Theoretical frameworks provide structure and context when a specified phenomenon is examined and they provide guidance and direction to move the research forward. A theory is "an idea that explains experience, interprets observation, describes relationships, and projects outcomes" (Parker, 2005, p.4). Utilizing a systematic approach to describe and explain a phenomenon in a structured manner results in a greater understanding of that phenomenon (Parker, 2005).

For the purpose of this study, two sensitizing theoretical frameworks were used. The first framework was adapted from Jeanne Quint's (1967) theoretical perspective, Model of Nursing Care of the Dying. The second framework was Benner's (2001) Novice to Expert model of nursing practice. This chapter will provide a description and critique of these two frameworks and their relevance to the study.

Quint's Model of Nursing Care of the Dying

Description of Quint's Model. As a nursing leader, teacher, and researcher, Dr. Jeanne Quint Benoliel played a key role in the development of knowledge concerning how nurses care for the dying patient and their family (Quint, 1967). Quint's area of theoretical work focused on how nurses received their education in regards to the provision of end of life care. She identified that nursing educational programs were not adequately preparing nurses for the responsibility to care for dying patients. In particular, Quint found the majority of nursing students entering training had minimal exposure to death and dying. Without the necessary education and emotional support to deliver end of life nursing care, Quint proposed that dying patients would

receive inadequate nursing care. She also postulated that when nursing students were involved

in traumatic and emotionally unsettling death related experiences, such situations would

negatively affect students over the long term and place them at risk to develop feelings of

inadequacy as a nurse throughout their career. Lastly, Quint theorized that the lack of positive

experiences in caring for dying patients would increase the likelihood that a nurse would

withdraw from being personally involved with the death of a patient, resulting in the patient

receiving inadequate care (see Figure 1).

| Exposure to the Dying & Lack of Education | → | Death Anxiety & Negative Attitudes | → | Withdrawal from Care of the Dying |
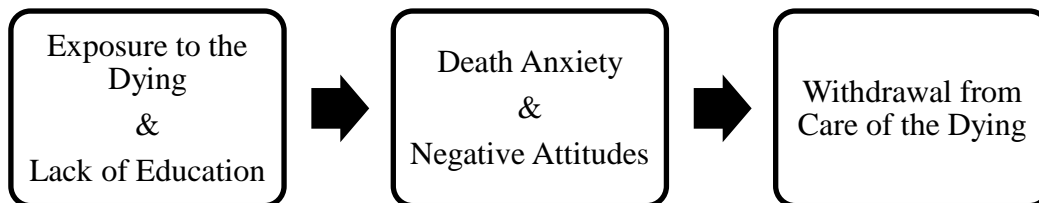
Figure 1. Quint's Theoretical Model

   Quint (1967) identified that it was critically important for health professionals to receive

education in end of life care if they were to care effectively for dying patients. Without this

education, Quint postulated that nurses exposed to care of the dying patient would adopt the

behaviour of surrounding professionals and limit their involvement in death-related situations.

   Critique of Quint's Model. Quint's theoretical framework has not been systematically

tested (Degner & Gow, 1988); however, empirical reports exist which support her perspective.

Degner and Gow utilized Quint's framework in a quasi-experimental study which evaluated the

effectiveness of two different educational approaches in preparing nurses (n = 306) to care for

dying patients. The first approach examined third year nursing students who received death

education via an integrated approach throughout their four-year degree program. In comparison,

the second approach examined nursing students who received a required third year course in

palliative care that included death education and supervised clinical practice. The study found

that participants who received the required palliative care course had an initial increase in death

anxiety, but they also had improved attitudes towards death at the end of the course. One year

after graduation, self-reports of participants receiving the required course indicated that they felt

more comfortable engaging dying patients in conversations regarding their emotional concerns

and their preferences on where to die. This group of participants also reported taking

responsibility to inform family members of changes in regards to the patient's condition (Degner

& Gow, 1988). These findings support Quint's theoretical assertion that nurses provided with

education on care of the dying may be less inclined to withdraw from the patient. However, a

limitation of the study is that no other objective measure was used to verify whether or not

students were actually performing the self-reported behaviours.

In an effort to understand nurses' attitudes toward death, Shusterman and Sechrest (1973)

conducted a quantitative study with hospital nurses working in surgical and medical units of care

(n = 98). The authors reported that more experienced nurses were satisfied with traditional care

provided to dying patients. Behaviours which aligned with traditional care included isolating the

dying patient from other patients and refraining from informing patients of their true prognosis

(Shusterman & Sechrest, 1973). These are the types of behaviours Quint was concerned novice

nurses may emulate when not provided with sufficient education and support when providing

end of life nursing care.

Pearlman, Stotsky, and Dominick (1969) completed a study of 59 participants which

included nurses, student nurses, and healthcare aides working in nursing homes to explore their

attitudes toward death and dying. Nurses who had five or less experiences with death were

found to have a more open attitude toward death compared with nurses who had six or more

experiences with death (Pearlman et. al., 1969). More experienced nurses felt uneasy discussing death with their dying patients, while less experienced nurses were less defensive during these conversations with dying patients (Pearlman et. al., 1969).

In a study of 403 nurses, Rooda et al. (1999) studied nurses' attitudes towards death and caring for dying patients. Nurses who were more fearful of death had less positive attitudes towards caring for dying patients compared with nurses who were less fearful of death (Rooda et al., 1999). Attitudes of nurses who cared for a greater percentage of dying patients were more positive about providing end of life care than nurses who had cared for a smaller percentage of dying patients (Rooda et al., 1999). Although, participants had a mean of 14.5 years of nursing experience, attitudes toward caring for dying patients were not found to be significantly related to nursing experience. Unknown from the data presented was whether nurses who cared for a greater percentage of dying patients were more experienced or less experienced than nurses with less exposure to care of the dying. Greater understanding in regards to nurses' attitudes in caring for dying patients would have been gleaned from this study had information related to the distribution of nursing experience and the frequency of exposure to dying patients been reported.

Some research related to death anxiety in nurses working within the emergency department (ED) setting has been conducted. However, in general, studies tend to focus on sudden traumatic deaths. Payne et al. (1998) completed a mixed methods comparison study of hospice nurses and emergency nurses to measure participants' attitudes towards death, as well as to identify individual strategies to cope with caring for the dying. Emergency nurses (n = 20) were found to have a higher death anxiety than their hospice counterparts (n = 23) (Payne et al., 1998). Half of the emergency nurses were unable to recall an experience where they felt they had cared for a dying patient particularly well; limited time spent with patients was the prime

explanation given for the inability to recollect a positive experience. Conversely, hospice nurses were more likely to recall both good and challenging experiences related to caring for a dying patient (Payne et al., 1998).

Quint's model identified factors that influence the provision of nursing care of the dying patient. Researchers examining care of the dying in the adult ICU (McClement & Degner, 1995), inpatient pediatric units (Hawkins, 1995), adult medicine unit (Harbeck, 1995), personal care home (Wowchuk, 2004), and community (Helwar, 1994) have suggested revisions to Quint's initial model to more fully capture the factors influencing nursing care of the dying in those settings. Therefore, Quint's model has been revised to include additional factors that are relevant for nurses working in the ED (see Figure 2). A review of the literature suggests that additional factors not included in her original model impact end of life care of patients received in the ED. These factors include the lack of empirical data to direct the provision of end of life care in the ED and the transitional environment of the ED with an emphasis on recovery.
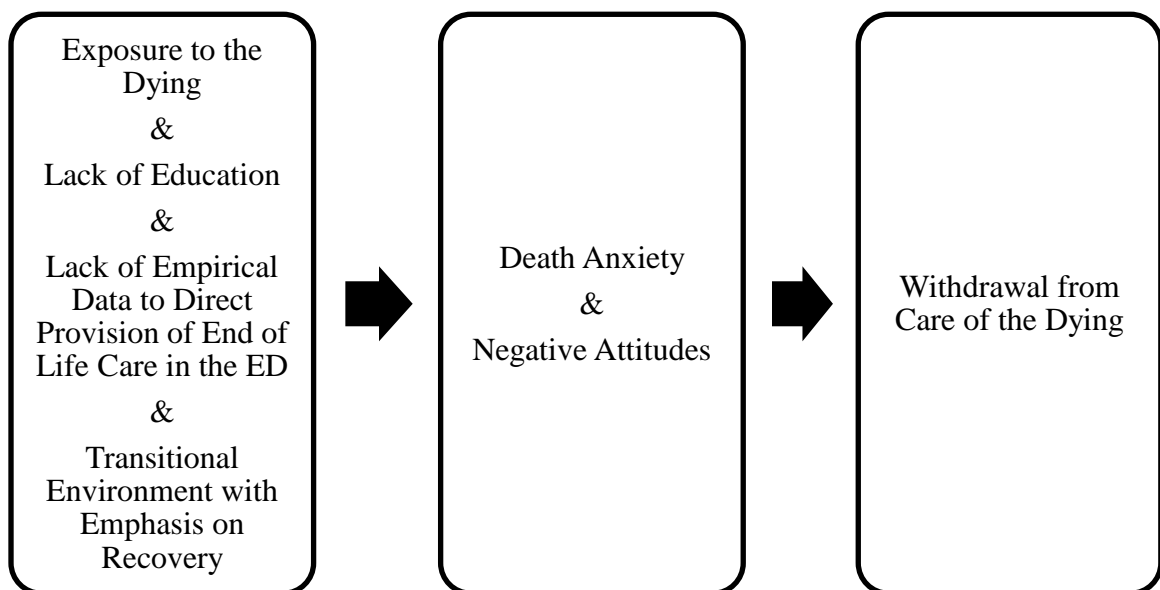
Figure 2. Revised Theoretical Model

Benner's Novice to Expert Model

    Description of Benner's Model. Educator and researcher Patricia Benner has empirically examined skill acquisition and the clinical judgement of nurses in practice. In particular, she was interested in the nature of expert nursing practice (Benner, 2001). Benner adapted a model of skill acquisition initially developed by Herbert Dreyfus and Stuart Dreyfus in which they studied the acquisition of skills of chess players and airline pilots. The Dreyfus' model states that in the process of acquiring and developing a skill, there are five levels of proficiency which include: novice, advanced beginner, competent, proficient, and expert (Benner, 2001). The assumption of this model is that performance will be improved with experience and mastery of a skill (Benner, 2001).

    Benner suggested that the Dreyfus Model of Skill Acquisition could be generalized to nursing as it takes into account that the gain in skill performance is based on both experience and education (Benner, 2001). It provides a basis for the clinical knowledge development and career progression that occurs in nursing. Benner applied the five levels of proficiency to nursing in with the goal of clarifying the characteristics of the performance of a nurse at the different stages of skill acquisition (see Figure 3).

    Benner (2001) stated the study of the performance of the proficient and expert nurse would make it possible to describe both expert nursing performance and the resulting patient outcomes. She further postulated that this knowledge could be utilized to develop the scope of practice in nurses who have the ability and desire to achieve excellence.

Level I: Novice

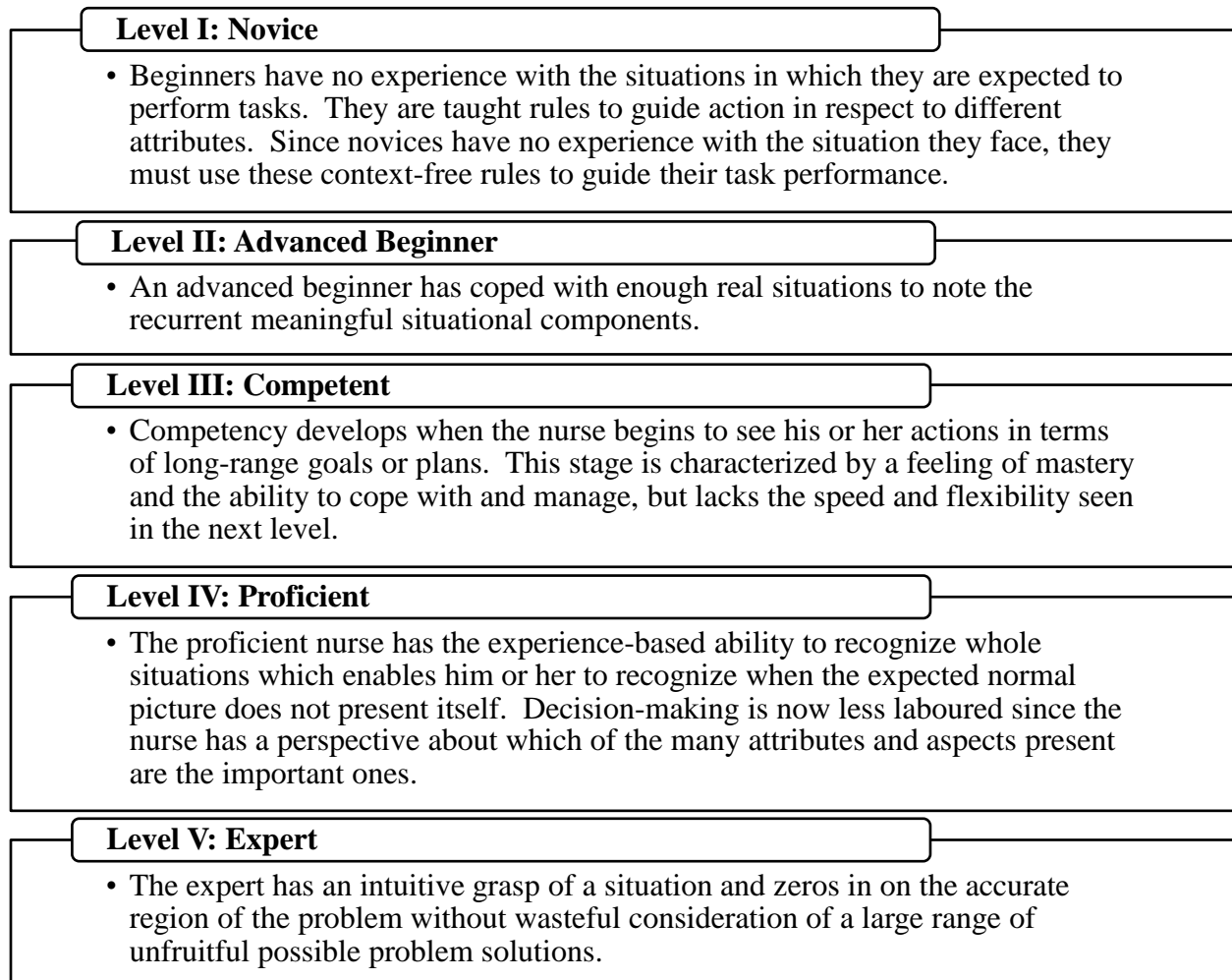- Beginners have no experience with the situations in which they are expected to perform tasks. They are taught rules to guide action in respect to different attributes. Since novices have no experience with the situation they face, they must use these context-free rules to guide their task performance.

Level II: Advanced Beginner

- An advanced beginner has coped with enough real situations to note the recurrent meaningful situational components.

Level III: Competent

- Competency develops when the nurse begins to see his or her actions in terms of long-range goals or plans. This stage is characterized by a feeling of mastery and the ability to cope with and manage, but lacks the speed and flexibility seen in the next level.

Level IV: Proficient

- The proficient nurse has the experience-based ability to recognize whole situations which enables him or her to recognize when the expected normal picture does not present itself. Decision-making is now less laboured since the nurse has a perspective about which of the many attributes and aspects present are the important ones.

Level V: Expert

- The expert has an intuitive grasp of a situation and zeros in on the accurate region of the problem without wasteful consideration of a large range of unfruitful possible problem solutions.

Figure 3. Benner's Adaptation of the Dreyfus Model

Critique of Benner's Model. Benner's (1984) seminal work, "From Novice to Expert,"

has been widely used in nursing education, research, and clinical practice. However, there has

been considerable debate and critique of her theory. Benner has been most frequently criticized

for not providing either an adequate description of expertise, or clear criteria on how a nurse

attains *expert* status (English, 1993). English critiques the fact that Benner states that not all

nurses with the appropriate experience will become experts in their area of practice and that no

explanation is provided as to why this may be the case. As well, concern has been expressed that

Benner provides no additional guidance to assist nurses in becoming an expert nurse other than

working through the steps (English, 1993). English goes on to state that this creates an inner

sanctum that not all nurses have the same opportunity to enter.

Despite the assertion that expert nurses are a valuable asset to patient care and to the

healthcare system, little is known about what conditions foster the development of an expert

nurse (Haag-Heitman, 2008). In order to gain an understanding of these conditions, Haag-

Heitman (2008) conducted an exploratory qualitative descriptive study with 10 expert nurses to

examine their perceptions of personal and environmental factors that influence the development

of the expert nurse on a medical unit. Choosing diverse and dynamic work, engaging in a

lifelong self-directed focus, maintaining a positive and engaged demeanour, being influential and

self-confident, and being innovative were identified as personal factors that contribute to an

expert's development.

The concept of intuition as a component of an expert nurse has also generated significant

debate. Benner and Tanner (1987) define intuition as "understanding of a situation without a

rationale" (p.23). English (1993) criticizes Benner's original work for not defining and

addressing the concept of intuition and states that further work done by Benner and Tanner

(1987) places less significance on the role of intuition as compared to Benner's original work.

Cash (1995) also criticizes Benner's model for the use of intuition due to the opinion that the use

of intuition does not advance the status of nursing. Cash states that in order for intuition to be

effective, one must already have power in order to have credibility. Thus, the use of intuition

only reinforces the power struggles that exist within the culture of healthcare, in particular the

struggles between physicians and nurses.

In Benner's (1996) response to Cash's critique of her work, she reinforces that she does

not discount scientific work and the correct methodology is determined by the question being

asked. In regards to the concept of intuition, she asserts that she is not suggesting that intuition

be used to legitimize one's actions, but rather stresses the importance of clinicians and scientists

discussing and validating the concept of intuition in an intelligent and respectful manner. Benner

explains that intuition exists regardless if one acknowledges it or not and therefore, it is best to

engage in discussion rather than ignore the subject. In response to Cash's suggestion that she

underestimates the power gradients with the use of intuition, Benner confirms that her focus has

not been on power relations, rather, her goal has been to clarify what the power dialogues are

about.

The validity of the concept of intuition has been reinforced through research conducted

within the ED setting. A phenomenological study of 14 expert emergency nurses in Australia

was completed to explore the experience of intuition in emergency nursing (Lyneham,

Parkinson, & Denholm, 2008). Lyneham et al. (2008) reported the use of intuitive decision-

making as a valid component of the decision-making process of expert nurses and identified that

intuition contains 3 phases: cognitive intuition; transitional intuition; and embodied intuition.

Thus, while Benner's theory has generated considerable criticism, it has also received

significant support within the literature. Despite English's earlier criticism (1993) of Benner's

theory, he acknowledges its strength is that her work is embedded within clinical practice and

ties theory with practice. The Novice to Expert theory is simple (Gobet & Chassy, 2008), easy to

understand, and can be used in a variety of organizations and settings (Shapiro, 1998). It

provides good descriptions of aspects that a nurse will experience as he or she acquires skills; in

particular, descriptions related to the variations in the ability to problem-solve and the speed in

which that occurs within each stage (Gobet & Chassy, 2008).

Relevance of Selected Theoretical Frameworks to this Study

The works of Quint and Benner were appropriate sensitizing theoretical frameworks for this study. Their theoretical perspectives each provided a meaningful context in which to examine and describe expert nurse behaviours in care of the dying adult in the emergency department. The theoretical framework put forward by Quint's (1967) research served to guide the literature reviewed prior to the study and provided a context for the discussion chapter of the study's findings. Awareness that nurses' education and exposure to dying patients may be directly related to their involvement in the provision of care of a dying patient sensitized the researcher to explore factors specific to the ED that impact what nurses do in caring for dying patients.

Benner's (2001) model provided the foundation for studying expert emergency nurses who provide care for the dying adult patient and their families. Her work informed the research methodology, in particular, providing guidance for inclusion criteria to guide the selection of the sample during the recruitment phase of the study.

Finally, use of these two theoretical frameworks aided the researcher to make meaningful comparisons between her findings and other studies examining expert nurse behaviours in care of the dying that have also been guided by Quint and Benner's theoretical work (Degner et al., 1991; Harbeck, 1995, Hawkins, 1995; McClement & Degner, 1995; Wowchuk, 2004). As such, the study reported on here serves to expand and extend the developing body of empirical work examining the nature of expert nursing practice in end of life care.

Summary

This chapter has provided an overview and critique of the two frameworks used to guide this study. The relevance and rationale for use of the selected frameworks has been described.

The next chapter will provide a description of the methods and procedures used to conduct the

study.

Chapter Four: Methodology

Introduction

This chapter provides an overview of the research methodology used to identify expert nursing behaviours in the care of the dying adult patient in the emergency department (ED). A description of the research design, characteristics of qualitative research, the sample and setting for the study, and the process utilized for data collection and data analysis are described. The steps taken to ensure rigor of the project as understood from a qualitative perspective are discussed. Ethical considerations surrounding the conduct of the study are also identified.

Design

A qualitative descriptive research design was used to address the aims and questions of this study. Such an approach is indicated when there is limited empirical knowledge or understanding regarding an issue or problem and further exploration is required (Creswell, 2007; Sandelowski, 2000). Given the lack of empirical work examining expert nursing behaviours in care of the dying patient in the ED, a qualitative approach was warranted. The overall purpose of a qualitative descriptive research design is to present the findings of phenomena in everyday language (Sandelowski, 2000). Thus, the data requires less abstract levels of interpretation in comparison to other methodologies such as phenomenological or grounded theory descriptions. Nonetheless, as argued by prominent nurse researcher Margarete Sandelowski, qualitative description is "especially amenable to obtaining straight and largely unadorned answers to questions of special relevance to practitioners and policy makers" (Sandelowski, 2000, p.337).

Characteristics of qualitative research. A clear definition of qualitative research is not easily found and previous definitions have evolved over time (Creswell, 2007). Despite that lack of a static definition, there are common characteristics that contribute to the foundation of

qualitative research. Presented below is a list of these characteristics, along with examples of

how each attribute influenced this study.

- The qualitative researcher is the primary instrument for data collection and analysis

  (Creswell, 2007). The researcher often collects data by observing behaviour and

  interviewing participants. For example, in this study, data was collected from

  participants via face-to-face interviews conducted by the researcher.

- Qualitative research often involves fieldwork in order to collect data in a natural setting

  that is not contrived and allows the researcher to gather information through

  conversations and observation (Creswell, 2007). In this study, interviews were conducted

  in a location of the participant's choice. All participants opted to complete the interview

  in their own homes which facilitated a comfortable, safe and natural environment within

  which the participant could share information.

- Qualitative research often uses multiple sources of data, such as interviews, observations,

  and documents with the goal of identifying themes that cross all sources of data

  (Creswell, 2007). In this study, three sources were used to collect data. These included:

  participant interviews, field notes that documented the researcher's observations, and a

  reflective journal that documented the researcher's personal experiences, reactions, and

  reflections.

- Qualitative researchers utilize inductive data analysis as a means to build concepts,

  hypotheses, and theories from the details of the data (Creswell, 2007). Analysis of the

  data collected in this study began with coding raw data, grouping this data into

  categories, and eventually developing themes.

- Qualitative researchers are focused on learning the meaning that individuals attribute to an event or issue they have experienced (Creswell, 2007). In this study, data collection sought to gain understanding and identify what expert emergency nurses considered important in the provision of end of life care of dying patients in emergency; thus, behaviours identified in this study were a result of the meaning participants gave to this issue and were not the meaning ascribed by the researcher.

- Qualitative researchers utilize an emergent design that permits flexibility as a means to gain understanding of the issue. Qualitative researchers are focused primarily on the process of research rather than the outcomes of the research (Creswell, 2007). For example, although a semi-structured interview guide was developed to facilitate and guide the interview process, the interviewer remained open to explore ideas presented by the participant not originally included in the interview guide. As well, data analysis occurred concurrently with data collection which permitted the researcher to seek information from participants about potential themes that were already emerging from previously coded interviews.

Setting and Sample

Setting. The plan for this study was that recruitment of participants would occur at three emergency departments within the city of Winnipeg. The decision to recruit from more than one site was made with the hope that a sample sufficient enough to ensure data saturation would be recruited. It was also hoped that this recruitment plan would create an opportunity to explore the extent to which the emergency departments and the experiences of those nurses caring for dying patients in them were similar and different. All of the emergency departments identified as recruitment sites for the project were situated in hospitals within the Winnipeg Regional Health

Authority (WRHA). On average, 5370 emergency visits occur weekly within the WRHA

(Government of Manitoba, n.d.) which include visits to adult emergency departments and urgent

care locations.

Despite attempting to recruit from three sites, enrolment into the study was slow. Thus,

the researcher, in consultation with her advisor, explored the possibility of adding an additional

ED site located 90 minutes away from the city of Winnipeg. Approval was received from the

Education/Nursing Research Ethics Board (ENREB) to amend the study protocol in this way.

Managers at the additional site requested the researcher visit the facility for a tour of the

emergency department. The researcher made multiple attempts over the period of four weeks to

reach the site contact person to make arrangements for a visit to the facility. However, the site

contact person did not respond to the researcher's request for a return phone call or email

response. As it was not possible to gain timely entry into this additional facility, and in the

interest of feasibility a decision was made to remain with the three original recruitment sites.

Those sites will now be described.

Facility A – The first facility was an 800 bed tertiary care facility and is designated as the

provincial trauma centre. On average, the 36 bed emergency department has approximately

1000 emergency visits per week. There were a total of 13 nurses working during the day and

evening shift, with the staffing level reduced to 12 nurses for the night shift.

Facility B – The second facility was a 231 bed community hospital with an average of 575

emergency visits per week. This 25 bed emergency department has undergone structural

renovations and at the time of the study, this ED was in the last phase of the department's

renovations. These renovations meant that the department's observation unit was relocated to a

different floor within the hospital and was separated from the rest of the ED. There were a total

of 11 nurses working during the day and evening shift in this facility, with the staffing level

reduced to 10 nurses for the night shift.

Facility C – The third facility was a 270 bed faith-based community hospital with an average of

475 visits to the emergency department each week. No further information was collected

regarding the emergency department as no invited participants took part in the study from this

facility.

        The researcher worked as an emergency nurse at one of the three remaining EDs within

the Winnipeg Regional Health Authority (WRHA). As well, the researcher provided education

and training to nurses at the remaining two EDs on a recently implemented clinical computer

application. This educational role was fulfilled as part of the researcher's role as a Clinical

Informatics Specialist within WRHA's technology and information department (Manitoba

eHealth) and not as part of her role as an emergency nurse. However, in order to keep the

researcher's role as nurse versus researcher clear to potential study participants, it was decided

not to recruit nurses from these departments.

        Sample. A two-phased approach was used to recruit the sample of nurse experts who

participated in this study. Phase 1 of the study was a nomination phase that provided all

registered nurses working in the EDs at each of the three previously described facilities the

opportunity to nominate a nurse colleague who demonstrated expert care of the dying patient in

the ED setting as per the descriptors of such care detailed on a nomination form provided to the

nurses by the researcher.

        In order to roll out phase 1 of the study, the researcher first needed to have the

opportunity to meet with the ED nursing staff at each of the three facilities to describe the study,

the purpose of each phase of the study, and the nature of involvement from nurses in each phase

of the study. Finding the opportunity to meet with ED nursing staff proved to be somewhat

challenging. Initially, the researcher had planned to contact the nurse manager of the ED in each

of the facilities to make arrangements to come and speak to nursing staff at the next regularly

scheduled staff meeting. However, the significant time lag between when future staff meetings

were scheduled, and the need to begin participant recruitment required abandoning this approach.

Alternatively, the researcher sought permission from each of the nurse managers to come and

speak to ED nurses on a one-to-one basis or in small groups-either while nurses were working on

the floor, or when they were coming and going from the staff lounge during breaks. During the

time that she was able to spend with nurses, the researcher provided information about the

purpose of the study, the phases of the study, and the nature of participation in it. She particularly

stressed the purpose of phase 1 of the study, in which all registered nurses working in the ED of

the facility were invited to nominate a nurse colleague who demonstrated expert care of the

dying patient in the emergency setting. Nurses were invited to ask questions and seek

clarification about any aspect of the study. In order to provide nurses with an opportunity to take

their time to complete the nomination form for phase 1 of the study, and to provide those ED

nurses whom the researcher had not been able to speak with personally the opportunity to learn

about the study and participate in phase 1, arrangements were made with each facility to place a

study information sheet (see Appendix A), a study disclaimer (see Appendix B), and a

nomination form (see Appendix C) in each ED nurse's facility mailbox.

The nomination form contained descriptions of expert nursing behaviours in care of the

dying based on the work of Benner (1984) and other researchers (Harbeck, 1995; McClement &

Degner, 1995; Wowchuk, 2004) who have conducted qualitative work examining expert nursing

behaviours in care of the dying. The content of the nomination form was also informed by the

researcher's own experience as an ED Nurse (see Appendix C).

In addition to demonstrating evidence of the expert nursing behaviours described on the

nomination ballot, the following inclusion criteria for nominees applied:

i)   employed as a full-time or part-time registered nurse within the ED;

ii)   involved in direct patient care;

iii)   a minimum of three years emergency nursing experience - Benner (1984) suggests it

        takes three to five years working within a specific patient population to become a

        proficient nurse. Nurses will transition from proficient to expert nurses at different

        rates. For the purpose of this study, a minimum of three years of emergency nursing

        was required in order to provide a greater opportunity for nurses to be identified as

        expert nurses as so deemed by their colleagues.

iv)   Willing to provide written informed consent and be interviewed.

Those nurses who opted to anonymously nominate a colleague were not required to

provide written consent to participate in the nomination process. Rather, they were provided with

a study disclaimer (See Appendix B) and completion of the nomination ballot was taken as

evidence of their willingness to participate in the nomination phase. No nurses returned the

completed nomination form directly to the researcher. Rather, they completed the nomination

form and mailed the ballot back to the researcher in the self-addressed stamped envelope

provided.

In order to facilitate the timely return of nomination ballots, a reminder statement was

placed at the bottom of the form asking nurses to please return their ballot within one week.

However, despite this reminder, initial response rates were low. Nurse managers at each of the

facilities permitted a reminder email to be sent to the ED nurses about completion of the

nomination ballot. The email reminded nurses that an information package was located in their

mailbox and they were still welcome to forward their nominations. This email was written by

the researcher and contained the researcher's contact information, but it was sent on behalf of the

researcher from the department administrative assistant at Facility A, and from the nurse

managers at Facility B and C. Interestingly, since the researcher's email contained phone and

email contact information, two nominations were received via email.

Phase II of the study involved recruitment of the nurse experts nominated by their peers

in Phase I. The researcher reviewed the nomination ballots that had been cast. The researcher

ranked the names of nominated nurse experts according to the number of times each nurse was

nominated by his/her colleagues. The top five nominees from each of the recruitment sites were

invited to take part in the second phase of the study (see Appendix D for copy of invitation).

Invitations were placed in sealed, confidential envelopes, and addressed to each expert nurse.

These individual invitations were then placed in larger envelopes. For Facility A, the package

containing the invitations was sent via the regional internal mail system addressed to the nurse

educator. The nurse manager at Facility A had vacated her position and the nurse educator was

fulfilling some managerial duties in the absence of a manager. For Facility B and C, the

researcher hand delivered the larger envelopes, which were addressed, to the nurse manager of

each ED department. The individual invitations were then hand delivered to each nurse by their

nurse manager for Facility B and Facility C. During communications with the nurse managers

and nurse educator to request their assistance in the delivery of the envelopes, the researcher

reinforced that participation was voluntary and the researcher was only requesting assistance to

ensure the participant received the invitation.

A purposive sample of registered nurse experts (n = 6) was recruited from Facilities A and B (3 nurse experts per facility). No response was received from the invited nominees from Facility C. Purposive sampling, a type of convenience sampling, is appropriate to use when the researcher is seeking participants who are particularly knowledgeable about the issue being studied (Polit & Beck, 2008; Creswell, 2007). As the aim of this research project was to identify expert nursing behaviours, this type of sampling approach assisted the researcher in selecting experts who provided meaningful data about the phenomenon of interest.

The final sample size for the study was not calculated in advance as is the case with quantitative research. Rather, consistent with the tenets of qualitative research, the researcher continued interviewing with the aim of reaching data saturation. Data saturation refers to the point in the data collection process when no new information is obtained from informants and redundancy occurs (Polit & Beck, 2008). Previous studies examining expert nursing behaviours in care of the dying in other clinical settings suggest that if the participants are able to provide rich, detailed description about providing care for the dying, a sample size of ten participants may be sufficient to reach data saturation (Degner et al., 1991; McClement & Degner, 1995; Wowchuk, 2004). There was evidence of beginning approximation of saturation in the data after interviews were completed with six participants. In order to help ensure more fulsome saturation, the goal in this study was to recruit a total of 10 emergency nurses. However, owing to the recruitment challenges previously described, this was not possible.

Nominated nurse experts willing to participate in the study contacted the researcher via telephone, email, or mail using the researcher's contact information provided on the invitation to participate. The four participants who telephoned the researcher or mailed the response card from the invitation were contacted by the researcher via telephone to determine a mutually

convenient date, time, and location for individual interviews to occur. The two participants who expressed their interest to participate via email were contacted by the researcher via email to make arrangements. All of the participants chose to have the interview completed in their own home.

A semi-structured interview guide based on the literature and prior studies examining expert nursing care of the dying was used to help guide the interview process (See Appendix F for copy of semi-structured guide). Interviews were audio recorded and ranged in length from 60-120 minutes depending upon how much the participant wished to share. Demographic data were also collected (see Appendix G for copy of demographic tool), so that the researcher was able to describe the characteristics of the sample.

After the data were coded and themes identified, the researcher contacted participants to offer them the opportunity to provide the researcher with feedback regarding the accuracy with which she had captured the information they had shared. Participants were given the option to have this discussion via in-person, telephone, or email communication. Of the six participants, two took part in the second interview. Both interviews were completed face-to-face and ranged from 30 -60 minutes. One interview was conducted in the participant's home and the other interview was conducted in the participant's office at work. The follow-up interviews were not audio-recorded. Rather, the researcher took notes during the interview, as well as wrote comments in the margins on a copy of the participant's transcribed interview that was highlighted by the researcher as areas seeking further discussion or clarification.

Field notes were also recorded after each initial and follow-up interview to describe the context in which the interview occurred. Field notes are descriptive and reflective (Polit & Beck, 2008). Descriptive notes contained descriptions of the environment, the researcher's

observations regarding the participant and her reactions to the investigator, and the dynamics of

the interview. This information was recorded as thoroughly and objectively as possible (Polit &

Beck). A reflective journal was utilized to document the researcher's personal experiences,

reactions, and reflections of each interview. This provided an opportunity to identify effective

strategies and areas for improvement for the next interview.

Data Analysis

The demographic data were analyzed using descriptive statistics. Verbatim transcription

of each interview was completed by a hired transcriptionist. The goal of data analysis for this

study was to identify common themes within the data (Polkinghorne, 1988). Data analysis

occurred concurrently with data collection. Interview data were analyzed using constant

comparative content analysis (Polit & Beck, 2008). This analytic process required the researcher

to code and categorize newly obtained data, and then compare these results with previously

coded data from the study to identify similarities and differences (Creswell, 2007). For example,

new data that emerged from the second interview were reviewed to evaluate the extent to which

it was congruent with the coding scheme that had emerged from the first interview. Data were

then clustered and categories were sorted and refined. This inductive method of analysis allowed

for a critical examination of the data in order to gain meaning (Polit & Beck, 2008).

The researcher immersed herself in the data by initially reading the transcribed interviews

in their entirety multiple times. The analytic process utilized open coding, which examined

individual words, phrases, and sentences of the text to capture what is occurring in the data

(Creswell, 2007; Polit & Beck, 2008). This coding process allowed the data to be clustered into

developing categories of information that best explained the data. The categories were compared

and contrasted until each category was mutually exclusive of the other and until no new

categories were produced. The categories generated from the data analysis resulted in a list of expert nursing behaviours in the care of the dying adult in the ED. Operational definitions were written for the major categories identified from the study (see Appendix J, Table B2).

The researcher sought assistance from her thesis advisor in regards to coding procedures, clustering data, and sorting categories to ensure all critical nursing behaviours were identified. The researcher and her thesis advisor independently reviewed the interview transcripts and met to compare coding schemas. Discussion regarding the retention of final themes occurred, with any divergent perspectives being explored and discussed to the point of consensus. The researcher and her advisor communicated regularly during the data analysis process to discuss the emergent findings, and to identify follow-up questions to be posed and probes to be used in follow-up interviews with participants.

Ethical Considerations

The study adhered to the Tri-Council Policy Statement regarding "Ethical Conduct for Research Involving Humans" (Canadian Institute of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010). The human rights' of participants were protected in this study in the following manner:

1. Prior to the onset of data collection, ethical approval to carry out this study was obtained from the University of Manitoba's Education/Nursing Research Ethics Board (ENREB). Approval for an extension was received twice as the study extended beyond the initial one year approval period. Access approval was also obtained from the Winnipeg Regional Health Authority's Research Review Committee, and site access secured from each of the respective hospital sites. Approval was also received from the

Education/Nursing Research Ethics Board (ENREB) to amend the study protocol to

extend recruitment locations to include a facility outside of the Winnipeg region.

2. Written informed consent was obtained from participants in Phase 2 of the study (See

    Appendix H). Participants in phase 1 did not sign a consent form, but were provided with

    a study disclaimer in which it was stated that their completion and return of the

    nomination ballot denoted their willingness to take part in Phase 1 of the project (see

    Appendix B for study disclaimer). Participants in both Phase 1 and Phase 2 were

    provided with the researcher and thesis advisor's phone numbers and email addresses as

    well as contact information for the Human Ethics Secretariat at the University of

    Manitoba if they had any questions or concerns regarding the study.

3. To maintain anonymity, nurses who chose to participate in the first phase of study were

    asked not to place their names on the nomination form they submitted.

4. All nominees who accepted the invitation to participate in the second phase of the study

    were advised verbally and in writing that participation was voluntary and that they had

    the right to withdraw from the study at any time without penalty.

5. All study data were stored in a secure fashion throughout the project. Completed consent

    forms were stored in a locked cabinet in the researcher's home office and separated from

    the transcribed interview data, and demographic forms. To maintain anonymity, all

    participants were assigned a code number in place of individual names on data collection

    forms and in all field notes. Names and any identifying information gathered during the

    interview were replaced with pseudonyms at the time of transcription. Only the

    researcher and transcriber had access to audio recordings. The data obtained will be held

for a period of seven years; after this time period recordings and transcripts will be

destroyed and treated as confidential waste.

6. During the interviews with participants, it was anticipated that discussing death and

specific dying patients that participants had cared for could evoke emotional responses of

sadness in some participants. The researcher made known to the participants that she was

available to the participants and planned in advance to spend additional time with any

participants who became upset. Alternatively, if the participant preferred, the researcher

would seek out a support person of the participant's choice. In the event a participant

became distressed, the researcher was willing to stop the interview and provide emotional

support. Participants would then be given the option to continue with the interview,

continue it at a later date, or to withdraw from the study if they chose. No participant

requested the interview be stopped nor did any participant withdraw from the study.

Steps to Ensure Rigor

Steps were taken throughout the project to maintain rigor. In qualitative research, the

goal of rigor is to ensure the participants' experiences are accurately represented (Streubert &

Carpenter, 1999). The following approaches were used to enhance the rigor of this study.

Prolonged engagement refers to sufficient time being spent collecting data in order for

the researcher to gain an in-depth understanding of the group being studied (Polit & Beck, 2008).

The researcher ensured participants' statements and the issues they identified were thoroughly

explored and clarified to ensure an appreciation and understanding of both the meaning of the

experience and the context in which it occurred. Participants were offered the opportunity for a

second interview to allow the researcher to clarify understanding of the original data and to allow

the participant to verify findings to date and provide additional information.

Obtaining rich, thick descriptions and data saturation required that rapport and trust be developed between the researcher and participant. Utilizing prolonged engagement facilitated the development of a trusting relationship (Polit & Beck, 2008). Initial face-to-face interviews were conducted in each of the participants' homes as per their preference. Conducting the interviews in their homes reduced the risk of interruptions and disturbances and increased the opportunity to clarify and probe further into ideas of particular interest. Prior to beginning the interview, the researcher provided the participant with a description and purpose of the study, outlined the interview process, and reiterated the estimated duration of the interview in the attempt to gain rapport. Broad open-ended interview questions were used, as well nurses were asked to share stories regarding their experiences in care of the dying in the ED. Both of these strategies facilitated the sharing of detailed descriptions about the topic of interest for this study.

Member checking was another method the researcher used to validate and assess the credibility of the findings and interpretations of the data (Creswell, 2007). Member checking was accomplished through verification of findings through debriefings and discussions with participants (Polit & Beck, 2008). The first opportunity to member check occurred at the end of the initial face-to-face interview. The researcher provided a brief summary of issues and ideas put forward during the interview. Participants were each asked to verify or clarify the information to ensure that their meaning was understood.

The second opportunity for member checking occurred once data analysis had begun and themes were established. The researcher contacted the participants to extend an invitation to participate in a follow- up interview. They were invited to provide feedback on how well their ideas were captured as well as provide further information or clarification if desired. Participants were given the option to complete a review of the findings in-person, over the telephone, or via

email communication if desired. Face-to-face interviews were completed with the 2 participants

who engaged in the second interview. Both participants confirmed the accuracy of the

researcher's analysis of the data. Of the four remaining participants, no response was received

from three remaining participants and the fourth participant emailed the researcher with

expressed interest, but after the researcher initiated contact to make further arrangements, no

additional response was received from the individual.

Confirmability is a process criterion (Streubert & Carpenter, 1999) and refers to the

objectivity of the data and interpretations of it (Polit & Beck, 2008). Creating an audit trail is

one approach used to address the issue of confirmability. An audit trail is a systematic collection

of material and documentation of the analytic process that would allow another individual to

come to congruent conclusions about the data (Polit & Beck, 2008). This requires that the

findings reflect the participants' voice, versus being imbued with the researcher's biases,

motivations, and perspectives (Polit & Beck, 2008). To facilitate this process, the researcher

compiled a list of assumptions about the issue of expert nursing care in the ED prior to beginning

the study. Raw data, data reduction and analysis products, process notes, and data reconstruction

products are useful records in creating an audit trail (Polit & Beck, 2008). For the purpose of

this study, the researcher documented all key word or codes directly on the interview transcripts.

As well, coding procedures and lists of codes, needed for identifying categories and themes were

recorded. Original audiotapes, the researcher's journal, field notes and draft copies of study

findings are being securely stored.

Transferability refers to the extent that the study findings can be transferred and have

meaning to others in similar situations (Polit & Beck, 2008; Streubert & Carpenter, 1999). The

researcher facilitated transferability by providing a clear description of the selection and

characteristics of the participants, the facilities in which they worked, and detailed information

regarding data collection and analysis processes and procedures (Graneheim & Lundman, 2004).

Also, providing rich, thick descriptive data allows the reader to evaluate the applicability of the

findings to other contexts (Polit & Beck, 2008; Creswell, 2007). Incorporating direct quotations

from the interviews together with a comprehensive presentation of the findings as are presented

in the Findings Chapter (Chapter 5) also enhance transferability (Graneheim & Lundman, 2004).

        Triangulation is an approach to research that uses more than one research strategy or data

source in one study (Streubert & Carpenter, 1999). The four types of triangulation strategies

include: data triangulation, investigator triangulation, method triangulation, and theoretical

triangulation. Utilizing this strategy helped capture a more complete picture of the phenomena

being studied (Polit & Beck, 2008). In this study, data, space and investigator triangulation were

used. Data triangulation uses multiple data sources to validate conclusions (Polit & Beck, 2008).

This study utilized interview data, field notes, a reflexive journal, and relevant literature

examining expert nurse behaviours in end of life care. Space triangulation occurs when data are

collected on the same phenomena at different sites (Polit & Beck, 2008). This study utilized

space triangulation by collecting data from nurses working at both a tertiary hospital and a

community hospital to explore for similarities and differences in nursing behaviours across these

sites. Investigator triangulation occurs when researchers with diverse backgrounds and expertise

work on the same study (Streubert & Carpenter, 1999). The committee members involved in this

study include experts in both medicine and nursing disciplines which allowed for varied

perspectives that informed the development of the study protocol.

Summary

   This chapter presented the study's methodology and the procedures used to identify behaviours which expert nurses deemed central to the provision of quality end of life care to the dying adult patient in the emergency department. A description of the qualitative approach used to conduct the study was provided. The setting, sampling approach, recruitment strategies, data collection and data analysis procedures were discussed. Ethical consideration as well as steps to enhance rigor were also presented. The next chapter will present the findings of the study.

Chapter Five: Findings

Introduction

This chapter provides a report of the findings of the study completed to identify expert nurse behaviours in the provision of quality end of life care to dying adult patients in the Emergency Department (ED) setting. The characteristics of the sample and the five critical nurse behaviours that emerged from the analysis of the transcribed interviews completed with six expert nurses are presented.

Demographic Characteristics of the Sample

A purposive sample of six emergency department registered nurses identified as experts by their nursing colleagues in the care of the dying adult patient participated in this study. The characteristics of the sample are summarized in Table C3 (see Appendix J). All of the participants were female. They ranged in age from 38-59 years, with a mean age of 51.7 years. Years of experience as a nurse ranged from 10-38 years, with participants having an average of 26.1 years in practice. The average number of years spent as an emergency nurse was 19.6 years, with individual experience ranging from 5-34.5 years. Five of the participants obtained a registered nursing diploma and the remaining participant held a baccalaureate nursing degree. Two of the participants were working toward a post-diploma degree in nursing. None of the participants identified having completed a specialized palliative care course.

Expert Nurse Behaviours in Care of the Dying Adult Patient

Five themes were identified by expert nurses as being critical when caring for a dying adult patient in the emergency department. The five major categories of nurse behaviours that emerged from the data were: 1) providing comfort; 2) honouring the personhood of the patient; 3) responding to the family; 4) responding after the death of the patient; and 5) responding to colleagues. Examples taken directly from the data are presented to provide support to the

findings and illustrate the identified behaviours. In order to maintain the participants'

anonymity, pseudonyms have been substituted for all names in the exemplars provided.

Providing Comfort. Providing comfort for the patient was identified by participants as a

critical behaviour when caring for a dying adult patient in the ED. Nurses in this study reported

the following three key behaviours that contributed to providing comfort for the patient: i)

reducing and eliminating physical symptoms; ii) providing basic nursing care; and iii) modifying

the environment.

Reducing and eliminating physical symptoms. Interventions that reduced or eliminated

distressing physical symptoms, in particular symptoms related to pain and difficulty in breathing,

were a vital component in providing comfort. Based on their assessments, nursing knowledge,

and expertise, the participants sought to initiate interventions early on to assist in symptom

management. This included requesting verbal orders for analgesic, anti-emetic, and anti-

secretory medications from the emergency room physician rather than waiting for orders to be

written only after the physician had completed his/her own assessment. For example, this nurse

described how she would secure an intravenous line for the purposes of administering IV

medication, and then secure a verbal order for analgesic as opposed to waiting for an order to be

written on the chart:

> Michelle: "a lot of us who have more experience will start an IV, get a verbal order for
> some morphine, at least if they're in pain, at least let's give them something to keep them
> comfortable."

It was evident in the interviews that management of pain was a top priority in care of the dying.

This nurse stated emphatically:

> Maria: "If they are going to be passing away in my emergency department the best that
> we can hope for is that they die pain free."

Nurse experts in this study, understood that the aggressive management of one symptom often

resulted in the improvement of other symptoms, and thus enhanced comfort for the patient.

Nurse Theresa explained it this way:

> Theresa: "he's short of breath...no he's having secretions, dry up his secretions, give him some medication, dry them up, make him more comfortable, then you won't need the oxygen on as much."

When patients were known to the regional palliative care program and symptom

management was difficult to achieve in the emergency department, nurse experts in this study

indicated that they consulted palliative care clinical nurse specialists (CNS) for assistance in

managing symptoms. Although not accessible 24 hours per day, the CNS was an additional

resource to call upon in working to achieve patient comfort. This participant said:

> Amelia: "We do have access to a clinical nurse specialist on days for the palliative care program who are great resources for um knowing the patient…or giving us advice. They'll come in and they'll assess and that's great…. I have used um the clinical nurse specialist often for that [bed availability] and for um symptom issues."

Providing basic nursing care. In conjunction with reducing and eliminating symptoms,

expert nurses identified providing basic nursing care as a key aspect to ensuring patient comfort.

This basic care consisted of such things as providing dying patients with mouth care, toileting

them, providing warm blankets, and regular repositioning of them on the stretcher to ensure they

were in a comfortable position. Participants believed that when they had the time and

opportunity to provide 'hands on' basic nursing care, as opposed to delegating such care to a unit

assistant, they were providing a higher quality of patient care. Nurses identified the importance

of providing excellent basic nursing care, and equated it to the type of care they themselves

would want to receive, were they the patient. This nurse explained:

> Maria: "I try and do for those patients what I would want done for me, mouth care, washing the face, cleaning up a dirty bottom, um a clean gown if they uh uh if they need it, fresh bed linen, positioning with pillows, whatever is required."

Sometimes, nurses identified that they required assistance to provide patient care, such as

for turning or dressing changes. In such instances, as described by this participant, nurses

mobilized the help of unit assistants to assist in completing the necessary care.

Michelle: "You'll go in, I'll grab my healthcare aide and we'll turn and position the patient."

Nurse experts in this study identified that the ability to provide comfort to their desired

standard was sometimes not possible because of a lack of resources. Sometimes, as described by

this nurse, the resources in question were basic articles such as adequate amounts of bedding:

Joyce: "Some nights we're scraping for blankets …we are often short on pillows."

In other instances, the resource that was lacking was a palliative care bed to which the patient

could be transferred - a transfer that nurses believed would help ensure that the patient would be

made comfortable. This nurse explained her frustration with the lack of available beds:

Theresa: "they are on the palliative care program and they're coming in because of increased shortness of breath or whatever else is going on and there's no beds [in the hospital], and they're sitting in the waiting room and there's no beds [in the emergency department], which is what happened the other night."

Modifying the environment. Along with the physical aspects of providing comfort

through symptom reduction or elimination and implementing basic nursing care, nurses stressed

that an important part of providing comfort included modifying the environment of the ED in an

attempt to reduce the patient and his/her family's full exposure to all that was going on there.

When asked what an ideal environment would be for a dying patient, all the participants stated

that it was not an emergency department because of the noise level, the high activity level within

the department, the lack of privacy, and the limited amount of physical space. Nurses identified

that optimally, dying patients and their families should be cared for in an environment that is

calm, quiet, and private. Data exemplars from these participants illustrate how the emergency

department does not emulate a tranquil environment. Nurse Joyce spoke about how the

behaviour of some of the patients seen in the ED might be upsetting for family members:

> Joyce: "the environment, I mean they're watching us run around, they're watching some,
> like some of the patients that come in, I mean and we get a lot of overdoses and violent
> patients and belligerent, and they're swearing up a blue streak and they're right beside
> somebody who's in their last moments."

In this exemplar, Nurse Amelia explained how the physical layout of the ED failed to afford

family members privacy to express their emotions:

> Amelia: "We had to take them around, through the waiting room, past the ambulances
> and everybody could see them crying and upset, and it's just like oh my God, this is so
> not good."

Nurse Joyce lamented the cramped physical space that made it difficult to comfortably

accommodate the family members of dying patients:

> Joyce: "the rooms are very small, even that room, you know you could, you could cram
> in probably just about, well there's solid doors on it so there's a limit, you can cram them
> in, but it's not necessarily comfortable."

To achieve greater physical comfort and a more peaceful environment, participants

identified the most optimal solution was to transfer the patient out of the department to a hospital

ward. Patients transferred to a ward not only change locations but they also are transferred from

their emergency stretcher to a hospital bed that nurses in this study believed was more

comfortable. Participants felt that the private and semi-private rooms on hospital wards provided

an environment that created more privacy for the patient and family and provided a more

comfortable, spacious environment for the family spending time at the bedside. These nurses

explained:

> Caroline: "She did, she actually went up to the reassessment area. In a private area and
> then uh about six hours before she died, uh they got her a private room up on unit…"

> Joyce: "…if they had a place to lay down and a pillow and a blanket for themselves and
> nutrition, spiritual care, and even grief counseling."

As part of facilitating a transfer, nurse experts in this study explained that they contacted

the on-call palliative care team member to confirm if a patient was currently part of the regional

palliative care program and, if so, enquired whether a bed was available for the patient.

> Amelia: "Some of the older nurses that do charge they can access it, um I think they might access uh often for bed flow. They just want to know um a) are they on the program and b) is there a bed available."

However, nurses also stressed that it was not always appropriate to transfer a patient who

was imminently dying. In such instances, study participants believed it was more appropriate for

the patient to remain in the emergency department as the disruption of transferring the patient

may cause more distress for the family. Participants felt strongly that patients should not die in

an elevator or an ambulance while being transferred to another ward or facility. As described by

these nurses, dying during a transfer was a worse outcome than dying in the emergency

department:

> Theresa: "…what happens if she dies in the ambulance? That's not a pleasant, that's worse than dying in a comfortable bed in the emergency department."

> Joyce: "it was horrible how he's probably in his last thirty minutes and he's getting shipped into a Medivan and getting driven across the city. And like I say, I don't even know if he made it there."

If a transfer was not possible, then participants indicated they tried to make

modifications within the emergency department to create a more optimal environment for

patients and families. These modifications ranged from adjusting the temperature and lighting to

relocating the patient to a quieter spot within the department. This participant spoke of the

importance of turning down harsh, overhead lighting to promote a more comfortable

environment:

> Maria: "We can still dim the ones (lights) over the patient."

Nurse Michelle provided an example of how physical resources are utilized to modify the

department to facilitate patient comfort.

> Michelle: "we've got the blankets, we've got the privacy, we can make it a little bit
> warmer."

This participant underscored the importance of caring for the patient in a place within the

department that had enough room to accommodate family members:

> Caroline: "We try to get them (patient) a room uh that's big enough for the family to go
> in."

When transferring patients within the department, for example, moving them from

resuscitation room to a non-monitored bed, nurses identified the private locations that facilitated

privacy and space for the patient and family often physically distanced the nurse from the

patient. These nurses described the barriers of the department layout:

> Theresa: "…but that quiet spot is usually removed from, it is down the hall away from
> the nurse."

> Joyce: "One of the rooms that we often use for our people who are dying is kind of
> around the corner and it's not easy to see it all and it's a bit of a private room."

Honouring the Personhood of the Patient. The nurses' actions in caring for dying

patients strongly focused on honouring the personhood of the patient. Honouring personhood

involves the nurse treating the patient as a person regardless of their health status. This in turn

speaks to the importance of providing care in a holistic, ethical, and respectful manner. Nurses

honoured the personhood of the dying patients in the following ways: i) communicating with the

patient; ii) learning the patient's story; iii) being emotionally and physically present for the

patient; and iv) advocating for the patient.

Communicating with the patient. Nurses acknowledged they sometimes cared for

patients who had made multiple visits to the emergency department. Frequent trips to the ED

enabled nurses to be able to get to know the patient's personality and develop a rapport with

them. It also allowed the nurse to see the progression of the patient's illness. However, it was

more often the case that nurses' first and only encounter with the patient occurred when the

patient was dying. The opportunity to get to know the patient and develop a rapport was limited

in such cases. Regardless of whether they knew the patient from previous visits to the ED or not,

the participants in this study recognized and treated dying patients in ways that affirmed their

value as a person, despite the ravages of their disease. The nurses regularly communicated with

patients through speech and touch regardless of the patient's level of consciousness. This

participant described the way she interacted with dying unconscious patients in her care. Evident

in this exemplar is that the nurse provided the patient with explanations about the care and

interventions she was providing as opposed to merely executing psychomotor skills.

> Michelle: "You know, I always talk to them, always talk to them. I always say, I'm
> doing this, I'm doing that, you know, it's a nice day outside you know, that kind of
> thing…"

> Another nurse described how she maintained a connection with patients through touch.

Amelia's exemplar identified the way in which touch can confer reassurance to a dying patient.

> Amelia: "But I think touching the patient, showing them that it's okay, and just for no
> reason, just going in and touching their hand."

Learning the patient's story. As stated previously, it was uncommon for emergency

nurses to know their patient prior to the existing episode of care. Frequently, nurses were unable

to verbally interact with the dying patient due to the patient's altered level of consciousness. In

these situations, nurses gained information from family members to better learn about their

patient. This allowed the nurse to discover some background information and details of the

patient's life so she would come to know the patient as a person. This nurse described how she

engages family to talk about their loved one:

> Maria: "…ask them about the patient, what's he like, what did he do, what, what were his interests, does he have any children, grandchildren, um what did, what did he do for a living…"

For patients known to the palliative care program, nurses consulted with the program's clinical nurse specialists in order to glean information that may not be readily available or known by the emergency staff, but may inform the provision of end of life care. This information ranged from past medical history to insights about family dynamics. This nurse described the type of information she sought in which to better understand her patient's story and thereby improve the care provided:

> Amelia: "They (palliative CNS) can offer us some insights uh, and little tidbits about the family or the patient and just little, little things that might help."

Being emotionally and physically present. Participants acknowledged the importance of being physically present with the dying patient. They stressed that physical presence extended beyond the provision of physical care into the attitude and deportment of the nurse providing the care in a way that ensured that the patient was the focus of their attention.

> Caroline: "we can get the resources like you know you can do all the medical stuff that needs to get done, you can, but I think sometimes it's the actual presence of a person and, and their attitude and their caring is much more important."

Nurses in this study were adamant that no patient in the ED should die alone. When there was no family at the bedside, participants took action to ensure that they stepped in to fill the void. Nurses presented themselves as an anchor and support system in order to allay the patient's fears and provide reassurance. Joyce provided an exemplar of a colleague, who as an expert nurse, remained composed at the bedside and spoke confidently to calm the patient and to ensure the patient knew that he could depend upon the nurse.

> Joyce: "[the patient's] eyes were like wide and scared and just staring at her…and she just held his hand and 'I'm here for you and I'm not going to leave you and we're just going to go through this together'…The patient's going to die and I'm just going to be a rock here while he does and no, he won't be alone."

Amelia's description underscores the role that the use of touch plays in nursing behaviours aimed

at ensuring patients do not die alone:

> Amelia: "I just had to just go and sit with this lady and hold her hand. I just, I couldn't
> leave her to die alone."

The busyness of the ED sometimes made it extremely difficult for nurses to remain at the

bedside of a dying patient. Caroline's anger and frustration at being pulled away from her

bedside vigil is captured in this exemplar:

> Caroline: "I was trying to spend some time with her and they just kept calling me and I
> remember at one point I just got really angry, and I said I am not letting this woman die
> alone."

Advocating for the patient. Nurses advocated for patients when they felt that the

patient's best interests were at risk of being forgotten, either by family or health care staff.

Nurses were alert to the fact that family dynamics sometimes created an uncomfortable and

tension-filled environment that shifted family members' focus away from the patient. A

component of acting as the advocate included being the patient's spokesperson, as described by

this nurse:

> Joyce: "sometimes to just get one decision-maker, one leader in the family, and uh yeah
> they don't always agree, there's dissension, there's one person thinks this is best and the
> other person thinks that's best for the patient, so I think the nurse has to become a real
> leader then to speak for the patient."

Nurses believed that patients should be allowed to have a dignified death which

precluded unnecessary interventions or undue hardship being placed upon them. Nurses spoke

out when they perceived the care being provided by the health care team did not honour the

personhood of the patient. This nurse explained how she voiced her concern over the treatment

of a dying patient:

Caroline: "it was actually at "Hospital X" emerg and it was end stage Ca, like nothing, there, there was not a hope of this um patient making it. And because it was a teaching hospital they were doing a lot of stuff. And so, and I said to, I said stop it… I said you are preventing this patient from dying with dignity..."

Responding to the Family. In addition to caring for the dying patient through providing comfort and honouring personhood, nurses in this study indicated an important part of expert care of the dying patient involved caring for the family. Such care was seen by nurse experts as an extension of caring for the patient. Once the patient had been made comfortable, the focus often shifted to caring for the family. This nurse described how her focus of attention shifts in this regard:

Theresa: "it's not necessarily the patient that needs a nurse at that point, it's the family that needs the nurse, the patient needs to be made comfortable and needs some basic care, yes they're palliative, but the family is needing support"

Nurses were acutely aware that they were impacted by their own personal experiences with the deaths of loved ones. The awareness of these experiences in turn influenced how nurses approached and provided care for the family. This nurse explained:

Caroline: "…I know how I reacted and I know what I had to go through, so I, I put myself in their position and try to empathize with them as much as I can."

Participants in this study identified four behaviours that were important in caring for the family members of dying patients in the ED. These included: i) reducing the potential for future regret; ii) responding to the family's need for information; iii) ensuring the well-being of family members; and iv) supporting cultural traditions and spiritual or religious beliefs.

Reducing the potential for future regret. Nurses reported it was important to engage in behaviours that would reduce the potential of future regret for family members after the patient had died. Future regret refers to reflecting on a situation and wishing it had occurred differently. Participants did not want bereft family members to reflect on a behaviour or interaction in the

ED and wish they had done or said something differently or missed an opportunity. Nurses were aware that the risk for future regret exists and therefore they facilitated behaviours to reduce this risk. These behaviours, described below, were implemented by nurses while the patient was still living, and continued after the patient's death.

First, participants explained that they wanted family members to focus their attention on their loved one and to make the most of their remaining time together before death occurred. Nurses believed that a way to help reduce the potential for future regret involved facilitating patient and family interaction with one another in the emergency department so that nothing important was left undone or unsaid. This nurse explained the importance of family members taking the opportunity to express thoughts and sentiments to the patient, and described what she did to facilitate such interaction:

> Maria: "Encourage the family to say whatever is necessary. If you know that the death is imminent, encourage the family to tell them that they love them, uh to say the final things that they want to say so that they have no regrets when they walk out the door."

Nurse experts in this study recognized that whether interactions between families and patients occurred through speech, touch, or participation in care, family members often felt unsure or hesitant about how to interact with their loved one in the ED, and seemed to require permission or affirmation from staff to do so. Nurse experts identified that they encouraged family members with direct statements and prompted action by asking direct questions. This participant described how she includes family when providing physical care:

> Amelia: "…I want to do mouth care, do you want to help me? If they want to help you let them help."

When families were apprehensive in regards to being involved in care, this nurse provided suggestions on how the family may wish to participate:

Michelle: "I think they need to be told to talk to the patient…. They like to be involved. 'Oh, should I touch them?' Oh, by all means! You know, touch them, talk to them, you know, read to them if you're not comfortable just talking."

Nurses in this study explained that they also engaged in behaviours that facilitated family members' communication of final words to their loved one even after the patient's death. As described in the following exemplar, to reduce the risk of future regret about things left unsaid, this participant reduced physical barriers between the patient and family, and encouraged family to express themselves:

Caroline: "One thing I like to do if somebody has died, I will tell the family members I will take down the side rails and I will say please touch your family member, and say what you need to say to them before we leave…"

Nurses in this study believed it was important to keep families - both those at the bedside and those not physically present - informed of any changes in a patient's condition, particularly when those changes signaled that death would likely occur within hours or days. Such information was seen as being important in helping families to make decisions regarding work, child-care, and travel plans. For families who wanted to be at the bedside when the patient died, this information influenced their decisions. This nurse explained how a family made a decision as to whether they chose to stay or leave the bedside once they were provided information:

Joyce: "And they wanted to be there when she died and they always say well, how long do you think it will be? And I'll say I really don't know. It's totally out of my hands, you know. Well he has somewhere to go; I said is it that important? You need to stay here because I don't know, it could be an hour, it might be all day, you know. And they said okay, then we'll cancel the plans and we'll stay here, I said good decision. You know, so people sort of have to be made aware that it might not be five minutes."

Participants spoke of wanting to shield family members from the rest of the people in the department. Providing a designated room for families to utilize which allowed them to freely come and go, use the phone, and provide privacy was seen as important in this regard. However, in one facility this room was occasionally used to assess and treat patients while at the other

facility, the family room was located at the back of the waiting room. The location of this room

presented challenges in providing privacy for families and potentially caused emotional distress

for grieving family members. Participants described what family members may encounter when

walking from the family room to the resuscitation room:

> Theresa: "…taking the family through the waiting room, past triage, past the screaming patient that's in the security room to get to the resus room."

> Amelia: "We had to take them around, through the waiting room, past the ambulances and everybody could see them crying and upset, and it's just like, oh my God, this is so not good."

> Nurses felt the cardiac monitors were frequently a distraction for families and at times

caused the family's focus to shift from the patient to the monitors. Nurses did not want the last

memory of the family to be of declining vital signs and visual slowing down of the heart rate

displayed on the cardiac monitor.

> Theresa: "I find a big one is turning off monitors...numbers and they're moving and you're watching them tick down and it's not the last memories you need."

> Akin to the rationale for modifying the environment for patients, nurses believed that

families also benefited from this intervention. Nurses felt that a modified environment

accommodated and promoted the connection between the patient and family. They mentioned

that in a busy emergency department, it was challenging to have large numbers of visitors at the

patient's bedside. There frequently was not enough physical space to accommodate large

families. Whenever possible, nurses did not restrict the number of visitors at the bedside.

However, if a patient was located in the resuscitation room and another emergent patient was

being brought in, the nurses mentioned they may need to ask family to step out and wait in the

family room if available.

Relocating patients and families within the department often provided them with a quieter, more private environment by removing them from the high activity areas of the department. One participant referred to relocating patients and families as "making it non-emerg," but she also followed this with a statement indicating that it wasn't always possible to achieve this goal. This nurse explains the benefit of moving to a quieter location:

Amelia: "no reminder of what's going on outside of them because it only matters what's happening with them."

Nurses also recognized that patients were relocated to help facilitate patient flow if the waiting room was full with extended wait times. This nurse described a situation when relocating a patient within the department assisted with through-put of patients and facilitated family to be present at the bedside:

Caroline: "The emergency department was just so busy. That they couldn't afford to keep her using a monitored bed and because the numbers of family, the number of family members that were coming all the time, they just used the room upstairs."

Responding to the family's need for information. Nurse experts in this study stressed the importance of being able to respond to the family's need for information. Inherent in this was the ability of the nurse to discern the family's need for information and the type of information they required. Participants acknowledged that the information needs of each family was different and that family members had varying comfort levels regarding discussions about issues related to death and dying.

Joyce: "Sometimes they really lean on you and they need you to answer a lot of questions…And they need you to offer some stability and safety and comfort and reassurance and just feel like there's somebody there that's walking with you…And taking care of you at the bedside and, and sometimes they just need you to be in the background and just know that you're available, but don't necessarily tap in to you as much as others."

Nurse experts in this study were aware that the busy environment of the ED often pulled them in many directions, making it difficult to respond to families' information needs in an

unhurried fashion. However, nurses felt it was imperative that an interaction should not be

impacted by the variety of other factors occurring in the department. This nurse explained:

> Amelia: "You don't ever want them to feel like they're taking your time."

Another participant reinforced this behaviour of not rushing exchanges with family and further

described the importance of being focused and present with each conversation:

> Joyce: "…you want that family to feel like you're actually there for them and giving
> them their undivided attention."

Nurses successful in these types of interactions had learned to adapt to the ever changing

work landscape within the ED. Nurse experts explained that they viewed themselves as playing

the role of various characters within a scene while various patients and scenes occurred

simultaneously. This was done in a genuine manner but it was necessary to meet the needs of

multiple individuals. These nurses explain:

> Maria: "You have to pop yourself out of that mould, pop yourself into the, the next
> mould, do what you have to do, pop yourself out of that mould and back, so you, you
> multitask with, keeping in mind that you have to provide the care for the, for, for
> everybody so."

> Amelia: "you know you've got different hats and faces and stuff that you put on for
> different situations and you just make sure they're as comfortable as they can be and that
> you're not making them, giving them the wrong impression sort of thing."

Nurses ensured families had the necessary information to make treatment decisions. One

participant described a situation with the spouse of a gentleman diagnosed with liver cancer. The

wife felt overwhelmed in having to make some difficult decisions regarding her husband's care.

The nurse ensured this woman had all the information she needed and encouraged her to ask as

many questions as she needed answered.

> Joyce: "…helping her feel like she had all the answers and that she was making good
> decisions for him and she was supporting him and doing everything she could for him…I
> said, we'll get the answers to make sure that you are clear on why we are [providing
> comfort care]."

In conjunction with providing them with necessary information to make decisions, nurses also

understood that families often sought clarification in regards to the care being provided. Nurses

recognized that seeking clarification was not a reflection on the care they themselves provided,

but rather reflected the need of the family to be reassured that the patient was not suffering. In

some instances, providing information in the form of reassurance about the patient's comfort also

provided comfort for the family member.

> Joyce: "I think a big thing for the family they often need reassurance that he's, that the patient's not…Um I think they often want reassurance that he's, they're not, the patients not having pain…That the patient is not suffering in any way."

An important facet of responding to a family's need for information included making

certain families understood information that was provided to them by other healthcare

professionals. This nurse indicated that she would directly ask family members if they required

additional clarification:

> Theresa: "and I've been doing it for a lot of years, so I find that I just generally say, 'do you have any questions about what the physician had, had to say?'"

Keeping families informed on the status of wait times and bed availability were key

pieces of information for nurses to communicate on an ongoing basis. This participant described

how she keeps dying patients and their families informed when family are located in the waiting

room and there are no available beds in the department:

> Caroline: "just letting them know that we're working on trying to get a bed for them, we'll get them back as soon as we can, things like that."

Nurses felt it was necessary to be honest and direct in communicating information to

family about patient prognostication. When families were provided with honest prognostic

information, it provided the opportunity for them to begin the grieving process in anticipation of

the patient's death. With this type of knowledge, family members were able to begin to prepare

themselves for the patient's death. This nurse explained how family interactions with their dying

relative may hold therapeutic benefit for the family members in the future when equipped with

this information:

> Maria: "You have to allow them the opportunity to say what they have to say, to acknowledge the fact that they're going to be lonely or miss the, their loved one. But to start that grieving process because if they start before the patient dies it will actually in some instances ease it after the patient is gone."

Ensuring the psychological and emotional well-being of family members. Nurses were

concerned for the well-being of family members and consulted with various disciplines within

the health care team to ensure the family's psychological and emotional needs were met. Nurses

recognized that the patient and family required someone to sit and spend time with them at the

bedside. When nurses were unable to fulfill this need, they engaged the assistance of an

appropriate team member. In general, team members from the spiritual care or social work team

were consulted as described by these nurses:

> Amelia: "…if we don't have all the time in the world to talk to them we can start the conversation, we can get our social worker involved, pastoral care involved."

> Caroline: "We have a fantastic chaplain. She comes in even when she's not on call if we're stuck we can call her and she'll come in and do spiritual care."

If these resources were not available, nurses sought assistance from the psychiatric nurse

working in the emergency department as described by this participant:

> Caroline: "We were really fortunate that night we had our psychiatry nurse, our PEN nurse on and they, they step in as well at that point and they helped deal with the family."

> Nurse experts in this study recognized there were certain patient care scenarios that had a

greater emotional effect upon them as individuals than others. Such scenarios in turn influenced

the nurse expert's behaviours to ensure the psychological and emotional well-being of family

members were met. In circumstances when nurses were affected emotionally to a greater degree

than usual, they felt a sense of responsibility to ensure the individual would be cared for.

Emergency nurses rarely know what happens to a family member after they leave the emergency

department, but this participant described how she needed to be assured that a young woman

would be cared for after the death of her mother:

> Amelia: "I needed to know what happened and how was she doing and what was going to happen for her that day because I needed to know that there was a plan for her cause she was all alone...I was relieved, you know, when the grandma and the aunt were coming in and so this girl was looked [after]."

From personal experience, some participants knew how overwhelming the days

following the death could be for bereft family members. Making funeral arrangements may

demand much of a person's time and energy and requires many decisions to be made. The

participants reinforced to family members that they still needed to care for themselves physically

and emotionally:

> Caroline: "I say 'there are going to be people that are going to be calling on you right, left and center, you're not going to know if you're up or down.' I say, 'but in spite of all of that, you have to take time to grieve, you have to eat and you have to sleep or else you're going to collapse.' And I make a point of telling them that."

These participants wanted to ensure that there were support persons for family members

to lean on and therefore, they probed family members of dying patients to determine what type

of support system they had in place. This participant described the types of potential questions

she asked family members when seeking out information regarding their potential support

systems:

> Caroline: "do you have somebody that you can talk to, do you have somebody to stay with you, do you have a priest, do you have a counselor, do you have a friend, somebody to help you get through this?"

Supporting cultural traditions and spiritual or religious beliefs. Nurse experts in this

study identified that an important aspect of responding to the family concerned supporting their

cultural traditions and spiritual or religious beliefs. This was most often accomplished by taking

advantage of the cultural and spiritual care resources that existed in the facility. Regardless of the

fact that nurses were frequently of different cultural backgrounds and had different spiritual and

religious beliefs than the patients and families for whom they cared, their actions played a role in

fulfilling families' spiritual and cultural needs at the end of life. This nurse stressed the

importance of asking specific questions to ascertain potential spiritual and cultural needs:

> Theresa: "I have asked family about religion and or different cultural beliefs, it's sort of like okay what would you, is there anything you would like to do now, is there anything that you would, anybody you need to bring in, to come see them, is there any tradition that you want to do now?"

> Nurses stated that at times it was challenging to understand or support different cultural

displays of emotion even though they knew in certain cultures such overt displays and

expressions of grief were a sign of respect toward the departed. In such cases, nurse experts

stressed the importance of adopting a non-judgmental stance:

> Joyce: "So that at times I think that we have a hard time not being judgmental. And uh we feel too that it uh, they create a bit of a display in emerg, I mean it's a big open box right and everybody can see so and I think sometimes we feel awkward and uncomfortable with that."

> Although nurses identified addressing spiritual care as part of a holistic approach in care

of the patient and the family, they always sought permission prior to initiating this component of

care.

> Caroline: "I try to promote um, is providing the spiritual aspect to the people that are involved, it's, it's, like it's not always accepted and, and -- but at least I know that I've offered it. "

Responding after Death of the Patient. Nurses recognized that care of the patient and

family continued after the patient had died. Three behaviours identified by the participants as

important when responding after the death of the patient included: i) providing family members

with privacy and time with the patient's body; ii) delivering notification of death; and iii)

demonstrating respect for the body post-mortem.

Providing privacy and time with the body. When the patient died in the emergency

department, nurses provided support for the family after the death. The primary supportive

behaviour was to provide privacy for the family in order to have sufficient time with the body of

the patient to say their good-byes. These nurses explained:

> Caroline: "we'll let them spend as much time as they need to um with the family member."

> Amelia: "so you want to make sure that the family does have opportunity for whatever they need, you know."

If circumstances had not allowed for a more private location to be found prior to the

death occurring, participants tried to make this possible after death. Sometimes, this meant that

nurses need to carve a private space within the emergency department for the family. This nurse

describes how such a space was created:

> Theresa: "we were able to cordon off the back part of our resus room and give them the privacy and time..."

Similar to how nurses felt that no patient should die alone, nurses considered it essential

that family members not be alone after the death of their loved one. While in the department,

nurses continuously checked in on the individual(s) while still respecting their privacy. This

nurse describes how she balanced providing support for a spouse while still allowing him privacy

with his wife's body:

> Caroline: "there was nothing I could do, but I just stood there and and to be with him to, you know, I left him alone, but I would go back and check on him."

Delivering notification of death: When patients had died before the family had arrived in

the ED, nurses played a role in informing family that the patient was dead. Nurses in this study

indicated that they carefully considered the best way to break the news to the family. There was

agreement among study participants that such information should ideally be given in person. In

instances when nurses had been closely present during the patient's death, nurses considered

delivering the death notification as maintaining continuity of care for the family members. This

participant described the importance of delivering this information even when her shift had

ended:

> Amelia: "these three people walked in and, I saw out of the corner of my eye and I started
> to walk to "S" and I just said "S", I can't go yet. And I have my coat on, my big boots
> and I turn around and I, I walked back to the girl and I said you know who I was…"

Demonstrating respect for the body post-mortem. Nurse experts in this study described

behaviours that were respectful of the patient's body after death had occurred. Nurses ensured

that patients' bodies were clean and covered appropriately prior to family viewing the body. No

participants discussed washing the entire body; however, visible blood and emesis were washed

off. Soiled gowns and bedding were also replaced with clean ones. If invasive interventions

such as nasogastric tubes, foley catheters, and intravenous cannulas were not removed prior to

death, they frequently remained in situ post-mortem as a requirement of the medical examiner

where the patient dies, and has been in hospital less than 24 hours. Nurses covered the body with

a blanket with arms positioned in a manner so the individual's hands were easily accessible for

the family to reach if desired. This nurse viewed these actions as comfort for the patient and the

family:

> Caroline: "…I don't know why I do this but even after a person has died, I will put a
> warm blanket on them. Its, I, I, I know. It, it doesn't make any sense, but to me a warm
> blanket is comfort."

Responding to Colleagues. Participants discussed the importance of responding to the

needs of their colleagues during and after the death of a patient. Responding to colleagues

included: i) mentoring novice nurses in providing end of life nursing care; ii) providing support

to nursing colleagues during the episode of care; and iii) providing support to all colleagues

following the death of a patient.

Mentoring novice nurses. Nurses spoke to the fact that new graduate nurses were now

hired to work in the emergency department without being required to have previous medical or

surgical nursing experience. All of the nurse experts in this study had worked on a medical or

surgical ward prior to becoming an emergency nurse. Expert nurses identified that some of their

novice nursing colleagues did not have the life experience or nursing experience to provide

holistic end of life care. Participants identified that new graduates were often focused on

completing tasks to ensure physical comfort was provided, but they were not at a level of

proficiency in which they could also care for psychosocial needs of the patient and family. One

participant provided an example of how lack of knowledge regarding symptom management in

end of life care resulted in less than optimal care:

> Theresa: "There was one patient that was getting um morphine subcue and the nurse
> didn't know and she was giving subcue injections of morphine, so taking care of the pain
> control. But not realizing yeah, we could put a butterfly in and then just give it that way."

Participants acknowledged that everything was not learned during a nurse's initial

education program, and that a great deal of information and skill was acquired while engaging in

clinical practice. This participant described her own experience of learning from nursing

colleagues and how her knowledge based was developed over time:

> Theresa: "I mean I wasn't taught it either but it's more of I was taught by other nurses
> and, you know, the sisterhood. On down the line, you know of the, knowing about the
> Scopolamine. Knowing about the Atropine, um knowing it's okay to give five
> milligrams morphine and if they stop breathing you did not do it, you made them
> comfortable so they weren't struggling anymore."

Therefore, participants identified the importance of mentoring novice nurse colleagues to

facilitate their development. Such mentoring sometimes took the form of having colleagues work

alongside them in order for them to observe the care provided. This participant explained:

> Maria: "It doesn't take a long time, you just have to pull them in with you and, you know,
> let them watch what you're doing."

Providing support to nursing colleagues during the episode of care. Nurses recognized

that their nursing colleagues may struggle with different aspects of providing either physical or

psychosocial care to the dying patient and family. Participants in this study described that they

supported nursing colleagues who struggled with either care of the patient or the family. For

example, when they observed that a colleagues' reaction was to distance themselves from a

situation because they were afraid of expressing emotion at the bedside, nurses provided

affirmation that families would not be upset if a nurse displayed emotions. This participant

explained:

> Theresa: "'Do you think the family's going to be upset that you're upset that their loved
> ones dying?' No they're going to be okay with it."

When nurses required and requested assistance in providing support for the family, expert

nurses were able to provide the necessary support. This nurse described how she was able to

support a nursing colleague who requested her assistance:

> Caroline: "I've had a nurse that came and called me once and said these people need
> somebody to pray with them, can you go in and do it. I've done that. So they, like they're
> asking for somebody and the chaplains not here, can you go in and do it and so I've gone
> in."

At times, assistance was not required with care of the dying patient; rather assistance was needed

to ensure care was provided for the remaining patients within the nurse's assignment. Nurses

relied on their colleagues to provide care for the rest of his/her patient load when unable to step

away from the bedside as stated by this participant:

> Maria: "If you're tied up with that patient then hopefully your partner can pull the slack
> on the other beds in, in your area."

Nurses relied on each other for emotional support as well as clinical knowledge. When

nurses experienced challenging care situations, nurse experts provided support by listening to

expressions of emotion or frustration from their colleagues, as well as providing advice and

expertise on how to approach various care situations. Nurse experts also indicated that they were

both providers and recipients of collegial support: This participant described how she relies on

other colleagues for support:

> Joyce: "I think we rely on each other a lot. Yeah, especially when you walk out of their room and you don't know either or you need to you know vent a little, not vent but release a little bit of your own… like, oh, I don't know what to do with this because such and such is happening or this family is saying this or, you know, upset because of and so you want to problem solve right. So for sure we rely on each other for our own probably emotional support and for knowledge."

Participants felt it was essential to support their colleagues as needed and they felt these

behaviours were more readily accomplished when they were assigned the role of charge nurse.

A nurse in charge of the department had a bigger picture of what was occurring and could

recognize when a colleague needed assistance providing care to a dying patient or their family

member, and could provide the support when it was needed.

> Amelia: "The charge nurse can go in and help the nurse, or if the nurse has got a really good rapport with the patient and the family then I can take over looking after other patients for that [nurse]."

Providing support to all colleagues following the death of a patient. Nurses who

participated in this study also provided support to, and cared for, their colleagues after the death

of the patient. Participants were aware that care of colleagues went beyond their nursing

colleagues and extended to other members of the health care team. In particular, nurse experts

were mindful of the support that might be required by the health care aides who work alongside

nurses and provide direct care of patients.

When a member(s) of the health care team felt apprehensive as to whether they could

have done something better in the care of a patient, study participants reported that they provided

reassurance and perspective on the situation. This nurse described how she supports colleagues

by reassuring them about the appropriateness of the care they provided:

Caroline: "I do. And and I'll go see, I'll, I'll spend time with the younger ones if they've had a patient whose died because you know they cry, they're upset. I just reinforce no, there's nothing that you could have done. You did the best nursing care that you could, um this is, you know, it was going to happen."

Nurses were also supportive of colleagues who, with no previous experience with death,

encountered it for the first time in the ED. One participant described finding a health care aide

colleague in the back room of the ED crying and the support she provided.

Theresa: "I found her in the back room crying and when I approached her to find out what was wrong, she said it was the first time she had ever seen a dead body. It had happened a few days before, but she was having a hard time with it. I told her that the first one is probably the hardest one. We sometimes forget what it is like to be that new."

Summary

This chapter has presented a description of demographic characteristics of the sample,

and the five behaviours and their sub-themes deemed as critical by nurse experts when providing

care for the dying patient in the emergency room setting. Chapter 6 presents a discussion of the

findings in relation to past research and pertinent literature, and outlines the implications of the

study for nursing education, practice, and future research.

Chapter Six: Discussion

Introduction

This chapter discusses the findings of the study in relation to existing literature examining expert care of the dying, and the research questions driving the study. Limitations of the study, along with its implications for nursing education, practice, and research, are also presented.

Participant Reactions to Being Nominated as a Nurse Expert

Consistent with past studies examining the nature of expert nursing practice, the majority of participants in this study did not view themselves as experts in providing end of life care to dying patients in the ED, and expressed surprise in being nominated by their colleagues. Participants felt honoured to be nominated despite feeling that care they provided to dying patients was just 'part of being a nurse.' When recalling clinical experiences and situations about the care of dying patients, it was sometimes challenging for participants to separate situations where patients were being actively resuscitated compared with situations where patients were receiving comfort care measures. Nurses were able to more readily provide examples of situations where the patient died and resuscitation efforts were unsuccessful However, the participants were also able to articulate interventions that contributed to quality end of life care for dying patients. Although their ability to implement these interventions was not always possible due to the environment of the emergency department, participants were resolute to the fact that they tried their best.

Expert Nurse Behaviours in the Care of the Dying Adult Patient

From this study, five behaviours were identified as being critical in the provision of nursing care of the dying adult patient in the ED. These behaviours included: 1) providing

comfort; 2) honouring the personhood of the patient; 3) responding to the family; 4) responding

after the death of the patient; and 5) responding to colleagues. Each of these behaviours will be

discussed in relation to existing literature.

Providing comfort. Providing comfort was identified by nurse experts in this study as a

critical behaviour in care of the dying patient who presented to the ED. Three key behaviours

contributed to providing comfort for the patient: i) reducing and eliminating physical symptoms;

ii) providing basic nursing care; and iii) modifying the environment.

Reducing and eliminating physical symptoms. Nurses in this study identified that

reducing and eliminating distressing symptoms—most notably management of pain and

dyspnea—were critical in providing comfort care for patients. Nurses ensured patients were

comfortable through early intervention and aggressive management of symptoms. Typically

they worked together with the emergency physician in managing symptom distress. The

palliative care clinical nurse specialist (CNS) was also consulted if symptom management was

difficult to achieve.

Previous research examining expert nurse behaviours in care of the dying has also

identified providing comfort as an important aspect of care performed by nurses (Degner et al.,

1991; Harbeck, 1995; Hawkins, 1995; Helwar, 1994; McClement & Degner, 1995; Wowchuk,

2004). Degner et al. (1991) in their study examining expert care behaviours of nurses caring for

palliative inpatients identified that reducing physical discomfort--particularly through pain

management--was important. McClement and Degner (1995) in their qualitative study

examining expert nurse behaviours in care of the dying adult in the ICU identified the nurse

behaviour of reducing both physical and psychological pain. Harbeck (1995) completed a

qualitative study of expert nurse behaviours in care of the dying patient on an adult medical ward

and determined that along with reducing physical pain, providing comfort also incorporated the

prevention of unnecessary procedures, including resuscitation. In particular, nurses challenged

tests and procedures that were ordered when the results of such tests and procedures would not

change the outcome, or have a positive effect for the patient. Harbeck also reported that the

nurses in her study would sometimes refuse to carry out an order if the physician could not

provide a sound rationale for its purpose (Harbeck, 1995). Hawkins' (1995) qualitative study of

expert nurses caring for dying children in the hospital setting described providing comfort in

terms of reducing physical pain and satisfying children's psychological and emotional needs.

Similarly, Helwar's (1994) study examining expert nurse behaviours in care of the adult dying of

cancer in the community reported that providing comfort encompassed reducing physical,

psychological, and emotional pain, as well as responding to the patient's spiritual and

informational needs. Wowchuk (2004), in her qualitative study of dying adult residents in the

personal care home, found that providing comfort consisted of reducing physical and

psychological suffering, advocating for the dying person, shielding the person from stressful

family dynamics, and ensuring that changes in medical status were addressed by the attending

physician.

Providing comfort through symptom management is consistent with critical care nurses'

perceptions that managing a patient's pain and discomfort facilitates a good death (Beckstrand et

al., 2006). As part of a larger quantitative American study, Beckstrand and Kirchhoff (2005)

examined critical care nurses' perceptions of obstacles and supportive behaviours when

providing end of life care to the dying. Participants were asked to provide suggestions to change

end of life care in ICUs. Fifty-six percent of the 861 nurses who returned completed

questionnaires provided suggestions related to providing a good death for patients. Managing

symptoms was identified as an important strategy in this regard (Beckstrand et al., 2006).

The importance of providing adequate symptom management is reinforced by studies

seeking patients' perspectives in regards to end of life care. Many patients express fear they will

suffer due to pain and other distressing symptoms, and view the management of these symptoms

as a key component in receiving quality end of life care. In a qualitative study to identify and

describe elements of quality end of life care from the patients' perspective, Singer et al. (1999)

completed face-to-face interviews with participants (n=126) receiving dialysis, living with

human immunodeficiency virus (HIV) infection, and residents of a long-term care facility.

Receiving adequate pain and symptom management was identified by these study participants as

one of the five domains of quality end of life care (Singer et al., 1999). The remaining four

domains included: avoiding inappropriate prolongation of dying; strengthening relationships

with loved one; achieving a sense of control; and relieving burden. Receiving adequate pain and

symptom management was the least reported domain (22% of participants) compared with

avoiding inappropriate prolongation of dying which was the most frequently reported by

participants (68%).

Steinhauser et al. (2000) completed a qualitative study in the United Sates to determine

factors considered important at the end of life from the perspectives of patients with advanced

chronic illnesses (n = 340), their family members (n = 332), physicians (n = 361), and other

health care providers (n = 429). Being free of pain was an attribute ranked by all participants as

being very important at end of life. A slightly larger percentage of physicians (99%) and other

healthcare providers (97%) identified being pain-free as a very important factor at end of life

compared to patients (93%) and their family members (95%) (Steinhauser et al., 2000).

Volkner, Kahn, and Penticuff (2004) completed a descriptive qualitative study to explore what people with advanced cancer wanted in regards to personal control and comfort at the end of life. Seven people with advanced cancer diagnoses were interviewed. Control of pain and other symptoms associated with disease was identified as one of the six themes that emerged from this study (Volkner et al., 2004).

Providing basic nursing care. Essential to providing comfort for nurse experts in this study was the opportunity to provide basic nursing care. Whenever possible, emergency nurses preferred to be involved in delivering basic care such as toileting, repositioning, and mouth care rather than delegating these activities to other members of the health care team. Providing 'hands on' care allowed them to provide the type of comfort that they themselves would like to receive. The provision of comfort related to hygiene and other basic nursing interventions were behaviours identified in other studies examining nurse experts in various care settings. Attention to hygiene was noted by ICU nurses (McClement & Degner, 1995), pediatric nurses (Hawkins, 1995), medical nurses (Harbeck, 1995), and community nurses (Helwar, 1994). Nurses' preferences as to whether they preferred to be directly involved in this care or whether these activities were delegated to other staff members were not identified in these studies. Nurses working on a ward or in the ICU may regularly perform these aspects of care on their own based on personal preference or existing workflow of the unit. As a result, identifying a preference regarding the delegation of this facet of patient care may not have been relevant for expert nurses caring for dying patients in other hospital care settings.

The expert nurses in this study identified lack of time, due to workload and staffing resource challenges, as the key factors that impinged upon their ability to provide their desired level of end of life care for patients. This is consistent with the findings of a quantitative study

completed by Beckstrand et al. (2008) in which 272 emergency nurses ranked selected obstacles

and supportive behaviours of the health care team and family members in providing end of life

care in EDs. Having workloads too high to allow adequate time to care for dying patients and

their families was identified by emergency nurses as the greatest obstacle in the provision of end

of life care in the ED.

Modifying the environment.   Modifying the environment of the ED was identified by

nurse experts in this study as an important behaviour in helping to provide comfort to patients.

Specifically, nurses explained they modified the environment by transferring patients out of the

department, moving patients to quieter locations within the department, or lowering bright

lighting and modifying the temperature of patients' rooms. Other studies examining the nature

of expert practice in care of the dying have described modifying the environment as a way of

providing comfort, albeit in different ways than those described by the nurse experts in this

study. Wowchuk (2004) highlighted the necessity of providing a comfortable environment by

creating a physical setting that was home-like and familiar to the dying personal care home

resident and his/her family. Wowchuk's study was conducted in a personal care home and,

therefore, this physical space was considered the person's home.

Harbeck (1995) identified the importance of creating an environment that was conducive

to patient and family interactions and limiting behaviours that maintained a "hospital"

environment on an adult medical unit. Creating a private space where chairs or cots could be

added for family members to use was the primary action taken to facilitate a more home-like

atmosphere. Expert nurses caring for dying inpatient pediatric patients also participated in

behaviours that fostered a home-like environment (Hawkins, 1995). Along with permitting the

child and family to bring many personal things, a set of household furnishings that included a

sofa-bed, dresser, and bedside lamp was made available for the dying children and their families

to use.

The behaviours of creating a home-like environment and making it feel less like a

"hospital" setting identified in the aforementioned studies are different from the ways in which

nurse experts working the ED modified the environment in the service of providing comfort.

The differences in what modifications are performed in various care settings may be attributed to

the transitional environment of the ED compared to the personal care home and inpatient hospital

units. With the awareness that the ED facilitates through-put of patients, there is always the

potential for patients to be relocated either within, or transferred out of, the ED to accommodate

other patients. Emergency nurses may not be able to foster a home-like environment as

described in other studies due to limited physical space and resources, as well as the potential

that the patient may be relocated. The transitional aspect of a patient's hospital stay is not

characteristic of, and therefore, may not be relevant in other care settings. For example, unlike

the emergency nurses in this study, expert nurses in both a hospital palliative care unit (Degner et

al., 1991) and a medical unit (Harbeck, 1995) did not identify modifying the environment as an

essential behaviour in the provision of end of life care. In both of these settings, there is no

anticipation that a patient will be relocated prior to their death and therefore the need to modify

the environment in the same way as an ED nurse is not present.

Nurses in this study believed that transferring patients out of the ED to a ward in the

hospital would help ensure that the patient was ultimately more comfortable. The behaviour of

transferring patients out of the emergency department was also identified by ED nurses who

participated in a study in the United Kingdom (Bailey et al., 2011a). The nurses (n = 11) who

were interviewed as part of Bailey et al.'s (2011a) qualitative study also strongly felt that the ED

was not the ideal location for death to occur.   Like the ED nurse experts interviewed in this

study, the nurses in the U.K. study perceived moving dying patients to a ward meant that the

patient would be placed in a bed and not a stretcher, and cared for in a location that was removed

from the busyness of the ED. The nurses in the U.K. study also felt that ward nurses had more

time to spend with the patient and the focus of the work performed on the ward was more

suitable to caring for the dying patient compared to the ED (Bailey et al., 2011a).

However, in contrast to the findings of Bailey et al. (2011a), the nurses in this study did

not identify that relocating dying patients within the department was meant to segregate and hide

them from other patients in the ED. Rather, participants believed that dying patients and their

family members had the right to privacy during this highly personal experience and modifying

the environment was a behaviour that facilitated privacy.

Honouring the personhood of the patient. The nurses' actions in caring for dying

patients strongly focused on honouring the personhood of the patient. Honouring personhood

requires that nurses treat the individual as a person regardless of their health status. This requires

that care be provided in a holistic, ethical, and respectful manner. Nurses in this study honoured

the personhood of the dying patient through: i) communicating with the patient; ii) learning the

patient's story; iii) being emotionally and physically present; and iv) advocating for the patient.

Communicating with the patient.   Communicating with the patient was identified by

expert emergency nurses as a key component in honouring the personhood of the dying patient.

When patients were conscious and able to converse, nurses engaged in conversation with patients

in an attempt to develop rapport and to get to know them. When patients were not conscious,

nurses continued to verbally communicate with the patient providing information, most often

describing the care that was being provided. Expert nurses also utilized touch as a

communication tool to provide reassurance and support for the patient. Akin to the use of

speech, nurses used touch with all patients whether conscious or unconscious. Providing

comfort and communication through touch has also been identified as a valuable tool by

emergency nurses in the United Kingdom (Bailey et al., 2011b). Touch has been identified as

one component that contributes to the use of "therapeutic self," and through use of 'therapeutic

self,' nurses were able to get to know a patient and recognize the individual needs of the patient

(Bailey et al., 2011b)

       Learning the patient's story. Emergency nurses also encouraged family members to

share stories of the patient as a way to gain knowledge and an understanding of who the person

was beyond what the nurse knew of them as a patient. Learning the patient's story was

important for ED nurses as they rarely knew a patient prior to the episode of care in which the

patient was dying.

       The desire of nurses to gain a greater understanding of, and develop rapport with the

individuals for whom they care has been previously reported in the literature. Developing

rapport with the patient and their family was important to expert nurses working in the

community caring for individuals dying of cancer (Helwar, 1994). The type of rapport built in

the community setting differs significantly from the type of relationship developed between an

emergency nurse, a patient, and their family. For instance, Helwar (1994) reported that

community nurses provided their home phone numbers for families to call if they required

support. The community nurses made the choice to provide this personal information to families

whom they believed would not abuse it. This depth of relationship and level of comfort with

family members was not evident in the emergency setting. This is most likely to due to the nature

of emergency work and the limited time spent with family compared with the nature of palliative

nursing care provided in a community setting.

       The literature indicates that nurses working on an adult medical unit established

connections with the patient by getting to know them as an individual rather than as a patient.

Harbeck (1995) reported that for nurses working on the medical unit, rapport was established by

being sensitive, empathetic, and a good listener, as well as being comfortable and at ease with

the process of death and dying. Identified in research conducted with pediatric nurses caring for

dying children was the importance of nurses connecting with the child and their family by

sharing of themselves in a personal way by developing relationships that at times led the nurse to

becoming a member of the family's support system outside of the hospital setting (Hawkins,

1995). Sharing of one's self in a personal way and the development of close relationships were

not reported by the emergency nurses in this study. This may be attributed to the limited time

and opportunity to develop this type of relationship in the ED setting. Exemplars described by

the expert nurses in Hawkins' study frequently involved patients with multiple admissions or

who had extended hospital stays prior to their death thereby creating a greater opportunity for a

relationship to develop with the patient and family; something that is unlikely to develop within

the ED.

       Being emotionally and physically present.   A crucial element involved in honouring the

personhood of the dying patient was the need for expert nurses in this study to be both

emotionally and physically present for the patient during each interaction. This was often

challenging because of the other activities occurring in the department that dictated nurses'

availability. Nevertheless, nurses wanted to appear unhurried despite the short intervals of time

they had available to spend with the patient. This finding is consistent with research findings

reported by McClement and Degner (1995) where expert ICU nurses also identified that being

both physically and emotionally available was an essential behaviour during patient interactions.

The ED nurses within this study were adamant that no patient should die alone. When

patients' family members were not present, participants took the initiative to ensure a staff

member was present at the bedside during the patient's death. This behaviour aligns with the

findings of a qualitative study of ICU nurses (n = 9) that described caring actions of nurses

aimed at ensuring dignity and comfort for the patient (Fridh, Forsberg, & Bergbom, 2009).

When patients had no relatives present, nurses felt a duty to act as a surrogate. They provided

reassurance to the patient that he or she would not die alone and ensured that the patient was

never left alone (Fridh et al., 2009).

Research examining expert care of the dying in the personal care home setting has also

documented that when a resident was near death and there was no family at the bedside, nurses

themselves would sit at the bedside of dying residents, or delegate a staff member to do so

(Wowchuk, 2004).

Advocating for the patient. In this study, the dying patient was the centre of all care

provided and when the focal point was shifted off the patient, emergency nurses played a role in

refocusing attention back on the patient. In so doing, nurses helped to honour the personhood of

the patient. In particular, expert emergency nurses spoke up when there was disagreement

amongst family members as to what was deemed best for the patient. Nurses kept the patient's

best interest in mind by advocating for the avoidance or cessation of unnecessary treatment

interventions that may cause the patient undue hardship. Expert nurses vocalized their concerns

to physicians when they perceived the patient was not being provided the opportunity for a

dignified death. Advocating on the resident's behalf was also found to be an essential behaviour

amongst expert nurses caring for dying patients in the personal care home setting (Wowchuk, 2004). Expert nurses within the personal care home setting advocated on the resident's behalf by shielding the resident from stressful family situations and ensuring changes in a resident's medical status were not ignored or attributed as normal changes due to old age (Wowchuk).

Advocacy behaviours identified in studies examining expert care of the dying amongst ICU nurses differ from the advocacy behaviours identified by ED nurses in this study. ICU nurses identified they had a defined role in assisting dying patients and fulfilled this role by helping patients and their families articulate preferences related to medical treatment (McClement & Degner, 1995). Previous studies of expert nurses in care of the dying patient also provided examples of advocacy nursing behaviours; although, these behaviours were categorized as 'enhancing the quality of life while dying' (Degner et al., 1991; Harbeck, 1995; Hawkins, 1995). Nursing behaviours found to enhance the quality of life while dying were behaviours that helped patients do things that were important to them (Degner et al., 1991, Hawkins, 1995) and promoted choice and personhood (Harbeck, 1995). Pediatric nurses made their patients feel special as a way of enhancing quality of life, and they also respected and supported the child's right to die with dignity as a means to facilitate the transition from curative to palliative care (Hawkins, 1995). Similar to the views expressed by emergency nurses in this study, dying with dignity meant patients were allowed to die without unnecessary interventions or undue hardship being placed upon them (Hawkins, 1995).

Research has been undertaken in the last decade to better understand what dignity means from the patient's perspective and factors that contribute or diminish the dignity of a dying person. Development of a dignity-conserving care model was the result of empirical research focused on better understanding how patients perceive and define dignity (Chochinov et al.,

2002).   Chochinov et al. (2002) completed a qualitative study of 50 advanced cancer patients

receiving palliative care. The findings of the study identified that an individual's perception of

dignity is influenced by three main areas: illness-related concerns, dignity conserving repertoire,

and social dignity inventory. Applications of these research findings to guide clinical practice

have been discussed in the literature (McClement, Chochinov, Hack, Kristjanson, & Harlos,

2004). Illness-related concerns are comprised of issues related to an individual's level of

independence and symptom experiences. Responding to patients' physical symptoms, ensuring

patients' need for information, and providing an opportunity to discuss concerns related to the

progression of their illness are recommended behaviours that reduce patients' physical and

psychological distress (McClement et al., 2004).

Along with managing symptom distress, the illness-related concerns area of the model

addresses the importance of health care providers both understanding and assessing the extent in

which a patient's independence has been affected - both cognitively and functionally. Dignity-

conserving repertoire speaks to the approach an individual uses to maintain their sense of dignity

(McClement et al., 2004). This aspect of the model guides healthcare providers to focus on

preserving dignity as determined from patients' perspectives and practices. Akin to expert

emergency nurses, McClement and colleagues encouraged healthcare staff to utilize behaviours

that view patients apart from their disease as a means to affirm "continuity of self" and to relate

to patients as individuals worthy of respect. Other behaviours that contribute to patient's

perspective of dignity-conserving care include encouraging and facilitating patients to participate

in activities that are important for them, involving patients in their care and treatment decisions

as desired by the patient and learning how patients wish to be remembered. These last three

behaviours that contribute to patients' perspective of maintaining dignity were not specifically

identified by emergency nurses. However, this may be in part due to the decreased level of

consciousness of the majority of patients described in the participants' exemplars, but further

study is required.

The dignity-conserving repertoire facet of the model developed by Chochinov et al.

(2002) speaks to three additional practices undertaken by terminally ill patients to help maintain

or bolster their sense of dignity. These include living in the moment, maintaining normality, and

finding spiritual comfort. External factors that influence the quality of an individual's interaction

with others inform the social dignity inventory component of dignity-conserving care

(McClement et al., 2004). Behaviours that healthcare providers can engage in that help in

maintaining patient dignity are similar to behaviours identified by emergency nurses that honour

the personhood of the patient. These include: being sensitive to and respectful of a patient's

privacy boundaries; identifying and facilitating patients' social support systems; and

demonstrating a caring and respectful care demeanor (McClement et al., 2004). Two additional

behaviours that also contribute to the social dignitary inventory include: exploring patient

concerns related to feelings of being a burden to others; and assisting patients with concerns

related to worries and concerns for their family after the patient's death. These additional

behaviours were not identified in the study completed with expert emergency nurses. This may

be attributed to the fact that these behaviours were not specifically addressed by the interviewer,

but also may be due to the fact that patients described by emergency nurses were unconscious

and were no longer able to communicate verbally.

Responding to the family. Participants in this study identified four behaviours that were

important in caring for the family members of dying patients in the ED. These included:

i) reducing the potential for future regret; ii) responding to the family's need for information; iii) ensuring the well-being of family members; and iv) supporting cultural traditions and spiritual or religious beliefs.

Provision of care for the family was considered by nurse experts in this study to be an extension of caring for the patient. That the patient and family constitute the unit of care is consistent with the philosophy of a palliative care approach (Ferris et al., 2002). Once patients' symptoms were managed and they appeared comfortable, nurses then were able to shift their time and attention to caring for family members. The shifting of the nurse's focus to caring for the family may also be due to the fact that in the majority of scenarios referenced by the nurses, the patients were unconscious.

Reducing the potential for future regret. For expert emergency nurses, reducing the potential for future regret meant family members were focused on the patient in order to make the most of the remaining time with the patient before his or her death. Nurses facilitated patient and family interactions by encouraging family members to express their thoughts and feelings, and ensuring final words were communicated. Family members were encouraged to speak to and touch their loved one. Nurses also offered family members the opportunity to participate in care of the patient if desired. To promote these intimate interactions, reducing physical barriers, shielding the family from the other people in the ED, and modifying the environment to provide privacy were key behaviours performed by the expert emergency nurse.

The desire to reduce future regret for family members during the provision of end of life care is supported by previous work examining the nature of expert nurse behaviours. Palliative care nurses reported what was important to the patient was often important to the family. Accordingly, when the needs of the patient were met then the family's risk for regret was

reduced (Degner et al., 1991). Degner and colleagues in their study of expert nurse behaviours

in care of the dying from the perspective of palliative care nurses and nurse educators reported

that nurses involved the family in physical care and used role modeling to assist the family to

develop the necessary skills to provide such care. Family members were also included in the

cleaning and wrapping of the body after the patient had died, if they so desired (Degner et al.,

1991).

Research conducted with nurse experts in the ICU also identified the behaviour of nurses

inviting family members to participate in the care of the dying patient, making them feel

welcome at the bedside as opposed to feeling that they were underfoot, and allowing family

members liberal access to the patient versus insisting that visitation hours be strictly adhered to

(McClement & Degner, 1995). In order to reduce the potential for future regret among family

members, research conducted with nurses working on the medical inpatient unit helped families

define and follow up with activities that were identified as meaningful to them. Experts in that

study also felt it was important for family members to be present at the death scene and therefore

continued to offer this opportunity to families; even those families who may have not have

expressed a desire to be present previously (Harbeck, 1995).

Community nurses caring for patients dying of cancer helped to reduce family members'

potential for future regret by acting as a liaison between family members and the dying patient

with the goal of helping patients and families to make amends, express their feelings, and to clear

their respective conscience before death occurred (Helwar, 1994). Pediatric nurses approached

reducing the potential for future regret from a slightly different angle compared with the current

and aforementioned studies. Pediatric nurses strived to heal rifts between the families and health

care providers that may have developed when parties had divergent ideas on the child's care,

such as when families did not want the child to know they were dying (Hawkins, 1995).

   Responding to the family's need for information. Responding to the family's need for

information was also considered an important nursing behaviour. Expert emergency nurses were

able to discern the family's need for information as well as the type of information they required.

In each interaction, emergency nurses delivered information honestly and in a sensitive, but

direct manner. Nurses strived to be present, engaged, and focused, during each conversation—

not allowing distractions within the ED to interfere.

   Research examining the nature of expert care of dying patients on a palliative care unit

conducted by Degner et al. (1991) also identified the importance of recognizing and responding

to a family's need for information. In that study, nurses responded to families in a calm, matter

of fact manner which contributed to family members' confidence in the nurse's ability to care for

the patient (Degner et al., 1991).

   Research examining the nature of expert care in the ICU reported that nurses responded

to a family's need for information regarding the patient's condition, the medical treatment being

received, and the patient's response to the treatment (McClement & Degner, 1995). Similar to

the emergency nurses in this study, ICU nurses identified the importance of being present and

able to clarify information received from other health care providers (McClement & Degner,

1995).

   Hawkins' (1995) study of nurses working with inpatient pediatric patients identified the

importance of nurses establishing good communication with the family in order to understand

how much information a family wanted or needed to have (Hawkins, 1995). Hawkins also

reported that providing information on a regular basis, honestly, and in everyday language were

important parts of responding to a family's need for information (Hawkins, 1995). Similar to ICU and emergency nurses, pediatric nurses in Hawkins' study made themselves available to families to clarify and reinforce the information provided by physicians. Recognizing that family members may not have understood or heard information delivered by physicians, the medical nurses in Harbeck's study also confirmed the family's understanding of information and clarified information as needed.

Harbeck (1995) reported that when the family unit was well-known to the nurse, nurses working with inpatient adults on a medical unit were able to gauge the delivery of the information they provided to families, the amount of information delivered, and they were able to identify the member who was most appropriate to receive the information (Harbeck, 1995). Akin to the emergency nurses in this study, information assisted family members to make choices as to whether to remain or leave the bedside (Harbeck, 1995).

Research examining the practice of expert nurses in personal care homes identified that nurses provided information and explanations to families about what to expect regarding anticipated changes in a resident's health status as death approached. Nurses also provided guidance to the family in the decisions families were required to make (Wowchuk, 2004). Amongst community nurses caring for patients with cancer, teaching family members was considered an integral part of the nurses' role in regards to sharing both clinical and theoretical nursing knowledge (Helwar, 1994). Community nurses often taught family members the skills required to provide physical care, and also provided information about the dying process and expected changes that would be seen in the patient as death neared (Helwar, 1994).

Research suggests that families may be impacted negatively when a loved one receives end of life care in a hospital setting. A qualitative study to gather suggestions from family

members (n = 29) of deceased patients in regards to improving end of life care in a tertiary care

hospital identified that family members were impacted by the routine and bureaucratic hospital

environment and expressed feelings of regret about the end of life experience (Pierce, 1999).

Families were dissatisfied when they had not been permitted to spend time at the dying patient's

bedside and when communication had not been honest and direct with both the patient and the

family (Pierce, 1999). Pierce suggested areas for improvement related to the environment and

communication aimed at negating the impact of the healthcare system on family members and

improving the experience of end of life care in a hospital setting. Allowing families to be

physically near the patient provided comfort for family members; however, many family

members needed to be encouraged and given opportunities to touch their loved one. As well,

family members felt it was important that they be involved in patient care such as turning or

basic hygiene. Family members also sought improved communication between health care

providers and the patient and their families. Strategies to improve interactions between these

parties included: providing information, taking the time to listen, and being respectful of patients

and families as people (Pierce, 1999). Consistent with the findings of the present study,

establishing a private and peaceful setting for dying was also viewed as an essential component

to improving end of life care (Pierce, 1999).

The literature indicates that communication with family members is considered to be as

important as communication with the dying patient (Dahlin & Giansivacusa, 2006). Zerwelch's

model for family hospice caregiving asserts that a nurse's communication sets the tone for all

care provided (Dahlin & Giansivacusa, 2006). When information is provided honestly, nurses

are able to connect with family members and family members are empowered to make decisions

(Dahlin & Giansivacusa, 2006). Communication issues on acute hospital units have been found

to be similar to the current study in the ED. Davis, Kristjanson, and Blight (2003) completed a

qualitative study with 60 nurses who worked in an acute cancer hospital setting. The purpose of

the study was for nurses to describe problems and strategies related to communication issues.

Communication between the nurse and the family was negatively impacted when there was a

lack of time to spend with the family and lack of privacy for the patient and family. Privacy,

time, and honest communication were identified by nurses to be important supportive strategies

for nurses to use with families of patients with advanced cancer (Davis et al., 2003).

The importance of meeting family members' information needs appears to influence

family members' physical and emotional well-being. Family members have been identified as

being a "hidden patient" as their psychological and physical health may be impacted by the

illness of the patient (Kristjanson & Aoun, 2004). A family member's grief may be complicated

by the memories they carry related to the palliative care experience (Kristjanson & Aoun, 2004).

Using a systems approach to family care, Kristjanson and Aoun synthesized existing empirical

work that examined how to support families in a palliative care context. Supportive behaviours

included providing families with information that is easily understood and provided in a straight

forward manner that does not cause them to feel overwhelmed. However, families were

negatively impacted when information was delivered in more public locations rather than in a

private setting. As well, families did not feel comfortable asking questions when they felt they

were bothering the healthcare provider.

Ensuring the well-being of family members. Nurses in the current study desired to meet

the information needs of family members. However, participants were aware that they did not

always have the time required to spend with family members, nor were they always the best

person to provide the necessary information. This awareness prompted nurses to seek assistance

from interdisciplinary team members.   Nurses regularly consulted spiritual care staff and social workers, who were able to spend more time speaking with family and provide responses to non-medical questions. Palliative care clinical nurse specialists (CNS) were consulted by nurse experts to determine bed availability, and provide insight into a patient's history or family dynamics that may not otherwise be known by emergency staff. It was noted that the CNS was consulted less often than spiritual care staff and social workers. A couple of factors may explain the reason as to why this was the case. The first reason is the fact that the availability of a CNS consult is generally limited to regular business hours which does not meet the needs of the 24 hour emergency care. Second, there may be uncertainty on the part of ED nurses in regards to the role of the palliative care CNS in the emergency setting. Participants in this study expressed the need for more education in regards to the overall regional palliative care program, how the program could work in relation to their facility, and how the CNS role could be better integrated into their nursing practice. Nurse experts in this study believed their emergency nursing colleagues were not familiar with the potential benefits to be gained when members of the palliative care team are engaged.

Research indicates that the role of the palliative care CNS may confer benefits for patients and family members. A qualitative study explored the perception of stakeholders (n = 27) within an acute care hospital and the potential benefits of the palliative care CNS role (Jack, Oldham, & Williams, 2003). The benefits of the role of the palliative care CNS identified included symptom control, psychological care, and being an advocate for both the patient and family members. This finding underscores the importance of close working relationships between ED nurses and palliative care CNSs.

Previous studies examining expert nursing care of the dying did not identify a need to consult other interdisciplinary team members to ensure the emotional needs of the family were met. Rather, as a means to ensuring the emotional well-being of family, nurses working in palliative care, adult inpatient medical units, and pediatric inpatient units sought to include family in providing care or to relieve them of the responsibility of providing care according to what was best for the family (Degner et al., 1991; Harbeck, 1995; Hawkins, 1995). Helwar (1994) reported that community nurses provided emotional support to family members by providing reassurance and encouragement. Emergency nurses in the current study also provided emotional support for family members using the time they had available. However, when a greater length of time was required to spend with patients than nurses had available, they engaged additional resources to meet this need. The fact that the use of interdisciplinary teams were identified in this study and not previous studies may be attributed to the increase in knowledge and understanding in regards to palliative care over the last two decades. As well, the CNS role was only emerging as a new role in nursing during the time these studies were conducted.

The use of interdisciplinary team members within the hospital care setting has also been examined within the literature. Incorporating effective interdisciplinary teams at times may be challenging (Connor, Egan, Kwilosz, Larson, & Reese, 2002; Coyle, 1997). However, literature suggests that implementing a collaborative approach practice model improves the quality of end of life care for dying patients and their families (Coyle, 1997; Llamas, Pickhaver, & Piller, 2001). Coyle (1997) proposed that collaborative practice creates an environment whereby potential problems are anticipated and identified early rather than being merely reacted to after the problem has occurred. Similarly, a systematic review of studies evaluating hospital based

palliative care teams using qualitative meta-synthesis and quantitative meta-analysis also

supported the use of interdisciplinary teams (Higginson et al., 2002). Although there were

variations in the interventions within the 13 studies reviewed for the meta-analysis, Higginson et

al. found a majority of studies demonstrated a positive effect on the quality of care provided to

patients and their families which suggests palliative care teams play a beneficial role within the

hospital setting.

        In a review of the existing literature on how teams function, Connor and his colleagues

sought to identify characteristics of high-functioning interdisciplinary teams (Connor et al.,

2002). Overall, interdisciplinary teams were found to focus on the biopsychosocial and spiritual

dimensions of an individual (Connor et al., 2002). Higher functioning teams encouraged and

permitted the patient and family to direct care in a manner that was consistent with their beliefs

and desires for end of life. As well, higher functioning teams were found to have clearly defined

roles within the team, and team members were allowed to grow and learn from their mistakes.

Rather than a traditional top down approach, leadership was shared amongst these teams.

        Literature has also suggested that EDs may benefit from the use of multi-disciplinary

palliative care team within the ED. In the development of palliative care guidelines for nurses,

Norton, Hobson, and Kulm (2011) put forward a recommendation for institutional change to

incorporate a multi-disciplinary palliative care team in EDs with high volumes of patients

receiving end of life care. It was suggested that a specialized team would support ED staff,

address the needs of the patient and family, participate in symptom management, give support to

enhance quality of life until death, aid in bereavement, and enhance communication between the

patient, family, and health care team (Norton et al., 2011). However, these recommendations

require evaluation in clinical practice to determine if these recommendations are beneficial and

contribute to improving end of life care in the ED.

   Supporting cultural traditions and spiritual or religious beliefs. Expert nurses in this

study supported families' cultural traditions and spiritual or religious beliefs in a holistic manner

regardless of the beliefs held they themselves. Despite the fact that nurses were not familiar with

many of the different cultural and spiritual practices of the patients for whom they cared, they

were comfortable asking questions in order to better understand, and thus attempt to meet the

needs of the patient and family. If the nurse's offer of spiritual care was accepted by family, or if

it was specifically requested by them, experts in this study involved the hospital's spiritual care

staff to help ensure that the patient and family's spiritual care needs were met.

   A common behaviour identified by expert community, pediatric, and adult medical

nurses as regards spiritual care was the ability not to allow their own beliefs to interfere with

meeting the spiritual needs of the patient (Harbeck, 1995; Hawkins, 1995; Helwar, 1994). Within

the hospital setting, both pediatric and adult medical nurses utilized spiritual care staff whether

they were a part of the hospital's spiritual care team or an invited member from the patient and

families' own spiritual care community (Harbeck, 1995; Hawkins, 1995). Nurses working on the

adult medical unit also provided spiritual support themselves through prayer and participating in

religious services and readings (Harbeck, 1995). Like the participants in this study, research

with expert pediatric nurses found that those nurses also demonstrated respect and sensitivity

towards the cultural orientation of the family and supported the traditional rites and rituals that

were important to the family (Hawkins, 1995).

   Accommodating the cultural needs of a patient and family has also been recommended as

a key component for nurses who provided end of life care in the ED (Norton et al., 2011).

Norton et al. acknowledged that it is impossible to have knowledge of every culture and the

differences that exist within them; however, they suggest that culturally sensitive care can be

provided when a health professional accepts this limitation and opens one's self up to

understanding cultural needs of patient and families (Norton et al., 2011). This behaviour was

evident among the nurse experts in the current study.

Responding after the death of the patient. Nurses recognized that care of the patient

and family continued even after the patient had died. Three behaviours emerged from the data as

being essential when responding after the death of the patient. They included: i) providing family

members with privacy and time with the patient's body; ii) delivering notification of death; and

iii) demonstrating respect for the body post-mortem.

Providing family members with privacy and time with the patient's body. Expert nurses

identified the importance of providing family members with privacy and time with the patient's

body after death occurred. However, participants balanced the family members' need for

privacy and their need for support by making themselves available to ensure that family

members did not feel neglected or abandoned by nursing staff.

Permitting family members to have time and privacy with the body to say good-bye was

a behaviour also recommended by pediatric nurses (Hawkins, 1995). Hawkins reported that

family members had difficulty leaving their deceased child behind and at times took the

additional action of accompanying the body to the morgue. Accompanying the body to the

morgue was not identified in this study with emergency nurses or in studies examining expert

care of the dying in other care settings involving adult dying patients (Degner et al., 1991;

Harbeck, 1995; Helwar, 1994; McClement & Degner, 1995; Wowchuk, 2004). Research

suggests that allowing family members to have time with the body is important in helping

families come to the realization that death had occurred (McClement & Degner, 1995). Similar

to the emergency nurses in this study, ICU nurses in a study conducted by McClement and

Degner (1995) were often aware of an awaiting admission, but felt it important not to rush a

grieving family from the bedside.

Studies examining nursing actions that support suddenly bereaved family members in

accident and emergency (A&E) departments have identified behaviours similar to those

identified in this study. Tye (1993) completed a qualitative study of 52 nurses working in A&E

departments in the United Kingdom. Providing a separate room for the family, allowing time to

listen to the grieving family members, and giving permission to the family to touch or hold the

body were among the ten most supportive nursing actions identified by participants (Tye, 1993).

A study completed in an A&E department in Hong Kong sought to identify what nursing actions

were perceived as helpful by suddenly bereaved family members (n = 76) (Li, Chan, & Lee,

2002). Family members also identified the importance of having the opportunity to view the

body while it was still warm, and to say goodbye (Li et al., 2002).

Delivering notification of death. Expert nurses in the current study identified that at

times, they were required to deliver the notification of death to family members who had not

been present at the bedside when death occurred. Nurses believed delivery of this information

should be done in person if at all possible in order to provide the greatest amount of support to

the family member. Limited data collected in the study prevents further understanding of how

nurse experts actually went about the delivery of such news.

Delivering the death notification was also identified as an important behaviour in care of

the dying resident in personal care homes, and was described as part of the nurse's work in

breaking bad news to family members (Wowchuk, 2004). Bad news included both providing

information regarding the worsening of a resident's condition or notification of their death.

Death notification was not identified in studies of expert nurse behaviours in care of the dying in

palliative care, adult medical units, pediatric inpatient units, community, or adult ICU (Degner et

al., 1991; Harbeck, 1995; Hawkins, 1995; Helwar, 1994; McClement & Degner, 1995).

Wowchuk proposed that the reason nurses within the acute care setting did not identify this

behaviour was due to the fact that unlike in the personal care home setting, physicians were

present in acute care settings, and often communicate this information to families. Though

physicians are not typically present in the personal care home setting, they are always present in

the ED. Thus, lack of physician availability would not appear to explain ED nurses' belief about

the importance of being involved in delivering death notifications. This issue requires further

examination.

Demonstrating respect for the body post-mortem. Nurses in this study were also

involved in the provision of care of the body after the patient's death. Akin to being respectful

of patients while they were alive, expert nurses were also respectful of the body post-mortem.

Cleaning the body of visible body fluids and blood, covering the body with a blanket, and

removing invasive lines when appropriate were primary behaviours that demonstrated respect.

Emergency nurses wanted the body to be placed in a peaceful and natural looking position, with

a pillow under the head and hands folded. In general, this preparation was completed before the

family was brought in to view the body. Similarly, research examining expert nursing care of the

dying from the perspective of ICU nurses identified that those nurses worked to create a peaceful

and dignified scene through the modification of the patient's appearance by removing invasive

lines and subduing the lighting (McClement & Degner, 1995). ICU nurses also demonstrated

respect for the body by talking to the body when providing post-mortem care, and approached

care in a gentle and unhurried manner (McClement & Degner, 1995). Likewise, research has identified that nurses working on an adult medical unit removed hospital equipment and positioned patients to appear peaceful and seemingly asleep (Harbeck, 1995). Pediatric nurses found caring for the body of a deceased child was an extremely difficult yet important component of end of life care, and research indicates that nurses used this time to express their grief and say their farewells (Hawkins, 1995).

The literature suggests that providing post-mortem care in a respectful and gentle manner reinforces to the family that the deceased person was important and valued (Berry & Griffie, 2006). Moreover, being allowed to spend time with the body is considered to aid the family's acceptance of the person's death (Berry & Griffie, 2006). As a means to facilitate the grieving process, Berry and Griffie recommend creating a pleasant, peaceful, and comfortable environment in which families can spend time with the body of their deceased loved one. As well, family members should be offered the opportunity to participate in care of the body and be permitted to engage in cultural or ritual traditions, if so desired. If comfortable, family members should be encouraged to touch, hold, and kiss the person's body. If permitted, removal of tubes, drains, and devices is also considered to be a component of post-mortem care. These recommended behaviours are consistent with actions taken by expert emergency nurses in this study.

Research examining the nature of expert nursing care of the dying on medical units and in the personal care home identified nursing behaviours that go beyond providing post-mortem care to include care of other patients who may have witnessed or become aware that a death had occurred (Harbeck, 1995; Wowchuk, 2004). Nurses in those care settings reported that they fielded questions from fellow residents and patients about what had occurred, and also provided

support to non-family members who experienced feelings of loss arising from the death. This

type of care for other patients in the ED following the death of a palliative patient was not

identified by emergency nurses in this study and may be attributed to the short and limited

contact patients have with one another in the ED. A review of the literature regarding the effect

on patients who have witnessed death suggest that patients' experiences and feelings about the

death of another patient may relate to whether the other patient died peacefully or in pain and

distress (Shelvington, 2007). When witness to a peaceful death, individuals may be comforted

by the care and attention provided by healthcare providers to dying patients and their family

members, and their feelings of fear related to death may be reduced (Shelvington, 2007).

However, when witness to a patient's death that is distressing, an individual's fear of death may

actually be exacerbated (Shelvington, 2007). Based on the review of the literature, Shelvington

proposed that informing patients of another patient's death, and offering them support and

understanding in coping with emotional effects that may result are an integral part of a nurse's

role. However, further study related to provision of care of emergency patients who are witness

to another patient's death—either while receiving comfort care measures or resuscitative

efforts—is required to better understand this issue.

   Responding to colleagues. Participants discussed the importance of responding to the

needs of their colleagues both while the patient was dying, and after the death had occurred.

Responding to colleagues included: i) mentoring novice nurses in providing end of life nursing

care; ii) providing support during the episode of care; iii) providing support following the death

of a patient.

   Mentoring novice nurses in providing end of life nursing care. Expert nurses in this

study were aware their skills in caring for dying patients and their families were acquired over

time and that new graduate nurses do not have the skill set to provide the same level of care.

Participants expressed concern that care for dying patients may be impacted by the fact that

nurses are now hired to work in emergency departments immediately after graduation and no

longer require previous work experience on a medical or surgical unit prior to being employed in

an emergency setting. Expert nurses agreed new graduates and new nursing hires benefited from

being mentored, but stated that this was not easily accomplished due to heavy workloads and

resource limitations. None of the participants in this study identified the existence of a formal

mentorship program in their EDs. Rather, they indicated that nurses primarily tried to mentor

their colleagues by bringing the less experienced nurse alongside them as the expert nurse

provided care.

In Helwar's (1994) study of nurses caring for dying patients on an adult medical unit,

expert nurses identified that they may take over the care of the patient if they were unhappy with

care provided by the assigned nurse after failed attempts to guide and support the nurse. This

differed from the behaviours identified by the emergency nurses in this study who explained that

care of a patient was only taken over if requested by the nurse assigned to the dying patient.

Within the pediatric setting, expert nurses provided encouragement and guidance, and facilitated

the learning of their less experienced colleagues (Hawkins, 1994). Similarly, the research

completed by Degner et al. (1991) identified nurse educators had an appreciation for nursing

students who sought out assistance from fellow students and nursing staff when students were

concerned with the quality of care they were providing or when they were concerned about the

personal impact that participation in care was having.

Providing support during the episode of care. Expert nurses in the current study were

aware that nursing colleagues may require support both during the episode of care and after the

patient died. Providing support during the episode of care was demonstrated when expert nurses

stepped in to care for their colleagues' remaining patient assignment in order to facilitate the

provision of one-on-one care for the dying patient. At other times, the expert nurse assisted with

the physical care or emotional support of the dying patient or their family. The data collected in

this study suggests that this type of assistance was given only when requested by the nurse caring

for the dying patient. Situations in which expert nurses might have provided assistance without

being asked to do so were not fully explored during the interviews. Further research is needed to

better understand the nuances of this behaviour.

When nursing colleagues distanced themselves from their patients due to their fear of

displaying emotions to the patient or family, expert emergency nurses provided affirmation that

it was acceptable to display emotions and that families would not be upset with this expression of

care about the patient. The expert nurse participants in this study also sought out fellow nursing

colleagues when they themselves required assistance to problem-solve, or when they needed

emotional support during challenging situations involving the care of dying patients.

Nursing professionals may express their emotions through crying for a variety of reason.

Tears may be used to convey emotions of empathy and compassion, but they may also be used to

convey feelings of frustration, anger, stress, and fatigue (Davenport & Hall, 2011). As a result of

the examination of the concept of professional vulnerability as it relates to crying and the nursing

profession, Davenport and Hall recommended that nurses should not negate the emotions that

they feel. Increased stress, anxiety, and frustration may occur as a result of a nurse ignoring

these emotions and ultimately impacting a nurse's vulnerability in a negative sense (Davenport

& Hall, 2011). In contrast, displaying emotion at an appropriate time may "enrich a healing

environment for both nurses and recipients of their care that can affect professional vulnerability

in a positive sense where empowerment, resilience, and motivation can prevail" (p.187).

In order for nurses to remain emotionally engaged in their work, nurses must participate

in behaviours of self-care (Davenport & Hall, 2011). Along with journaling and maintaining

balance between work and life, the authors suggested nurses seek a peer mentor who would

allow the nurse to debrief after challenging or emotionally draining situations (Davenport &

Hall, 2011). Although not identified by expert nurses as a "mentor," participants also reported

relying upon colleagues whom they respected for support and guidance in challenging situations.

Providing support following the death of a patient. After the death of a patient, nurses

provided reassurance and perspective on situations that caused their colleagues to question their

ability as to whether they had hastened death while managing a patient's symptoms or the quality

of care they provided. When death was a new experience for colleagues, expert nurses provided

support and reassurance when individuals were visibly upset and encouraged individuals to

express their thoughts and feelings about what they had witnessed and experienced.

Previous work examining expert nurses caring for dying patients also identified the

importance of supporting nursing colleagues while caring for dying patients during the episode

of care and after the patient died (Degner et al., 1991; Harbeck, 1995; Hawkins, 1995; Helwar;

1994; McClement & Degner, 1995). Common behaviours amongst these studies identified that

nurses supported colleagues by problem-solving, as well as providing emotional support,

encouragement, and reassurance as to the quality of care provided by the nurse.

Research has identified that nurses working in palliative care, community, ICU, and

medical units both provided constructive criticism and positive feedback from nursing

colleagues, and sought this kind of feedback in return (Degner et al., 1991; Harbeck, 1995;

Hawkins, 1995; Helwar; 1994; McClement & Degner, 1995). However, previous works also

identified the fact that nurses were not always comfortable providing feedback to their nursing

colleagues (Degner et al., 1991; Hawkins, 1995; McClement & Degner, 1995). Proactively

seeking feedback and providing critical feedback was not identified by the ED nurses in this

study. Discussion related to seeking or providing feedback was not explored during participant

interviews; thus it is not possible to determine whether or not ED nurses participate in this type

of reciprocal feedback and support. Further study is needed to explore the behaviours of ED

nurses in this regard.

There is evidence in the literature that the well-being of healthcare providers may be at

risk when they are ill-prepared or not supported while performing their duties. Burnout is "a

phenomenon characterized by fatigue and frustration, usually related to work stress and

dedicated to a cause, a way of life that does not match the person's expectations" (Pereira,

Fonseca, & Carvalho, 2011, p. 317).   A systematic review of fifteen empirical studies that

sought to identify burnout levels as described by palliative care nurses and physicians identified

both risk factors and protective factors related to burnout (Pereira et al., 2011). Risk factors

identified in the literature that increase reported burnout include: lack of self-confidence in

communication skills; time pressures; difficulty in delivering bad news; and dealing with pain,

suffering, death, and dying. In comparison, protective factors identified by studies that reduce

reported burnout include: having time to spend with patients and families; effective

communication; coping strategies for facing the death of a patient; and individual and/or team

prevention strategies.

The aforementioned risk factors for burnout have also been identified by expert nurses in

this study as challenges they face regularly working in the ED. Behaviours related to supporting

colleagues reported by expert nurses in this study may help protect nurses and other members of

the health care team against the risk of burnout. However, further investigation is needed to

better understand the nature of discipline specific and interdisciplinary support systems in the

ED, and nurses perceived support arising from these systems, and their effect on decreasing the

risk of burnout in health professionals caring for dying patients in the ED.

Relationship of the Study Findings to the Proposed Research Questions

The purpose of this study was to understand and describe the nurse behaviours identified

by expert emergency nurses in care of the dying adult patient in the emergency department (ED).

The first two research questions addressed behaviours that expert emergency nurses described as:

1) having a positive influence on the care of the dying adult in the ED setting, and 2) having a

negative influence on the care of the dying adult patient in the ED setting. The third question

was to compare the behaviours identified in this study with those identified by Degner et al. and

in their 1991 study. Research questions four and five sought to identify factors that emergency

nurses deemed either contributed or constrained their ability to provide optimal end of life

nursing care. A review of the study findings in relation to the proposed research questions is

presented.

Emergency nurses were readily able to identify behaviours that had a positive influence

on the care of the dying adult patient in the ED setting. Of interest was the fact that participants

had a greater challenge providing behaviours that had a negative influence on the care of the

dying patient. Participants were able to more easily describe factors that contributed to less than

optimal care rather than actual negative behaviours. In contrast, a number of nurses were unable

to recall a specific exemplar that demonstrated negative behaviours. The most clearly described

exemplar of negative behaviour provided by a participant was a situation in which a less

experienced nurse administered analgesia via subcutaneous injection rather than inserting a

subcutaneous butterfly set. The expert nurse believed her colleague's lack of knowledge caused

the patient unnecessary pain due to multiple injections. Accordingly, this lack of knowledge was

identified as having a negative influence on the patient's care. The difficulty experienced by

nurse experts in this study in being able to provide exemplars that were negative in nature is

consistent with findings of previous studies examining expert nurse behaviours in caring for the

dying. Researchers who interviewed nurses working in a pediatric unit (Hawkins, 1995), an

adult medical unit (Harbeck, 1995), a personal care home (Wowchuk, 2004), and the community

(Helwar, 1994), reported that it was more challenging for participants to provide examples of

negative behaviours compared to positive ones.

Several factors have been proposed to account for this noted difference. Helwar (1994)

put forward the idea that nurses may have been uncomfortable describing areas of their own

practice that may be less than optimal. Wowchuk (2004) further postulated that nurses' inability

to identify negative behaviours may have been impeded by the desire to appear competent, as

well as a reluctance to criticize fellow colleagues. In the personal care home setting where

Wowchuk's research was conducted, it was also possible that due to the fact that registered

nurses frequently work alone and do not regularly interact with other registered nurses during a

shift, the opportunity to observe negative behaviours may never have been presented (Wowchuk,

2004). With the exclusion of the last factor that involved an independent work environment,

these are plausible factors that may have contributed to the challenges encountered by the ED

nurses in this study.

The findings of this study identified five categories of expert nurse behaviours deemed

critical in the care of the adult patient dying in the emergency department. These included: i)

providing comfort; ii) honouring the personhood of the patient; iii) responding to the family; iv) responding after the death of the patient; and v) responding to colleagues. The third research question sought to compare this study's findings with the findings of Degner et al.'s study (1991) of expert palliative care nurses and nurse educators. Comparison of these two studies revealed several similarities between the data; however, there were a number of differences among the nursing behaviours reported between the clinical settings. The study completed by Degner et al. (1991) identified seven categories of expert nurse behaviours compared with the five categories identified in this study. Between the two studies, consistency existed amongst the following three behaviours: i) providing comfort; ii) responding to family; and iii) responding to colleagues. Four behaviours not identified in the current study were: i) responding during the death scene; ii) responding to anger; iii) enhancing the quality of life during dying; and iv) enhancing personal growth. Some of the behaviours performed by palliative care nurses captured in the theme of "responding during the death scene" were also identified as behaviours performed by emergency nurses in this study. However, emergency nurses performed these actions as a response to the family rather than specifically related to the death scene. For instance, providing information in regards to a change in the patient's health status, creating space for the family, and encouraging family members to be physically near the patient were behaviours engaged in by both palliative care and emergency nurses but for different purposes. Emergency nurses did not speak to the behaviour of responding to anger directed at the nurse from either patient or family. This may be in part due to the exemplars given by participants frequently included patients who were unresponsive; however, no data exists within this study since a question directly related to anger was not posed during the interviews.

Nursing behaviours that help patients do things that are important to them were described by Degner et al. (1991) as "enhancing the quality of life." This behaviour was not reported by emergency nurses and may be due to the difference in environments and limited time that patients spend in the ED. According to Degner et al. "enhancing personal growth" included behaviours that demonstrated the nurse had a defined personal role in caring for the dying patient. Participants were not directly asked about behaviours related to personal growth, nor did emergency nurses bring forward the receiving emotional rewards and experiencing personal growth as reported by palliative care nurses. However, emergency nurses also demonstrated they had a defined role in caring for dying. Assuming the role of patient advocate and mentoring less experienced nurses in care of dying patients were behaviours suggesting that emergency nurses were committed to the provision of quality end of life care of the dying.

Participants identified factors that facilitated and constrained the emergency nurses' ability to provide optimal end of life care in the ED. The environment of the ED was a key factor that influenced the care participants were able to give to a dying patient and their family. When asked what a "typical" day in the emergency department looked like, the common trends that comprised a typical day included the unpredictability of what may arrive through the emergency doors, the fact that the department was rarely "quiet," and the environment was never static due to the fluctuation in numbers of patients and their acuity levels. The environment was described as being loud and often chaotic with space and privacy limitations. The ED was not viewed by participants as an ideal place to die.

Access to resources was identified as both a contributing and limiting factor, depending upon the availability of the resource. Time, availability of staff, and physical resources were identified as resources that impacted the provision of care of dying patients in the ED. Lack of

resources was often related directly to the busyness of the ED and whether or not there was effective movement of patients through the department. Resources decreased as the volume of patients increased. Expert nurses felt they were able to provide optimal care when they had the ability to spend time with patients and their families. Nurses reported being able to spend time caring for the patient's physical needs, but they felt that optimal care occurred when they were able to spend time caring for psychosocial needs of patients and their families. This was the time when nurses were able to get to know the patient as a person and encourage the family to share stories of the patient. The ability to spend time with the patient and their family was frequently challenged due to heavy workloads and the necessity to care for the remaining patients in the department.

Additional resources to provide physical comfort, such as extra pillows for positioning, were reduced when the ED was busy simply due to the finite number of resources available. Limited resources within the entire healthcare system also played a role in the delivery of care of dying patients. In particular, patients and emergency staff were dependent upon the bed availability as to whether the patient would be transferred out of the ED to another ward or facility. Most participants noted the lack of beds available for patients already enrolled in the regional palliative care program as a significant challenge for patients and their families, as well as healthcare providers.

Relation of the Study Findings to the Sensitizing Frameworks

Quint's (1967) theoretical framework was used to sensitize this research study regarding nursing behaviours and the provision of end of life care. Quint proposed that lack of education when exposed to dying individuals would lead to increased death anxiety and negative attitudes, resulting in withdrawal of care of the dying patient.

The framework presented by Quint was helpful as a guide in completing a review of the

literature examining nursing attitudes towards death, nursing death education, and care of the

dying patient as presented in Chapter 2.   Along with a review of the literature and critique of the

framework, a revised theoretical model was presented in Chapter 3 to include additional factors

specifically related to the ED setting that may impact care of the dying patient (see Figure 2).

The lack of empirical data in which to direct emergency nurses in the provision of end of life

care, as well as environmental factors that included the emphasis on recovery and the transitional

nature of the ED were viewed as contributing factors in an emergency nurses' ability to provide

end of life care. The data of this study confirmed that the proposed revisions made to the model

as a result of the review of the literature, were relevant and appropriate.

| Exposure to the Dying & Lack of Education & Lack of Empirical Data to Direct Provision of End of Life Care in the ED & Transitional Environment with Emphasis on Recovery | → | Death Anxiety & Negative Attitudes | → | Withdrawal from Care of the Dying |
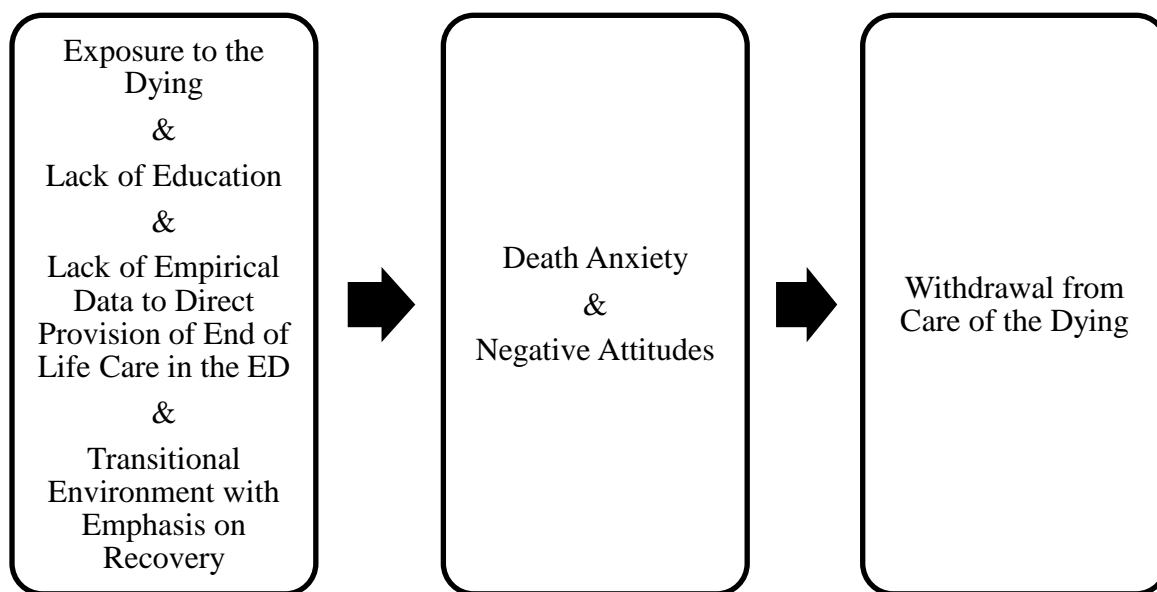
Figure 2 Revised Theoretical Model

Nurses in this study reported they had not received formal death education as nursing

students. Rather, participants had gained knowledge and experience with the assistance of more

experienced nurses. Quint suggested that exposure to dying patients without appropriate

educational support increased the potential for nurses to adopt the attitudes and behaviours of the

care providers around them. Although behaviours that indicated withdrawal of care were not evident in the information provided by study participants, Quint's work informed and increased the researcher's awareness for this behaviour to potentially be presented.

Quint's framework addressed the need for formal death education; the importance of educational support for nurses was reiterated by expert nurses in this study with their expressed recommendations for continuing education related to end of life care for all emergency nurses regardless of an individual's experience, comfort, and skill level. Based on the findings of previous studies and of the findings in this study, it is appropriate to revise the model to include the lack of empirical data to direct end of life care in the ED as a contributing factor in nurses' care of dying patients. As well, the findings of this study also confirm the transitional environment of the ED as an external factor which impacts care of the dying patient and thereby is appropriate to include within the revised model.

Benner's (2001) "Novice to Expert" framework helped to inform the inclusion criteria for participant recruitment such that nursing experts were identified. As well, the definition of an expert was used to inform the researcher's understanding of an expert nurse and how experts approach situations within their nursing practice. Participants in this study reflected Benner's descriptions of an expert in a variety of ways. Expert nurses in this study reinforced the foundation of Benner's framework that skill acquisition is developed over time. Participants reiterated that their comfort and skill level in providing care for dying patients had been developed throughout their nursing career. Participants also appeared to be unaware that that their nursing colleagues viewed their clinical acumen so positively, and were surprised to have been nominated by their nursing colleagues as providing expert level of nursing care that experts viewed as just part of their daily practice. These reactions supported Benner's (2001)

interpretation that clinical knowledge is gained over time and that nurses are often unaware of their clinical accomplishments.

Limitations of the Study

There are several limitations to this study. First, despite efforts to recruit a more robust group of participants, the sample size was very small and participants were recruited from only 2 hospitals within one urban regional health authority. The findings are thus not generalizable beyond the sample. A larger sample size may have resulted in the identification of behaviours beyond those that emerged in this study. All participants were female; it would have been beneficial to gain the perspective of nurses who are male in order to identify potential differences that gender may have as regards the identification of essential nurse behaviours in the provision quality end of life care in the ED. Although demographic data related to participants' ethnicity were not collected, the researcher observed that five of six participants were Caucasian and all were English speaking. The objective data suggests the study lacks ethnic diversity. A more culturally diverse sample may have identified potential perspectives and behaviours related to care of the dying that were not identified in this study.

The researcher's background as an emergency nurse may have influenced the nature of the data collected during the study. Due to her familiarity with the culture of the ED and its language, roles, and the functions of an emergency nurse, the researcher may have made assumptions and/or may not have sought explanation or clarification of participants' statements. As well, the researcher's lack of experience as an interviewer may have prevented the opportunity for further nursing behaviours to be discussed. At times, more clarification questions needed to be asked in order to gain a better understanding of the information being provided. Balancing the need to obtain responses from the interview guide while still providing

the participant the freedom to venture "off-track" may have prevented the researcher from

identifying behaviours that would have benefited from being further explored.

Member checking was a strategy used to verify the findings with participants to ensure

their voice was captured appropriately. However, only two of six participants opted to engage in

this process. Provisional verification of findings discussed with each participant at the end of

their initial face-to-face interview suggests that the researcher correctly captured the issues

individual participants identified about care of the dying in the ED. Although the researcher's

understanding of these issues developed over time as the study progressed and analysis became

more complete. Only a minority of the sample provided feedback about the more mature coding

schema that emerged. Though no suggested revisions or changes were requested by the two

nurse experts who provided feedback at the end of the study, the rigor of the study was not as

robust as regards verification of the findings as the researcher would have liked.

Implications of the Research

The findings of this study investigating expert nurse behaviours in the care of the dying

adult patient in the emergency department provide the foundation upon which recommendations

for education, practice, and future research can be made.

    Recommendations for Education.

1. Incorporating the expert nurse behaviours identified in this study may help to inform

   educational content related to emergency nursing of adults and the provision of end of

   life care to dying patients in the ED.

2. Incorporating the expert nurse behaviours identified in this study and those of previous

   works into palliative care curricular content will illuminate the similarities and

   differences of nurse behaviours in caring for dying patients in a variety of care settings.

3. Incorporating the expert nurse behaviours identified in this study and those of previous works into regional and facility Emergency Department nursing education days may facilitate continuing education opportunities related to the provision of end of life care to dying patients in the ED.

Recommendations for Practice.

1. Currently, no content related the provision of palliative care exists within the WRHA emergency department orientation delivered to emergency nurses who are new to working in an ED located within the region. Incorporating end of life nursing behaviours specific to the ED into this regional emergency orientation program may better prepare new hires working in this care setting. As well, providing information related to the role of palliative care CNS within the region and educating nurses on how this role may be utilized within the context of the ED may encourage emergency nurses to consult the expertise of these team members more often.

2. The expert nurse behaviours identified in this study can be used as building blocks upon which to promote an environment and culture where nurses actively seek feedback from nursing colleagues and provide feedback to colleagues as a means to facilitate reflective practice with the goal of providing the best end of life nursing care possible.

3. Including the behaviours identified in this study into nurses' performance evaluation may contribute to and encourage the development and incorporation of these behaviours into emergency nurses' acumen when providing end of life care in the ED.

4. Incorporating the behaviours identified in this study into a mentorship program for less experienced nursing staff may assist in the development their confidence, comfort level,

and nursing knowledge as a means to reduce the risk for the junior nurse to withdraw

from care of the dying patient and their family.

Recommendations for Research.

1. Further research using a large randomly selected sample is required to validate the

   findings of this study. Benefit would be gained from exploring the impact and relevance

   of these nursing behaviours from the perspective of the patient, family members,

   interdisciplinary team members, as well as nurses who are male.

2. Expanding future research to include rural and remote areas will contribute to identifying

   similarities, differences, and potential gaps in resources that may exist across ED

   locations.

3. Research is required to better understand the similarities and differences in care provided

   by emergency nurses for patients who present to the ED due to an unexpected event, such

   as a trauma or myocardial infarction and who subsequently receive a "palliative"

   designation, compared with patients enrolled in an existing palliative care program.

4. As described by Benner (2001), the development of an expert nurse is not determined by

   the number of years of experience as a nurse. However, with the hiring of new graduates

   to work in EDs, more research is needed to better understand how new graduates working

   in EDs may impact the provision of end of life care of the dying adult in this care setting

   – both positively and negatively. Related research may also seek to examine the learning

   needs of new graduates in the provision of end of life care in the ED.

5. As this study only examined what expert nurses say they do when providing end of life

   care, future research that includes an observational component may help to confirm the

   extent to which nurses' actions are consistent with what they say anecdotally. As well,

observing participants may help to identify other behaviours otherwise not identified in this study.

6. The current study did not provide clear understanding of how ED nurses participate in the behaviour of seeking and accepting feedback from nursing colleagues. Further research is needed to confirm the existence of this behaviour and how it is delivered and accepted within the emergency setting.

7. Delivering notification of death was a behaviour reported by expert nurses in this study. However, limited data collected in the study prevented further understanding of how nurses actually delivered the news. Future research to better understand how ED nurses deliver notifications of death may inform future ED nursing educational content.

8. Emergency nurses expressed frustration when dying patients were impacted by a lack of resources. Further research is needed to better understand whether emergency nurses have differing levels of frustration when a lack of resources impacts dying patients in comparison with other patients presenting to the ED.

Summary

The purpose of this study was to identify expert nurse behaviours in the care of the dying adult patient in the emergency department (ED). Interviews with six nurse experts led to the identification of five major categories of nursing behaviours in the provision of end of life care to adult patients in the ED. This chapter situated those behaviours in relation to existing literature examining the nature of expert nursing practice in care of the dying. Recommendations for practice, education and research were presented. Limitations of the project notwithstanding, the behaviours identified in this study build upon and extend previous works examining expert care of dying patients and their families, and thus makes a contribution to the development of an empirical model of expert nursing practice in end of life care.

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List of Appendices

Appendix A   Information Sheet of Nursing Research Project

Appendix B   Study Disclaimer

Appendix C   Instructions for Nominating Nurse Experts

Appendix D   Invitation to Participate in a Nursing Research Study

Appendix E   Letter of Reminder

Appendix F   Semi-Structured Interview Guide

Appendix G   Demographic Data Collection Tool

Appendix H   Participant Consent Form

Appendix I   Ethics Approval

Appendix J   Tables

Appendix A

U of M Faculty of Nursing Letterhead

Information Sheet of Nursing Research Project

Title of Study: Expert Nurse Behaviours in Care of the Dying Adult
                   in the Emergency Department (ED)

My name is Kristine Schellenberg and I am a student in the graduate program in the Faculty of Nursing at the University of Manitoba. I am conducting a nursing research project in your facility as part of the requirements for a Master of Nursing degree. I also work as a nurse in the emergency department at St. Boniface General Hospital. This research has been approved by the Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba, and approval to conduct this study has been received from this facility.

The purpose of this study is to identify nursing behaviours that expert nurses in emergency departments deem central in the provision of quality end of life care for the dying adult patient in the emergency department. As you are aware, death is not uncommon in emergency departments and dying patients present to emergency departments for varying reasons and under various circumstances. Death may be related to an unexpected event, such as a cardiac arrest, but it may also be anticipated, such as in patients with end stage diseases. For the purpose of this study, the focus will be on end of life care provided to patients for whom a decision has been made to provide palliative care measures, and whose *death is expected within hours or days*. The knowledge gained from this study will contribute toward the development of an expert model of nursing practice in the care of the dying adult patient in the ED.

This study involves two phases, and registered nurses employed by this facility who work in the Emergency Department are being invited to participate in Phase I of the study. Phase I involves the identification of registered nurse experts in the care of dying patients. Participation in this phase of the research involves all registered nurses working in the Emergency Department in this facility being invited to anonymously nominate from amongst their registered nurse colleagues "experts" in care of the dying adult patient in the emergency department. The characteristics of a nurse expert are described on the form that has been handed out to you. After reading each characteristic, please think about the nurses with whom you work, and name up to three of your colleagues whom you believe fit the description. You may write your own name if you feel it is appropriate. After you have completed the form, please place it in the envelope provided which may be immediately returned to the researcher or may be placed in the mail using the stamped envelope provided.

Nurse experts identified by their peers in this facility will be sent an "Invitation to Participate" in Phase II of the study through the inter-facility mail system. Phase II of the study involves an in-person audio recorded interview with me. The interview is anticipated to be one to two hours in length, and will be conducted at a time and location of the participant's choice. At a later date, the participant will also have the opportunity to provide me with feedback about the accuracy with which I have captured the information he/she has shared with me in the interview, and my

overall understanding of what expert care of the dying adult in the Emergency Department involves. This feedback session is anticipated to take approximately 30 minutes and participants may choose to have this discussion via telephone or in-person.

If you have any questions about this study, please feel free to contact me or my thesis advisor, Dr. Susan McClement. If you have any concerns or complaints about this project you may contact either me or Dr. Susan McClement at the aforementioned phone numbers or the Human Ethics Secretariat.

Appendix B

U of M Faculty of Nursing Letterhead

Study Disclaimer

Title of Study:		Expert Nurse Behaviours in Care of the Dying Adult
				in the Emergency Department (ED)

Principal Researcher: Kristine Schellenberg

Thesis Committee Members:

Dr. Susan McClement, Thesis Chair, Associate Professor, Faculty of Nursing, University of Manitoba

Dr. Marie Edwards, Assistant Professor, Faculty of Nursing, University of Manitoba

Dr. Paul Daeninck, Assistant Professor, Departments of Internal Medicine and Family Medicine, University of Manitoba, Consultant in Palliative Medicine, WRHA Palliative Care Program, Unit Coordinator, CancerCare Manitoba, St Boniface General Hospital.

Research funded by the Kathleen and Winnifred Ruane Graduate Student Research Grant for Nurses.

This research has been approved by the Education/Nursing Research Ethics Board (ENREB). If you have any concerns or complaints about this project you may contact the researcher, Kristine Schellenberg, the thesis advisor, Dr. Susan McClement, or the Human Ethics Secretariat.

If you are a registered nurse and wish to participate in this study, you are being asked to voluntarily give your opinion about the statements on this form. By identifying the name(s) of your nursing colleagues who best fit the description outlined in each of the following paragraphs and returning the form to the researcher, you will be giving consent to participate in this aspect of the study. This process is estimated to take you less than 10 minutes to complete.

The identities of those participating in the nomination part of the study will be anonymous, so please do not write your name or any identifying information on this form. You may choose not to respond to one or all of the paragraphs, if you so desire. Your decision not to participate in the nomination of a colleague will have no negative consequences for you or your employment in this facility. Any questions you have will be answered, and you may withdraw from this part of the study at any time. There are no known risks to you should you decide to complete this form.

You may complete the form today and return it directly to the researcher in the envelope provided or you may return the completed form via mail using the stamped envelope provided.

Appendix C

Instructions for Nominating Nurse Experts

Please read each of the following paragraphs carefully, and indicate the name(s) of the emergency nurse you work with who <u>best</u> fits each description. You may write the names of up to three nurses for each paragraph. The same nurse may be named for more than one paragraph. You may name yourself if you feel it is appropriate.

Nurses with a minimum of 3 years experience and work full-time or part-time may be nominated. Please write down the name of the nurse you wish to nominate, regardless if you are unsure if your colleague fits this criteria. The researcher will confirm this information when the nominee is contacted to participate in the study.

<u>Participation in the nomination phase of the study is anonymous, so please do not write your name (unless you are listing yourself as a nominee) or any other identifying information on this form.</u>

<u>Paragraph A</u>

These are nurses who realize that in certain situations there is little they or others can do to prolong the life of the patient. However, they are able to maintain a vision of what is possible when it comes to providing comfort for dying adult patients and their families. They help the dying patient maintain a sense of self-esteem and dignity.

Name _____

Name _____

Name _____

Paragraph B

These are nurses who coordinate and meet multiple patient needs by establishing nursing priorities which are altered as patient conditions change. They are calm in high stress situations and a sense of "unhurriedness" is conveyed in all patient and family interactions. They create an environment at the patient's bedside in which family members are welcome. As team players, they are able to respond to their colleagues' emotional needs and offer their assistance where needed.

Name _____

Name _____

Name _____

Paragraph C

These nurses are excellent communicators. They promote clear, rational communication between dying patients, their families, and other health care team members. They are sensitive to the needs of both the patient and family to talk about their impending loss and what it means to them. They can respond effectively to the fear and anger that dying patients and their families may express. They seem to be able to zero in on the accurate region of the problem.

Name _____

Name _____

Name _____

Appendix D

U of M Faculty of Nursing Letterhead

Invitation to Participate in a Nursing Research Study

Title of Study*:*   Expert Nurse Behaviours in Care of the Dying Adult
                         in the Emergency Department

Dear (Potential Participant):

My name is Kristine Schellenberg and I am a student in the graduate program in the Faculty of
Nursing at the University of Manitoba. I am conducting a nursing research project in your
facility as part of the requirements for a Master of Nursing degree. I also work as a nurse in the
emergency department at St. Boniface General Hospital. This research has been approved by the
Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba, and approval
to conduct this study has been received from your facility. Funding for this research has been
received from the Kathleen and Winnifred Ruane Graduate Student Research Grant for Nurses.

You have been nominated by your nursing colleagues, as an expert in the care of dying adult
patients in the emergency department. As a nursing expert, you are invited to participate in a
study that has been designed to discover the behaviours that expert nurses in emergency
departments deem central in providing quality end of life care of the dying adult patient. Death
is not uncommon in emergency departments, and dying patients present to emergency
departments for varying reasons and under various circumstances. Death may be related to an
unexpected event, such as a cardiac arrest, but it may also be anticipated, such as patients with
end stage diseases. For the purpose of this study, the focus will be on end of life care provided to
patients for whom a decision has been made to provide palliative care measures, and *whose
death is expected within hours or days*. The knowledge gained from this study will contribute
toward the development of an expert model of nursing practice in the care of the dying adult
patient.

Participation in this study is voluntary. If you agree to participate, you will be asked to take part
in an audiotape recorded interview with the researcher, Kristine Schellenberg, which will take
approximately one to two hours. The interviews will be scheduled for a time and at a place that
is convenient for you.

At a later date, you will also have the opportunity to provide Kristine with feedback regarding
her understanding of the information you have shared with her to ensure that she has accurately
captured the important things you wanted to communicate. This critique is anticipated to take
approximately 30 minutes and you may choose to have this discussion via telephone or in-
person. This meeting will also occur at a time and place convenient for you. If are interested in
taking part in the initial interview, but not the follow-up, that is fine.

If you would like to know more about the study prior to making a decision regarding possible
participation, please contact me via email or by phone. I have a private answering machine, so if

you do not reach me personally but would like to leave a message, please feel free to do so. Please include your name and your phone number so that I may return your call.

If you would like to take part in the study, please complete the box below:

```
_____     Yes, I agree to participate in this study.  You may contact me to arrange an interview.

Name: _____

Preferred means of contact

___ Phone (please provide telephone number):_____

___ Email: (please provide email address): _____
```

Once you have completed the box above, please:

1) Place the completed Invitation to Participate in the accompanying envelope addressed to the researcher
2) Seal the envelope, and
3) Drop the envelop into the mail

Alternatively, you can email me or call me to indicate your interest in taking part.

I will be sending out a reminder invitation in a few weeks, just in case you would like to take part, but have misplaced the original invitation, or have been too busy to respond.

If I do not receive a response from you after the reminder has been sent out, I will assume that you are not interested in taking part in the study, and will not contact you further.

Thank you for considering this invitation.
It is most appreciated if this form is returned within 1 week.

Appendix E

Letter of Reminder

Dear Colleague:

Thank you for taking the time to read this letter.

Two weeks ago, you received a letter from me inviting you to take part in a study examining expert nurse behaviours in care of the dying adult in the Emergency Department (ED). I contacted you, because you were identified by your nurse colleagues as having particular expertise in care of the dying in the ED.

If you have already responded to the invitation, thank you very much! I will look forward to interviewing you soon.

Participation in the study is voluntary. If I do not receive a response to my invitation to participate in the study, I will take this as an indication that you do not wish to take part, and you will not receive any further correspondence from me.

If you would still like to take part in the study, but have misplaced the original letter of invitation, another one is included for your convenience.

If you have any further questions, please do not hesitate to contact me by phone or e-mail.

Sincerely,

Kristine Schellenberg RN BN

Appendix F

Semi-Structured Interview Guide

Initial question to begin interview:

Can you describe a 'typical day' (to the extent that such a thing exists in the ED!) for you working in the ED?

Interviewer to describe for the participant what is meant by "dying patient" as it pertains to this study and then move to following questions:

1)   Tell me about the kinds of patients that you see coming to the ED who fit this description.
      Probe: are there patients with certain illness that present to the ED? (eg. Cancer, ESRD, ESHF, COPD?)
      Probe: what is often the reason for their ED visit? (eg. Social/family concerns, symptom management?)

2)   What would the ideal care of this patient look like?
      Probe: what would the physical care be like?
      Probe: what would the psychosocial care be like?

3)   What things/resources are necessary for you to be able to provide ideal care for this kind of patient?
      Probe: What nursing knowledge is needed?
      Probe: What knowledge does the rest of the health care team have to have in the ED?
      Probe: What kind of resources (physical and staff) are needed?

4)   What would the ideal care of this patient's family look like?

5)   What are some of the factors that make it difficult to provide ideal care to these kinds of patients and their families?

      a) Factors related to the staff?
      b) Factors related to the ED physical environment?
      c) Factors related to the patient?
      d) Factors related to the family?
      e) Other factors? (eg. Nursing experience, comfort with death and dying, previous experience)

6)   Can you describe for me an example where the care of the patient was exemplary?
      Probe: What made it exemplary? (who was involved; what was done; etc)

7)   Can you describe for me an example where the care of the patient and family was not as good as it could have been?

Probe: What happened to prevent the care from being all that it could have been?

Information that needs to be elicited from respondents in the course of collecting their narratives:

❖ The context of the incident (i.e. shift, time of day, staff resources, other happenings with the ED)

❖ A detailed description of what happened

❖ What were the nurse's concerns at the time?

❖ What was the nurse thinking about as they cared for that particular dying patient and/or their family?

❖ What did the nurse feel during and after the incident?

❖ What, if anything, did the nurse find most demanding about the incident?

Adapted from:

Benner, P. E. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park: Addison-Wesley Publishing Company, Inc., pp. 300-301.

Degner, L. F., Gow, C., & Thompson, L. (1991). Critical nursing behaviours in care for the dying. *Cancer Nursing, 14*(5); 246-253.

Appendix G

Demographic Data Collection Tool

I.D. #_____   Facility _____   Date _____

1. Age (years): _____

2. Gender: Female _____   Male _____

3. Years of experience in nursing: _____

4. Years of experience in emergency nursing: _____

5. Most *recent* level of nursing education completed:
   (Please check one)

   a) Registered Nursing Diploma   _____

   b) Post-Diploma Degree in Nursing _____

   c) Baccalaureate Degree in Nursing _____

   d) Masters Degree in Nursing   _____

6. Have you completed other educational preparation for care of the dying patient?
   Yes   _____
   No   _____

   If yes, please describe the type of educational preparation:

   _____

   _____

   _____

   _____

   _____

Appendix H

Participant Consent Form

U of M Faculty of Nursing Letterhead

Expert Nurse Behaviours in the Care of the Dying Adult
in the Emergency Department

Principal Researcher: Kristine Schellenberg

Thesis Committee Members:

Dr. Susan McClement, Thesis Chair, Associate Professor, Faculty of Nursing, University of Manitoba

Dr. Marie Edwards, Assistant Professor, Faculty of Nursing, University of Manitoba

Dr. Paul Daeninck, Assistant Professor, Departments of Internal Medicine and Family Medicine, University of Manitoba, Consultant in Palliative Medicine, WRHA Palliative Care Program, Unit Coordinator, CancerCare Manitoba, St Boniface General Hospital.

Research funded by Kathleen and Winnifred Ruane Graduate Student Research Grant for Nurses.

PARTICIPANT CONSENT FORM

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve.   If you would like more detail about something mentioned here, or information not included here, you should feel free to ask.   Please take the time to read this carefully and to understand any accompanying information.

I, _____, have been invited to participate in the above titled research project. The purpose of this study is to identify the nursing behaviours that nurses deemed expert by their nursing colleagues in care of the dying adult patient in an emergency department setting described as central in the provision of quality end of life care in this patient population. The findings of the study will help inform the development of a model of expert nursing practice in care of the dying.

You have been invited to participate because you were nominated by nursing colleagues as an "expert" in the care of adult patients who are dying in the emergency department. You have at least three years of clinical experience, and you are currently involved in direct patient care either as a full-time or part-time registered nurse.

If you consent to take part in the study, you will participate in an audio-recorded interview with Kristine lasting 60-120 minutes, scheduled for a time and at a place that will be convenient for you. During the interview, you will be asked to provide your perspective about what constitutes quality end of life care for dying patients in the emergency department, and the factors that both help and hinder nurses' abilities to provide such care.

At a later date, you will also have the opportunity to provide the researcher with feedback regarding her understanding of the information you have shared with her to ensure that she has accurately captured the important information you conveyed. Participants choosing not take part in the follow up interview are still welcome to participate in the first interview. The second interview is anticipated to take approximately 30 minutes and you may choose to have this discussion via telephone or in-person. This meeting will also occur at a time and place convenient for you. You may decline to answer any questions and you may withdraw from the study at any time without consequence.

There are no known risks to participating in this study and there are no costs associated with your participation in this investigation. If the interview takes place outside of your home, parking or transportation costs incurred by you to attend the interview will be reimbursed. The possibility does exist that the recounting of some of your experiences in care of the dying during the interview may be emotionally upsetting to you. In that event, the investigator will stop the interview and you will be given the option of ending the interview, and rescheduling for another time or provided the opportunity to discuss your feelings with the researcher or a support person of your choosing. Although you may derive no direct benefits from participating, the knowledge gained through this investigation will contribute toward the development of an expert model of nursing practice in the care of the dying.

You understand that your participation in this study is considered to be confidential. You will be assigned a code number, and your name will not appear on any documents or interview tape. Any names mentioned on the recordings will be replaced by fictional names in the transcribed document. This will protect your identity and the identity of the patients, families, and colleagues who will be discussed during the interview. You will also be asked to fill out a short information sheet about yourself (eg. level of education, years of emergency nursing experience, etc.).

All information collected is also considered to be confidential. Consent forms, audio recordings, and information sheets will be kept in a locked filing cabinet. Interview recordings will only be heard by the researcher, the thesis chair, and the individual hired to transcribe the recordings. The hired transcriptionist will sign a pledge of confidentiality. While results from the study may be published, your name or identifying information will not be used in any reports about the study and only grouped information will be used. You will have the opportunity to receive a summary of the study once it is completed if you so desire by completing the box at the end of the consent form.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject.

In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you wish to withdraw from the study, you may do so by simply informing the researcher of your wishes. Your decision regarding participation in this research project will in no way affect your employment.

Principal Researcher: Kristine Schellenberg
Supervisor: Dr. Susan McClement

This research has been approved by the Education/Nursing Research Ethics Board (ENREB). If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat. A copy of this consent form has been given to you to keep for your records and reference.

I agree to participate in this project.

Participant's Signature _____   Date _____

Researcher and/or Delegate's Signature _____   Date _____

I agree to be contacted by the researcher to determine my interest in participating in a follow-up interview. I understand by checking YES, that I am **not** consenting to take part in a second interview; only to discuss with Kristine whether or not I wish to take part in the follow-up.

Yes _____   No _____

I would like a summary report of the findings:

Yes _____   No _____

Please mail a summary of the report findings to:

Name: _____

Address: _____

            _____

Postal Code: _____

Appendix I

Ethics Approval

CTC Building
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APPROVAL CERTIFICATE

June 8, 2010

TO: **Kristine Schellenberg**   Susan McClement
         Principal Investigator

FROM: **Lorna Guse, Chair**
         Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2010:071**
         "Expert Nurse Behaviours in the Care of the dying Adult in the
         Emergency department"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

> Please note:
>
> -   if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Eveline Saurette in the Office of Research Services,   (e-mail eveline_saurette@umanitoba.ca, or fax 261-0325), including the Sponsor name, before your account can be opened.
>
> -   if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval;   otherwise the account will be locked.

> The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/ors/ethics/ors_ethics_human_REB_forms_guidelines.html) in order to be in compliance with Tri-Council Guidelines.

Bringing Research to Life

Appendix J

Table A1

Summary of Previous Research Investigating Critical Nurse Behaviours in Care of the Dying Patient

Degner, Gow & Thomson (1991) – Critical Nurse Behaviours in the Care of the Dying		
Behaviours	Operational Definitions	
	Positive	Negative
Responding during the death scene	➢ Behaviours that maintain a sense of calm ➢ Behaviours that maintain family involvement	➢ Behaviours that show the nurses' horror of the death scene ➢ Controlling behaviour that excludes family
Providing comfort	➢ Behaviours that reduce physical comfort, particularly pain	➢ Avoidance behaviour that results in neglect ➢ Poor symptom management due to poor knowledge base
Responding to anger	➢ Behaviours that show respect and empathy even when anger is directed at nurse	➢ Avoidance behaviour or angry response
Enhancing personal growth	➢ Behaviours that show the nurse has a defined a personal role in care for the dying	➢ Behaviours that show anxiety and lack of confidence in care for the dying
Responding to colleagues	➢ Behaviours that provide emotional support and critical feedback to colleagues	➢ Behaviour that show difficulty in providing or receiving support or criticism from colleagues
Enhancing the quality of life during dying	➢ Behaviours that help patients do things that are important to them	➢ Behaviours that show lack of respect for the patient or family
Responding to the family	➢ Behaviours that respond to the family's need for information ➢ Behaviours that reduce the potential for future	➢ Ignoring the family's need for information ➢ Refusing to discuss dying and spiritual issues even when the family clearly wants to do so

	regret ➤ Behaviours that include family in care or relieve them of this responsibility according to what's best for the family	➤ Passing judgment on family decision and family behaviours toward the dying

Table 1 (continued)

Harbeck (1995) – Critical Nurse Behaviours in the Care of the Dying		
	Operational Definitions	
Behaviours	Positive	Negative
Connecting	➢ Behaviours that promote the development of a relationship with the patient	➢ Behaviours that are reserved and distancing ➢ Behaviours that focus on tasks ➢
Supporting the Family	➢ Behaviours that connect and support the family and its members ➢ Behaviours that respond to the family's need for information ➢ Behaviours that include family in care or relieve them of this responsibility, according to their wishes ➢ Behaviours that reduce the potential for future regret ➢ Behaviours that prepare the family for the death event	➢ Judgmental behaviours ➢ ➢ Behaviours that disregard the family's questions ➢ Behaviours that demonstrate lack of family assessment ➢ ➢ Behaviours that demonstrate disregard for patient/family's wishes ➢ Avoidance behaviours ➢
Providing comfort	➢ Behaviours that reduce or eliminate physical pain ➢ Behaviours that prevent unnecessary procedures including resuscitation	➢ Withholding analgesics ➢ Failure to anticipate needs ➢ Avoidance ➢ Behaviours that are flippant ➢
Enhancing the quality of life while dying	➢ Behaviours that create an environment conducive to patient/family interactions ➢ Behaviours that promote choice and control ➢ Behaviours that promote personhood	➢ Behaviours that maintain a "hospital' environment ➢ Distancing or avoidance behaviours ➢ Strict adherence to hospital policies and procedures ➢ Seeing a disease not a person
Responding after death has occurred	➢ Behaviours that demonstrate respect and support for the family's realization of death ➢ Behaviours that create a dignified bedside scene	➢ Behaviours that show lack of respect for the family and their grief ➢ Behaviours that demonstrate lack of appreciation of the potential impact of the death scene

	➢ Behaviours that demonstrate respect for the body during post-mortem care ➢ Behaviours that demonstrate responding to other patients	➢ Rough impersonal handling of the body ➢ Ignoring other patient's need to acknowledge the death event
Responding to feeling	➢ Behaviours that demonstrate professionalism, respect and empathy wherever anger is directed	➢ Responding in anger
Responding to nursing colleagues	➢ Behaviours that provide emotional and concrete support and critical feedback to nursing colleagues	➢ Behaviours that demonstrate insensitivity to colleagues' needs
Enhancing personal growth	➢ Behaviours demonstrating the development of a personal role for the dying and their family	➢ Behaviours that focus on tasks rather than caring
Managerial Support	➢ Behaviours that recognize and support nursing work	➢ Reward only visible tasks

Table A1 (continued)

Hawkins (1995) – Critical Nurse Behaviours in the Care of Dying Children in the Hospital Setting		
	Operational Definitions	
Behaviours	Positive	Negative
Connecting	➢ Behaviours that promote a mutual closeness ➢ Behaviours that embrace the child and family	➢ Reserved behaviours ➢ Maintaining one's distance ➢ Behaviours that demonstrate over involvement, and loss of one's professional identity
Responding to the family	➢ Behaviours that support the whole family, including or relieving them of the responsibility for care according to what's best for the family ➢ Behaviours that bring families together ➢ Behaviours that foster a home-like environment ➢ Behaviours that respond to the family's need for information ➢ Behaviours that reduce potential for future regret ➢ Behaviour that support the child/family's cultural and religious beliefs and practices	➢ Passing judgment on family decisions and behaviours toward the dying child ➢ Controlling, or avoidance behaviours ➢ Judgmental, controlling behaviours that exclude family members, or force them to spend time together ➢ Providing a stark room, with harsh lighting and a rigid 'hospital' atmosphere ➢ Deferring to the physician ➢ Avoiding the family's need for information ➢ Providing ambiguous or conflicting messages ➢ Defensive behaviours, in response to a family's superior knowledge ➢ Refusing to discuss death and dying issues, even when the family wants to discuss them ➢ Cultural/ religious practices that interfere with the care of the dying child
Providing comfort	➢ Behaviours that reduce physical pain and discomfort ➢ Behaviours that satisfy the child's psychological and emotional needs	➢ Methodical behaviours, that demonstrate a lack of awareness of the child's suffering ➢ Poor symptom management due to inadequate knowledge base ➢ Distancing behaviours that result in psychological and emotional regret

Enhancing quality of life during dying	➤ Behaviours that respond to the dying child's need for information ➤ Behaviours that help dying children do things that are important to them ➤ Behaviours that make dying children feel special	➤ Withholding of information, or lying to the dying child ➤ Behaviours that demonstrate a lack of respect for the dying child and family ➤ Detached, impersonal behaviour
Responding to anger	➤ Behaviour that demonstrate respect and empathy, even when anger is directed at the health care team ➤ Behaviours that promote resolution when anger occurs within the health care team	➤ Denigrating, or angry responses ➤ Avoidance behaviours ➤ Passing judgment on the decisions and behaviours of colleagues ➤ Venting anger at colleagues ➤ Avoidance behaviours
Facilitating the transition to palliative care	➤ Behaviours that respect and support the child's right to die with dignity	➤ Aggressive behaviours that defy death, inflict pain and suffering, and prolong dying
Responding during the death scene	➤ Behaviours that acknowledge the child's dying ➤ Behaviours that support the child and family, as death approaches ➤ Behaviours that maintain a sense of calm	➤ Failure to recognize the child's dying due to poor knowledge base ➤ Avoidance behaviours ➤ Avoidance behaviours that result from the nurses' discomfort with care of the dying ➤ Behaviours that demonstrate the nurses' horror and anguish over the death scene
Responding after death has occurred	➤ Behaviours that demonstrate respect, and support the family's realization of death ➤ Behaviours that demonstrate respect for the body during post-mortem	➤ Avoidance, or controlling behaviours that restrict the family's expression of grief ➤ Rough, impersonal handling of the body ➤ Avoidance behaviours
Enhancing personal growth	➤ Behaviours that demonstrate that the nurse has defined a personal role in care of dying children and their families	➤ Behaviours that demonstrate anxiety and a lack of confidence in the care of the dying children and their families

Responding to colleagues	➢ Behaviours that provide emotional support, and critical feedback to nursing colleagues	➢ Behaviour that demonstrate a nurse's difficulty in providing timely or receiving support or criticism from colleagues

Table A1 (continued)

Helwar (1994) – Critical Nurse Behaviours in the Care of the Adult Dying of Cancer in the Community	
Behaviours	Operational Definitions
Developing rapport	➢ Behaviours that build relationships with the patient and family
Providing comfort	➢ Behaviours that reduce physical, psychological and emotional pain ➢ Behaviours that support patient's spiritual and informational needs
Coordinating care	➢ Behaviours that illustrate the nurse's knowledge of available resources and willingness to access them ➢ Behaviours that demonstrate the nurse's confidence in advocating and decision-making
Responding to the family	➢ Behaviours that respond to the family's need for information ➢ Behaviours that reduce the potential for future regret ➢ Behaviours that provide emotional support to the family
Responding to colleagues	➢ Behaviours that provide emotional support and critical feedback to colleagues
Enhancing personal growth	➢ Behaviours that show the nurse has defined a personal role in care for the dying ➢ Behaviours that show the nurse is intuitive in care of the dying

Table A1 (continued)

McClement & Degner (1995) – Critical Nurse Behaviours in the Care of the Dying in the ICU		
	Operational Definitions	
Behaviours	Positive	Negative
Responding during the death scene	➤ Behaviours that create a peaceful, dignified bedside scene for family ➤ Behaviours that support realization that death has occurred ➤ Behaviours that demonstrate respect for corpse during post-mortem care	➤ Behaviours that show lack of respect for family ➤ Judgmental behaviour that limits time family can spend with body ➤ Rough, impersonal handling of corpse
Responding to the family	➤ Behaviours that respond to the family's need for information ➤ Behaviours that reduce potential for future regret ➤ Behaviour that facilitate transition from cure to palliation	➤ Cursory explanations deferring to MD, showing off knowledge base ➤ Controlling behaviour that limits family and patient contact time
Responding to anger	➤ Behaviour that shows empathy and respect even when anger is directed at nurse	➤ Avoidance behaviour or angry response
Responding to colleagues	➤ Behaviours that provide emotional support and critical feedback to nurses	➤ Behaviour that show difficulty in providing timely, adequate feedback to nurses
Providing comfort	➤ Behaviours that reduce physical and psychological pain	➤ Avoidance behaviour that results in neglect of patients, particularly psychological neglect
Enhancing personal growth	➤ Behaviours that show nurse has a defined role in care for the dying	➤ Behaviours that show lack of confidence and anxiety in care for the dying

Table A1 (continued)

Behaviours	Operational Definitions
Wowchuk (2004) – Critical Nurse Behaviours in the Care of Dying Elderly Residents in the Personal Care Home	
Promoting the provision of psychosocial care	➢ Behaviours that ensure the resident did not die alone ➢ Advocating on the resident's behalf
Coordinating symptom management efforts	➢ Behaviours that reduced the physical and psychological suffering of residents ➢ Behaviours that involved advocating on the resident's behalf ➢ Endeavouring to avoid unnecessary hospitalization of the dying resident ➢ Behaviours that shield the resident from being caught up in the stressful dynamics of difficult or dysfunctional family relationships ➢ Behaviours that involved advocating on the resident's behalf to ensure the changes in medical status were addressed and not ignored as normal changes due to old age
Providing a presence/respecting privacy	➢ Behaviours that both provide a physical presence while also being cognizant of the family's need for privacy
Breaking bad news	➢ Communicating to family the information regarding the worsening of a resident' condition or the death of a resident
Educating family members	➢ Providing information and explanations to families about what to expect regarding anticipated changes in the resident's health status in the face of physical deterioration, and to provide details surrounding the death even t itself ➢ Provide guidance to the family in the decisions they are required to make
Providing a comfortable environment	➢ Creating a physical setting that was comforting, home-like and familiar to the resident and family ➢ Behaviours that attempt to make families feel more at home
Providing emotional support to health care team	➢ Behaviours that provide emotional support to members of the health care team following the death of a resident
Fielding questions regarding a resident's death	➢ Advising resident of the death of a fellow resident

| Supporting fellow residents after death | ➢ | Providing support to other residents who experience a loss following the death of a fellow resident |

Table B2

Expert Nurse Behaviours in Care of the Dying Adult Patient in the Emergency Department

Expert Nurse Behaviours	Operational Definitions
Providing comfort	➢ Behaviours that reduce and eliminate physical symptoms of the patient ➢ Behaviours that provide basic nursing care ➢ Modifying the environment to create privacy and limit dying patients' exposure to the environment of the ED
Honouring the personhood of the patient	➢ Communicating with patients through speech and touch regardless of level of consciousness ➢ Behaviours that aid the nurse in learning the patient's story ➢ Behaviours that facilitate the nurse to be emotionally and physically present in each interaction ➢ Advocating for the patient
Responding to the family	➢ Behaviours that reduce the potential for future regret ➢ Behaviours that respond to the family's need for information ➢ Behaviours that ensure the well-being of family members ➢ Behaviours that support cultural traditions and spiritual or religious belief
Responding after the death of the patient	➢ Behaviours that provide family privacy and time with the body ➢ Behaviours that facilitate delivering notification of death ➢ Behaviours that demonstrate respect for the body post-mortem
Responding to colleagues	➢ Mentoring novice nurses in the provision of end of life nursing care ➢ Behaviours that provide emotional support for colleagues during an episode of care and assist colleagues in the delivery of physical or emotional care to patients ➢ Behaviours that provide support following the death of a patient

Table C3

Demographic Information Summary

Characteristics of the Sample

Number of Participants	6
Gender	Female

Demographic Information

Demographic	Mean	Range
Age in Years	51.7	37-59
Years Experience as a RN	26.1	10-38
Years Experience as ED Nurse	19.6	5-34.5

Educational Preparation

Highest Level Achieved	Number of Participants
Nursing Diploma	5
Baccalaureate Nursing Degree	1
Specialized Palliative Care Education	0