Aim and intended learning outcomes
The aim of this article is to support nurses working in emergency and acute care settings, including the emergency department (ED), to understand the barriers to optimal end of life care and encourage them to consider how they can enhance care for patients at the end of life and their families. After reading the article and completing the time out activities you should be able to:

» Understand the fundamental principles of care in the last days and hours of life.
» Discuss the barriers to optimal end of life care in the ED.
» Explain the advantages and disadvantages of families being present during resuscitation.
» Outline the importance of advance care planning and shared decision-making.

Introduction
Patients present to the ED with differing levels of acuity. For those whose life is at risk there is often an expectation that ED staff will be able to provide life-sustaining or life-saving treatment (Dawood 2020, Carlin et al 2020). However, despite the best efforts of staff, some patients will die in the ED. The exact number is difficult to determine since the Office for National Statistics does not keep a record of the number of patients who die in the ED (Office for National Statistics 2018). One large teaching hospital in the UK estimated that approximately ten to 15 people die in its ED each month (McCallum et al 2018).

Optimal end of life care requires the involvement of the wider multidisciplinary team including nurses, doctors, physiotherapists, occupational therapists, psychologists, chaplains and social workers. However, the physical care of dying patients and the care of the body after death are usually provided mainly by nurses (Ferrell et al 2015, White and Meeker 2019). Caring for dying patients is regarded by some as one of the most fundamental of all nursing activities (Bailey et al 2011a, Moscrop and Robbins 2013). As such, it is an aspect of
People who are nearing the end of their life include regular and effective communication, involving re-assessing the person’s condition any symptoms should be managed. Be led by a senior responsible doctor and care should be focused on maintaining the needs of families and others identified as important to the dying person are actively explored, the needs of those important to them, and it is something that nurses can contribute to in any setting (Vanderveken et al 2019).

In its information for the public on the care of adults in their last days of life, the National Institute for Health and Care Excellence (NICE) (2015) explains that:

- People who are nearing the end of their life are entitled to high-quality care wherever they are being cared for.
- It is important that their wishes are respected and that they are involved in decisions about their care whenever possible.
- Care should be focused on maintaining the person’s comfort and dignity.
- Any symptoms should be managed.
- The dying person, and those identified as important to them, are involved in decisions about achieving optimal end of life care (Box 1).

Furthermore, the organisations represented in the Leadership Alliance for the Care of the Dying Person – which included the Nursing and Midwifery Council and the Royal College of Nursing – committed to ensure that care in the last days and hours of life would (Leadership Alliance for the Care of Dying People 2014):

- Be compassionate and tailored to the needs, wishes and preferences of the dying person and the needs of those important to them.
- Include regular and effective communication between healthcare staff, the dying person and their family as well as between staff.
- Involve re-assessing the person’s condition whenever it changes and responding to those changes in a timely manner.
- Be led by a senior responsible doctor and a lead responsible nurse with support from specialist palliative care services when needed.
- Be delivered by doctors, nurses, carers and others who have high professional standards and the skills, knowledge and experience needed to care for dying people and their families.

**Barriers to optimal end of life care in emergency settings**

Stressful and distressing situations

Emergency and acute care settings tend to be busy, stressful environments (Alqahtani and Mitchell 2019, Barleycorn 2019) in which it is challenging for nurses to work (Grover et al 2017) and provide optimal end of life care (Mughal and Evans 2020). Nurses in these settings are exposed daily to pain and trauma and experience high levels of stress and distress (Mughal and Evans 2020) and supporting the family of a deceased patient may add to their stress and distress (Walker 2014). Within one shift, ED nurses may be involved in a failed resuscitation attempt, a difficult conversation with a bereaved relative, providing last offices, clearing up the bed space and restocking the resuscitation trolley.

Certain cases can be particularly distressing because of nurses’ individual circumstances – for example, a nurse who has a five-year-old child may be particularly distressed when caring for a child of a similar age who is thought to be approaching death – and nurses’ ability to provide optimal end of life care may be negatively affected as a consequence (De Brasi et al 2021).

Nurses in the ED may find it upsetting to manage the care of the patient’s body after death, particularly if the person has died in a traumatic or violent manner (Schuster and Dwyer 2020). Furthermore, in the case of patients presenting to the ED with injuries sustained from a crime or assault, staff may face the challenge of being involved in forensic work (Filmalter et al 2018).
As pointed out by Fimlalter et al (2018), every trauma patient in the ED should be treated as a forensic case until otherwise advised and healthcare professionals must be able to identify forensic cases and collect evidence.

Focus on saving or sustaining life
Care in the ED is focused on saving people’s lives (Bailey et al 2011b, Wolf et al 2015, Hogan et al 2016). As part of this, nursing care in emergency and acute care settings concentrates on keeping patients alive (Giles et al 2019). Working in a fast-paced environment where the focus is on saving or sustaining life while also supporting dying patients can lead to a ‘dualistic culture’ (Scott 2013) in which speed, rigor and possibly a disconnection from one’s feelings exist in parallel with the emotions and spiritual questions that can arise when one is confronted with death and dying.

Sudden death has been described medically as death within 24 hours of the onset of symptoms (Saukko and Knight 2015). Despite the focus on saving or sustaining life, sudden death is a relatively common occurrence in the ED – in fact it may be the form of death that ED staff are most exposed to (Peters et al 2013). There is evidence that ED staff try to find meaning in their work even in situations such as the sudden death of a patient (Scott 2013, 2020). However, a sudden patient death often causes high levels of stress among nurses and can have severe negative effects on their mental health (Morrison and Joy 2016).

Lack of training
Because the focus in the ED is on saving or sustaining life, ED staff may feel uncomfortable, or be unsure about, providing end of life care. It has long been recognised that staff in emergency and acute care settings need support to provide optimal end of life care (Cauthorne 1975). More recently, Alqahtani and Mitchell (2019) found that insufficient education and training was a major barrier to optimal end of life care in the ED – one among many obstacles being a lack of understanding of what a good death looks like. The drive for more education and training in palliative and end of life care for staff in these settings is ongoing (Gloss 2017, Mughal and Evans 2020).

TIME OUT 2
Imagine that a nursing student on a clinical placement in your practice setting has never witnessed a resuscitation attempt. They ask you how to support the family of a patient who is due to undergo a resuscitation attempt. What do you advise?

Attempted resuscitation
One of the pivotal aspects of care in the ED is the ability to potentially resuscitate people who have experienced a catastrophic event that has caused cardiac arrest. However, not all resuscitation attempts are successful and the sudden death of a patient undergoing cardiopulmonary resuscitation (CPR) can be distressing and traumatic for the nurses involved (Blomquist and Lasiter 2022).

A long-debated question is whether the family should be present during attempted resuscitation. There is a growing body of evidence showing that witnessing resuscitation is generally positive for families (Pratiwi 2018, Sak-Dankosky et al 2019, Vardanjani et al 2021). Even if the patient dies, family members tend to be glad they were present. Family members who had witnessed attempted resuscitation reported feeling closer to their relative and included and respected by staff (Vardanjani et al 2021). Similarly, family members who had been present in failed resuscitation attempts experienced fewer complicated grief reactions than family members who had not been present (Erogul et al 2020, Saifan et al 2023).

From the viewpoint of nurses, however, it can be challenging to have family members present during resuscitation attempts. Staff may worry about what the family might hear during the intervention (Waldemar and Thylen 2019) and be concerned that the family will be upset (Waldemar et al 2021). They may have concerns regarding potential litigation and feel that they lack time to support the family (Grimes 2020). The literature supports the principle of having one member of staff dedicated to assist the family during resuscitation (Vardanjani et al 2021) but this is not always possible, which is a source of anxiety for nurses (Drewe 2017).

Situations where resuscitation is not attempted
Not all patients admitted to the ED undergo resuscitation. Some patients’ clinical condition does not warrant resuscitation. Some patients have a ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) recommendation in place. Others are deemed not well enough to undergo resuscitation. The last two scenarios can create challenges for staff because patients and families may not understand why the decision not to attempt resuscitation has been taken or contest it. Similarly, they may not understand what a DNACPR recommendation is (Tomkow et al 2023).

Key points
- Care in the emergency department (ED) is focused on saving or sustaining life, but some patients admitted to the ED die in the ED
- EDs tend to be stressful environments in which it is challenging to provide optimal end of life care
- Care at the end of life should be compassionate and tailored to the needs, wishes and preferences of the person and the needs of those important to them
- Ensuring that patients have a good death is something nurses can contribute to in any setting
- Reflection and self-care should be priorities for all healthcare professionals caring for dying patients
A DNACPR recommendation exists to inform clinical decision-making at the time of an emergency. Patients should be involved in discussions about resuscitation, but whether to make a DNACPR recommendation is ultimately a clinical decision. A DNACPR recommendation is not legally binding – it is a guide for the clinician who has to make a decision about whether or not to start CPR (Ballock and Ruck Keene 2023). DNACPR recommendations are made using recognised predictors of adverse outcomes and patients with a DNACPR recommendation in place have been shown to have received appropriate care (Sutton et al 2021, Piscator et al 2022).

**Decision-making and interprofessional communication**

Decisions regarding end of life care can be challenging to make in any setting, but even more so in settings where healthcare professionals have limited knowledge of the patient’s clinical condition, goals and values (George et al 2016). In recognition of these challenges, George et al (2016) published a consensus statement and research agenda on shared-decision making to support the provision of palliative and end of life care in the ED. The researchers acknowledged that it is essential to use shared decision-making to align care in the ED with patients’ wishes and preferences.

In a systematic review exploring the challenges of providing optimal end of life care in the ED from the perspectives of staff, Alqahtani and Mitchell (2019) found that one of the challenges related to communication and decision-making, with doctors and nurses potentially disagreeing about who has authority to make decisions. Nurses may find that this power struggle negatively affects interprofessional communication, leading them to feel dissatisfied with the quality of care and believe that they do not have a voice.

**TIME OUT 3**

An 86-year-old woman who lives in a nursing home has been brought to the emergency department in an ambulance. She has Parkinson’s disease and community-acquired pneumonia. Her respiratory rate is 12 breaths per minute and she cannot be roused. Do you need to consider the possibility that she is approaching the end of life? If so, what do you anticipate her care needs to be?

**Long-term conditions and advance care planning**

Patients presenting to the ED towards the end of their life include people who have a long-term condition (Amado-Tineo et al 2021), for example a nursing home resident who has Parkinson’s disease or a person with advanced cancer who lives at home. There is a perception among ED staff that the hectic, bright and noisy environment of the ED is not the appropriate setting in which to care for such patients (Mughal and Evans 2020). Avoiding admission to the ED is likely to be in these patients’ best interests, but this relies on advance care planning decisions having been made and on patients’ preferred place of care at the end of life being available and appropriate in an emergency. However, these conditions are rarely fulfilled.

There has been a focus on advance care planning in recent years, for example with initiatives such as ReSPECT, or Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person’s care if they no longer have capacity to make choices or express their wishes in a future emergency (www.resus.org.uk/respect/respect-healthcare-professionals). The aim is to encourage people to consider the care they want at the end of their life and ultimately improve their care (Eli et al 2020, Hendicott and Holt 2022, McDermott et al 2022). More work is required to raise awareness of the necessity of advance care planning and of initiatives such as ReSPECT.

**Learning, self-care, reflection and teamwork**

Nurses learn to cope with distressing situations throughout their professional lives, a transformation process described in the seminal work by Benner (1984) and explored by Huang et al (2016) among nurses caring for dying patients. Huang et al (2026) described a three-step process of ongoing learning and growth:

> First the nurse experiences emotional distress, which can be overwhelming.
> After some time the nurse finds a way to cope with that distress.
> Finally the nurse learns, through reflection and self-awareness, how to use their experiences to deepen their knowledge and ability to care without losing compassion or experiencing burnout.
Self-care should be a priority for any healthcare professional caring for dying patients (Stilos and Wynnychuk 2021). This was reinforced during the coronavirus disease 2019 pandemic (Cook et al 2021), when self-care was acknowledged as a crucial factor in staff being able to continue fulfilling their roles (Galanis et al 2021). For anyone working in healthcare (Lubinska-Welch et al 2016), particularly in the ED and critical care areas (Enns and Sawatzky 2016), it is important to take time for relaxation and exercise. In their personal lives, nurses can also nurture their well-being by interacting with family and friends and engaging in hobbies and other activities (Stilos and Wynnychuk 2021).

To enhance the quality of the end of life care they provide, ED nurses may find it helpful to reflect on what a good death looks like and consider what they can do to ensure dying patients experience a good death. They can attempt to find meaning in the situation by reflecting on the death of the patient and the care provided to them (Mason and Warnke 2017). Nurses also need to be aware that other team members may find it challenging to care for dying patients and make time to support their colleagues. Optimal teamwork is important in an emergency setting (Grover et al 2017), as well as self-awareness and a recognition of the challenges likely to be experienced when working in such an environment (Barleycorn 2019).

Debriefing, whether formal or informal, is commonly offered to healthcare staff after the death of a patient and has been shown to have positive effects on staff (Harder et al 2020, Gerace et al 2021). Nurses should also be offered clinical supervision, a process designed to support, educate and aid reflection (Baldwin et al 2022) that has been shown to improve job satisfaction and patient safety (Driscoll et al 2019, Saab et al 2021). To manage the distress or trauma caused by the sudden death of a patient undergoing CPR, nurses can employ coping strategies and techniques such as seeking emotional support, psychologically and/or emotionally distancing themselves from the situation, and focusing on problem-solving – that is, considering the technical side of the intervention and think about what may have gone wrong in order to learn (Blomquist and Laster 2022).

The fictional case study of Andrew and his family (Case study 1) provides an example of optimal end of life care in the ED.

**Conclusion**

End of life care is a fundamental part of nursing, but optimal end of life care is challenging to achieve in the ED, notably because of the stress and distress inherent to the setting and because care in the ED is focused on saving or sustaining life. Nurses working in the ED can, however, contribute to ensuring that the care needs of dying patients and their families are addressed, even in situations such as failed resuscitation attempts.

To enhance the quality of end of life care, ED nurses need to ensure that they look after their own well-being and that they support each other. Nurses may also find it useful to reflect on what a good death looks like and what they can do to ensure dying patients under their care experience such a death.

**TIME OUT 5**

Identify how overcoming the barriers to optimal end of life care in the emergency department applies to your practice and the requirements of your regulatory body

**TIME OUT 6**

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account. See: rcni.com/reflective-account

**Case study 1. Andrew and his family**

Andrew, a 49-year-old man, was brought to the emergency department (ED) after collapsing while playing five-a-side football on a Saturday afternoon. On arrival he was breathing but had a score of 4 on the Glasgow Coma Scale (GCS) (Mehta and Chinthapalli 2019). A computed tomography (CT) scan of Andrew’s head showed a large haemorrhage into previously undetected brain metastases. A CT scan of his chest, abdomen and pelvis showed that Andrew had metastatic lung cancer. By this stage, Andrew was completely unresponsive, with a GCS score of 3.

The clinical team in the ED, including staff nurse Tom, spoke to Andrew’s wife Lucy and his teenage son Liam, who had travelled with him in the ambulance. Considering the catastrophic nature of the brain haemorrhage and the advanced stage of Andrew’s cancer, the decision was made with the family not to attempt resuscitation. Andrew was moved to a quiet room in the ED designed for these situations. Tom spent time with Lucy and Liam, offering support, referring them to the chaplaincy team and ensuring they had food and drink – including finding a can of Liam’s favourite fizzy drink.

Tom was aware of the local policy on end of life care and ensured that anticipatory medicines were at hand in case Andrew developed pain, became agitated or showed other signs of distress, which did not happen. Andrew did not regain consciousness and died four hours later with his wife and son at his side. Tom supported the family until they were ready to leave and ensured they had information about the bereavement services provided by the trust. Tom and a colleague then performed the last offices for Andrew and handed him over to the mortuary staff.

Tom was supported throughout the care episode by the wider team, who avoided asking him to perform other tasks or cover for breaks or absences so that he could dedicate his time to Andrew and his family. Before going home that evening, Tom had a debrief with his team leader. Lucy later wrote to the department saying she was grateful for the care Andrew and the family had received.


'That's as hard a decision as you will ever have to make': the experiences of people who discussed Do Not Attempt Cardiopulmonary Resuscitation on behalf of a relative during the COVID-19 pandemic. Tomkow L, Dewhurst F, Hubmann M et al (2023). Age and Ageing. 52, 6, afad087. doi: 10.1093/ageing/afad087


Barriers to optimal end of life care

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. Optimal end of life care requires the involvement of which healthcare professionals?
   a) Essentially doctors
   b) Essentially the chaplaincy team
   c) Essentially social workers
   d) The wider multidisciplinary team

2. Ensuring patients have a good death is something that:
   a) Goes well beyond the role of nurses
   b) Nurses can contribute to in any setting
   c) Is not a concern to nurses in the emergency department (ED), where the focus is on sustaining life
   d) Is more important in hospices than in hospital

3. The five Priorities for Care of the Dying Person apply when it is thought that the person may die:
   a) Within the next few days or hours
   b) Within the next four weeks
   c) Within the next six months
   d) Within the next 12 months

4. The Leadership Alliance for the Care of Dying People has committed to ensure that care in the last days and hours of life:
   a) Is compassionate and tailored to the needs, wishes and preferences of the dying person
   b) Includes regular and effective communication between healthcare staff, the dying person and their family
   c) Is led by a senior responsible doctor and a lead responsible nurse with support from specialist palliative care services when needed
   d) All of the above

5. Sudden death has been described medically as:
   a) Death within one hour of the onset of symptoms
   b) Death within 24 hours of the onset of symptoms
   c) Death within 48 hours of the onset of symptoms
   d) Unforeseen death

6. Which of the following statements is accurate?
   a) Nursing care in emergency and acute care settings concentrates primarily on supporting patients to have a good death
   b) Rigorous care cannot exist in parallel with the emotions and questions that arise when one is faced with death and dying
   c) ED staff are unable to find meaning in situations such as the sudden death of a patient
   d) The sudden death of a patient often causes high levels of stress among nurses

7. Why can it be challenging for nurses to have family members present during an attempt to resuscitate a patient?
   a) Because they may worry about what the family might hear during the intervention
   b) Because they may be concerned that the family will be upset
   c) Because they may feel that they lack time to support the family
   d) All of the above

8. Which of the following statements is incorrect?
   a) 'Do not attempt cardiopulmonary resuscitation' (DNACPR) recommendation exists to inform clinical decision-making at the time of the emergency
   b) Patients should be involved in discussions about resuscitation
   c) Whether or not to make a DNACPR recommendation is ultimately the patient's decision
   d) A DNACPR recommendation is not legally binding

9. For a patient with a long-term condition who is nearing the end of their life, it is best to avoid presentation to the ED. However, this often relies on:
   a) Beds being available on an acute ward
   b) A DNACPR recommendation having been made
   c) Advance care planning decisions having been made
   d) The patient having mental capacity to make decisions about their preferred place of care

10. According to Huang et al (2016), nurses who care for dying patients go through:
    a) A three-step process of ongoing learning and growth
    b) Complicated grief reactions
    c) Post-traumatic stress disorder
    d) Compassion fatigue

This activity has taken me __ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent  □  Good  □  Satisfactory  □  Unsatisfactory  □  Poor  □

As a result of this I intend to: ____________________________

How to complete this assessment

This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question. You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently.

You may want to write a reflective account. Visit rcni.com/reflective-account

Go online to complete this multiple-choice quiz and you can save it to your RCNi portfolio to help meet your revalidation requirements. Go to rcni.com/cpd/test-your-knowledge

This multiple-choice quiz was compiled by Anne-Claire Bouzanne

The answers to this quiz are: 1. d 2. b 3. a 4. d 5. b 6. d 7. d 8. c 9. c 10. a

© RCN Publishing Company Limited 2023

emergencynurse.co.uk