

# Emergency Room Nurses Transitioning from Curative to End-of-Life Care: The Rural

## Influence

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## Abstract

Rural nurses typically fill several roles as needed from acute and extended care settings and to the emergency room. The nurse's role with aggressive curative efforts involves an intense clinical focus; while end-of-life care entails an intense psychosocial focus. Emergency room (ER) nurses commonly experience these two intense foci of care in succession.

**Purpose:** With the limited resources in rural hospitals, it was necessary to explore the rural influence on rural ER nurses transitioning from curative to end-of-life care. The goal was to capture areas of need to best support rural nurses caring for dying patients and their families in the rural communities.

**Method:** A secondary analysis using deductive content analysis incorporated Rural Nursing Theory to identify rural influences with rural ER nurses transitioning from curative to end-of-life care. In a primary study, Grounded Theory was used to explore ER nurses' personal transitioning when the focus of patient care changes from curative to end-of-life. Registered nurses (N=10; rural n=6, urban n=4) from four hospitals (2 rural and 2 urban) in four different counties in Upstate New York participated in semi-structured interviews. Analysis yielded 29 concepts and producing five categories: preparing caring, immersion, making sense, changing

gears, and reflecting. Three sub-processes, focus, feelings, and conflict were identified as common threads with conflict as a moderating factor influencing nurses transitioning from curative to end of life care.

**Findings:** The concepts of distance, resources, and familiarity had the greatest influence on rural ER nurses transitioning from curative to end-of-life care. The strongest characteristic of rural nurses was self-reliance. For this reason, adequate support and resources are essential to care for dying patients and their families in rural communities.

**Conclusions:** Implications for rural ER nursing include strategies to improve staff resources, access to education, and mentoring.

**Keywords:** Rural, End-of-life, Transition, Emergency, Nurse

## **Emergency Room Nurses Transitioning from Curative to End-of-Life Care: The Rural Influence**

Although “fewer than one percent of Emergency Room (ER) visits result in death,” nearly a quarter of a million deaths occur in ERs annually (Centers of Disease Control and Prevention, 2013, p. 29). Key efforts in the ER are focused on saving lives and prolonging life (Bailey, Murphy, & Porock, 2011). When curative efforts are exhausted and the focus of care changes to end-of-life; the nurse’s focus must change as well. Aggressive curative efforts may involve an intense physiologic focus; while end-of-life care may entail an intense psychosocial focus. Emergency room (ER) nurses commonly experience these two intense foci of care in succession.

Norton, Hobson, and Klum (2011) proposed guidelines for palliative and end-of-life care in the ER including nurse-to-patient ratios 1:1 or 1:2 when a nurse is caring for a patient at end-of-life. The authors recommend a multidisciplinary team be available for family, spiritual, and social needs. Considering the limited resources in rural communities, such recommendations may be difficult to maintain. Time and the nurse's comfort with caring for dying patients were among additional barriers to end-of-life care in the ER (Bailey et al., 2011). Exploring the needs of ER nurses in rural areas helps in developing strategies to best incorporate the proposed guidelines.

The dearth of literature on rural ER nursing further support rural populations are poorly represented in research (Morgan, Fahs, & Klesh, 2007). Beckstrand and colleagues explored Rural ER Nurses' perceptions of end-of-life care obstacles (Beckstrand, Gile, Luthy, Callister, & Heaston, 2012). The authors used a questionnaire to rank specific items by magnitude and frequency. Among the highest ranking obstacles were family and friends continually calling the nurse for updates as opposed to the designated family member, knowing the patient or family personally, and the poor design of the emergency room for end-of-life care. Nurses not being comfortable with caring for dying patients and/or their families was among the lowest ranking obstacles.

This article provides a brief summary of the primary project and a secondary analysis examining the rural influence of ER nurses transitioning from curative to end-of-life care. The primary study (Rolland, 2014) included rural and urban nurses and explored the social process of ER nurses transitioning when aggressive curative efforts are exhausted. Although all nurses in the study followed a similar process when transitioning from curative to end-of-life care, specific

rural concepts and dimensions were more evident among rural ER nurses. The aim of this secondary analysis was to further examine the rural components and identify areas of need for the development of education, resources, and supportive measures to assist nurses with end-of-life care in rural communities. This was accomplished by incorporating the theoretical framework of *rural nursing theory* (Lee & McDonagh, 2013) among the categories and sub-processes of the primary study's integrated model, *caring driven*.

### **Theoretical Framework**

Rural nursing theory originated by Long and Weinert (1989) and was later revised by Lee and McDonagh (2013). The theory highlights characteristics and dimensions unique to rural populations and nursing in rural areas. Lee and McDonagh organized rural nursing theory within three theoretical statements as follows:

**Theoretical statement 1.** “Rural residents define health as being able to do what they want to do; it is a way of life and a state of mind; there is a goal of maintaining balance in all aspects of their lives” (Lee & McDonagh, 2013, p.22).

The concept of *health belief* is important to understanding what constitutes health among the rural population. Having a disease process may not necessarily be viewed as having poor health as long as one can perform daily activities. A second concept is *isolation* and depicts the awareness of separation geographically, socially, and professionally. Another concept is *distance* considering mileage and time. Perception is a component of distance. Access to health is a consequence of distance (Lee & McDonagh, 2013).

**Theoretical statement 2.** “Rural residents are self-reliant and make decisions to seek care for illness, sickness, or injury depending on their self-assessment of the severity of their present health condition and of the resources needed and available” (Lees & McDonagh, 2013, p. 22).

*Self-reliance* is defined as a capacity to provide for one’s own needs characterized by independence, skills, and decision making. Additional aspects of self-reliance are self-confidence and self-competence. The concept of *outsider* has defining attributes including differentness, unfamiliarity, and disconnectedness involving cultures, practices, and beliefs. The concept of *insider* considers one’s relationship to a group physically or socially (Lee & McDonagh, 2013).

One who is long established in a place or a position is defined as the concept of *old-timer*. A *new-comer* is defined as newly arrived and unaware of the history of the area. *Resources* are defined as property or assets. Resources can be something accessed or something resorted to. *Informal Networks* consist of family members, friends, neighbors, and coworkers that supply emotional, physical, and social support (Lee & McDonagh, 2013).

**Theoretical statement 3.** “Health care providers in rural areas must deal with a lack of anonymity and much greater role diffusion than providers in urban or suburban settings” (Lee & McDonagh, 2013, p.20).

The concept *lack of anonymity* pertains to being visible and identifiable and characterized by diminished personal and professional boundaries. The concept *familiarity* is characterized by relationship, intimacy, and informality. The consequence of familiarity may be unwarranted intimate and personal interactions or behaviors. The concept *professional isolation* is characterized by the lack of resources to fulfill professional responsibilities and needs. Resources

for education, specialized staff, and technology may be difficult to access and may not be readily available (Lee & McDonagh, 2013).

## **Method**

Approval was obtained by the Institutional Review Board (IRB) of Binghamton University and a convenience sample of hospitals. Hospitals without an IRB completed a Letter of Approval. Informed consent was obtained from participants prior to interviews. Participants chose an alias to ensure confidentiality.

Emergency Room nurse managers distributed invitation letters to nurses who met inclusion criteria (registered nurse, at least 18 years of age, English speaking, and a minimum of one year of ER experience with direct patient care). Nurses willing to participate contacted the researcher and scheduled an interview.

Participants were recruited from four Upstate New York hospitals throughout four different counties. Both urban and rural hospitals were included to involve a more diverse sample considering the variation of services and experiences among hospitals. Two urban hospitals and two rural hospitals from Upstate New York participated in the study for the recruitment of ER nurses. The urban hospitals consisted of a mean inpatient capacity of 366 (range 242 - 489) and mean ER capacity of 24 (range 12 - 35). The rural hospitals consisted of a mean inpatient capacity of 22 (range 20 - 23) and mean ER capacity of 3 (range 2 - 5).

## **Participants**

The participants (N=10) were equal in gender (five male and five female). Rural ER nurses (n=6) were equal in gender (three male and three female) and were predominately Caucasian, ages 40 - 49, Associate Degree prepared, lived in a rural area, and had little experience working

in an urban setting. Urban ER nurses were equal in gender and were predominately Caucasian, age 30 - 39, lived in an urban area, and had little experience working in a rural setting. Education among urban nurses was equally represented with Associate and Baccalaureate preparation. Religious affiliation among both urban and rural nurses was predominately Christian.

Rural nurses averaged 15.4 years of nursing experience (range 5 to 30 years) with an average of 12.6 years ER nursing experience. They averaged 1.3 years of nursing experience in an urban setting (range 0 to 3 years). Urban nurses averaged 11.25 years of nursing experience (range 6 to 18 years) with an average of 9.7 years ER experience. The urban nurses averaged 1.5 years of nursing experience in a rural setting (range 0 to 6 years) (Table 1). Rural and urban was defined by Rural Urban Commuting Area Codes (RUCAs) (Rural Health Research Center, nd).

Table 1

*Demographics of Participants*

	Urban	Rural	Total
Male	2	3	5
Female	2	3	5
Age (mean years)	35	48	
RN (mean years)	11.25	15.4	
Urban ER (mean years)	9.7	1.3	
Rural ER (mean years)	1.5	12.6	
Total Participants	4	6	10

**Data Collection**

Data were digitally recorded and collected by the primary investigator using semi-structured interviews. The primary study involved grounded theory methodology as outlined by Corbin and Strauss (2008). Data were collected in accordance with constant comparative analysis and theoretical sampling. Data collection was complete once no new data emerged and

saturation was achieved. All data were transcribed by the researcher and rechecked twice against the recordings.

Trustworthiness was determined using three criteria, credibility, dependability, and confirmability (Polit & Beck, 2012). Credibility was supported by the degree of involvement with participants. In addition, brief summaries were shared with participants to confirm accuracy of their data. Dependability was maintained through a clear audit trail including memos, notes, and journaling documents. Confirmability was established by sharing data with experts seasoned in qualitative research and grounded theory. Summaries and themes were shared and confirmed by participants. In addition, a participant and ER nurse nonparticipants related the results to their personal experiences.

### Primary Study

The primary analysis revealed twenty-nine concepts producing five categories. The categories, also seen as phases, were labeled *preparing caring*, *immersion*, *making sense*, *changing gears*, and *reflecting*. The sub-processes found throughout the categories were based on the common threads of *focus*, *feelings*, and *conflicts* (Table 2).

Table 2

#### *Categories and Sub-processes*

Categories	Preparing Caring	Immersion	Making Sense	Changing Gears	Reflecting	
Sub-processes	Focus	Preparing self	Giving your all	Building a bigger picture	Customizing needs	Judgment
	Feeling	Hope	Detached emotion	Frustration	Relief	Delayed emotion
	Conflict	Readiness	Distraction	Knowing	Consensus	Coping



*Preparing caring* takes place prior to the nurse encounter with the patient. Nurses gathered information about the impending encounter to prepare what to do next. *Immersion* was the second phase. Once the nurse encounters the patient, his/her focus was primarily on the patient. As the situation deemed more critical, the nurse's focus intensified. Nurses responded almost instinctively. The third phase was *making sense*. Nurses described a trigger factor causing them to step back and reassess the situation. They questioned their skills, equipment, and knowledge. They were making sense of the situation to plan what to do next. The fourth phase was *changing gears*. Nurses inferred aggressive efforts were exhausted although curative efforts may or may not have been formally discontinued. Nurses' prioritized care directed toward a good death and highlighted psychosocial skills. *Reflecting*, the fifth and final phase, routinely did not take place until after the nurse left the workplace. Nurses' experiences evoked reflection, critique, and evaluation. They were able to vividly recall specific details from experiences ten or more years earlier.

Caring was the driving medium through the transitioning phases as nurses responded to what was needed next. The sub-process *conflict* was found to be a moderating factor. Transitioning was influenced by the degree of conflict experienced during a particular phase. The integrated model, *caring driven* illustrates the nurse's transitioning from the curative care role to the end-of-life care role (Figure 1).



Figure 1. Caring Driven

Note. Integrated model adapted from “The Personal Transitioning of Emergency Room Nurses when Care Changes from Curative to End-of-Life: The Rural Influence,” by R. A. Rolland, 2014, ProQuest Dissertations and Theses. Copyright 2014 by ProQuest.

The matrix and model for *caring driven* remained constant throughout the rural and urban data. Nurses moved through the phases in a forward motion; however, the movement through the process was greatly influenced by the degree of conflict. Unlike many transitions that portray a linear model, the cyclic model captures that every experience influences the nurse’s baseline

preparedness and readiness for the next event with caring for a patient where the focus of care changes from curative to end-of-life.

## **Secondary Analysis**

### **Content Analysis**

A secondary analysis was conducted using deductive content analysis (Polit & Beck, 2012) and incorporated *rural nursing theory*. Data were reviewed for content that exemplified the theoretical statements and concepts of rural nursing theory within each category of *caring driven*: preparing caring, immersion, making sense, changing gears, and reflecting (Table 3). A description of the categories and supportive data will follow.

**Preparing Caring.** Rural characteristics were most visible in this category. Nurses familiarized themselves with their resources and environment and prepared for probable situations. Although both rural and urban nurses triaged and treated patients, the goals were somewhat different. While urban nurses may hold and treat serious patients in larger ERs with access to diagnostics and advanced procedures, rural nurses focused on stabilizing and transferring seriously ill or injured patients. Rural nurses usually knew early into the patient encounter if transfer would be necessary. Although all the nurses prepared to care for patients in an emergent situation, rural and urban nurses prepared somewhat differently given the resources, the purpose, and capabilities of their specific facility. Most rural nurses worked or volunteered in the community as well, usually with a fire department or ambulance corps.

Table 3

*Theoretical Statements within Caring Driven*

	Theoretical Statement 1	Theoretical Statement 2	Theoretical Statement 3
Preparing Caring	If I don't, who's going to . . . I can do it so I need to do it.	You have to know them (resources) out here in the rural setting because, if you don't, you can get in trouble very quickly.	Maybe 90% of the time it's people that we know.
Immersion	When he went into cardiac arrest, it was a son and the brother-in-law who were doing CPR on him in the back of the pickup truck 20 miles out.	I would say after about 20 minutes of giving him meds, having him asystole, on the monitor, we intubated him. . . by that time the doctor was in.	The family was helping (in the ER) because they were hunting with him and they ended up bringing him in.
Making Sense	Time is brain, time is heart, time is everything.	The biggest resource we have is the staff that stays here, that gains the knowledge, every nurse here because sometimes you're alone.	With that gentleman, it was like I couldn't do anything right.. What else could you do?"
Changing Gears	It's almost like I flip a switch in myself. CPR, IVs, breathing for the patient, all that other stuff . . . You don't need that anymore.	Somebody had to see what the family's needs were at that time.	I had a real emotional tie to that as a friend and people that I work with so I wanted do more and more and a lot more.
Reflecting	He wanted help and we didn't get their soon enough.	I always feel that we're limited at what we can do because we are a small size but, what we can do, we do very well.	It was really hard seeing my neighbor die.

The health and well-being of a community depended on the skills and knowledge of its dwellers. Eric was committed to help maintain health in his community. After the death of a young boy, he questioned continuing in the field healthcare. Then he thought,

*If I don't, who's going to? I care enough to do this and I'm knowledgeable enough, so why waste that. And even though it's not a comfortable situation all the time, and sometimes it's very uncomfortable the situations we're put in, I can do it, so I need to do it.*

The perception of *isolation* and the concept of *distance* influence health and a way of life in the rural community. Edgar was a nurse in the ER, as well as a member of the EMS, and noted the ambulance covered over a twenty mile radius. Although rural nurses recognized the barrier of distance, they did not see themselves as totally isolated. Technological resources such as tele-stroke and tele-medicine gave nurses the tools and information needed to care for patients and stabilize for transport. When Melissa was asked if she felt isolated, she answered, "No," and expanded further about her perception and effect of distance and time.

*I know that a helicopter is eight minutes away. . . There is some frustration. . . We may need an ambulance and it's going to be a two hour ETA. Ok, we are going to find the next thing. It may be the helicopter. It may be calling a local volunteer ambulance.*

Medical staff may not be on site when patients first arrive. Nurses were *self-reliant* and required advanced training to prepare and take charge of situations until medical staff was available. The nature of the ER was described as not knowing what was coming in next. Many times nurses were alerted by scanner and Emergency Medical Services (EMS) correspondence. Other times patients walked in unannounced. Rural hospitals were minimally staffed in the ER with nurses within the hospital who are cross-trained to assist in the ER when needed. One remote rural hospital did not staff the ER around the clock, but opened the ER when needed. RN staff within the facility were trained and prepared to address emergency situations. Eric described the operations of his particular ER.

*We cross-train to work together all the time; so there is nobody in the ER. The lights are off all day long...If someone comes in and they want to be seen in the ER, there is a little cord and they pull it. We get this buzzer at the nurse's station and we have to go down and reset the cord.*

Melissa worked in various settings and compared working at a larger hospital that having more staff and resources narrowed your responsibilities, autonomy, and accountability. She explained:

*You have all your resources ready there. As a nurse, it is nice to say, "I need something," and respiratory is there... I had the intensivist there (larger hospital)...but I really didn't have to think a whole lot. I mean, I did but, there was always somebody higher. . . I felt kind of distant from that care. I wasn't able to be more of a one on one team. I did feel like part of a team but, it was a very large team. Here we have the resources as well. People were a phone call away. I am now responsible, which could be a good or bad thing but, I am more responsible of having to do that breathing treatment. Is it working? If not, are they on the ventilator? Do I adjust the settings? You know what you need to do? I am always a phone call away from somebody. I have my computers.*

Melissa continued to explain the importance of being connected and knowing your resources. "You have to know them (resources) out here in the rural setting because, if you don't, you can get in trouble very quickly."

The concept of *insider* and *outsider* as perceived by the residents (dwellers) and community was demonstrated through the *connectedness* and relationship of the rural dweller with the healthcare system and providers. Many nurses recognized the comfort and value the residents

ascribed with the local facilities and providers and the reluctance to travel outside the community even for a higher level of care.

Melissa shared how she saw her patients and community dwellers' perception about transferring to an outside facility.

*You have people who are about forty five minutes just from us let alone and now adding another hour on to that for them to go to \_\_\_\_\_. You have a lot of elderly people here ... "I have come to this hospital for years, if you guys can't fix me then don't worry about it."*

Bill spoke of a close relation and her reluctance to travel to a larger hospital with a higher level of care to manage her cancer. "She didn't want to go anywhere else. . . She said she loved \_\_\_ hospital. . . but, she liked this little hospital and knowing all the nurses." Melissa reiterated,

*Our hospitalist will come down and talk with them and make them aware of what is available. A good portion of the time, they are able to convince them to go. But some of the elderly, no. They are like, "I have had a good life. I'm ok with this and just let me either go home or could I go upstairs?" ... Some people are very adamant. They don't want to go to a bigger place. . . They just don't feel like they get that same care.*

Judy relayed her feelings about treatment at a larger hospital while caring for a close relation, "You are a number. You are a patient just like everyone else. . . In the cancer center you were just a number. Up here in the rural area you are family."

The data captured nurses' *familiarity* and *lack of anonymity* among the rural community among. Gabrielle clearly illustrated, "a lot of the time, maybe 90% of the time, it's people that we know, like community members, friends, and family members of people we work with."

Melissa depicted,

*Being in that small community, they know you. I can't go to the grocery store without having anybody asking, "How is so and so doing?" or "Hey, I feel much better!" Sometimes it is a benefit and sometimes it is not so much of a benefit. You want to go under cover but, they know that and they respect that.*

Eric made a point to note that he was not familiar with a particular patient, "This was someone I didn't know. He was passing through town, just happened to be going through."

Rural nurses prepared themselves knowing the majority of the patients they encountered were known or familiar to them personally or through a relation. When asked to recall a situation or patient encounter rural nurses spoke of how they knew the patient before they went into details about the encounter. Gabrielle recalled a young man, "A young man we took care of JL. Maybe he was 45; I don't think he was even that old. He was a smoker and drinker and a very nice guy and you see him out all the time he was very nice." Bill captured the relationship and connectedness of the community and staff.

*It was a situation two houses down. Actually we lived in \_\_ for 15 years. We ended up selling our house to the gentleman I am talking about. He ran a business...was a very good friend ... His wife went on to nursing school and was very good friends with my wife...So anyway we ended up selling them our house. There was a call one night that he had collapsed on the floor. At the same time his brother was a family nurse practitioner practicing here.*

**Immersion.** Immersion encompassed both urban and rural nurses with minimal components specific to rural communities. Nurses engaged in aggressive life-saving measures with little room for emotion or distraction. Nurses described their actions as robotic, mechanical,



and instinctive. Rural dwellers are *self-reliant* to do what was necessary when it is necessary. Gabrielle shared the experience of a patient and his family, “ When he went into cardiac arrest, it was his son and the brother-in-law who were doing CPR in the back of a pickup truck 20 miles out.”

Physicians were on call and may not be on site. In some instances, a nurse practitioner may be the first line to medical staff. Nurses were *self-reliant* and responded to a situation until medical staff arrived. Gabrielle recalled a situation where she was in charge, “I would say after about 20 minutes of giving him meds, having him asystole, on the monitor, we intubated him. . . by that time the doctor was in.”

Since *resources* for the family can be limited in rural hospitals, family’s needs may distract the nurse who is immersed in aggressive or resuscitative efforts. However in emergent or critical situations, rural families either stepped back to not interfere or helped as an extra set of hands as previously noted by Gabriel about family members doing CPR, “The family was helping because they were hunting with him and they ended up bring him in.”

Eric recalled a family choosing to gather in the waiting room as opposed to witnessing resuscitative measures assuming the family did not want to disturb efforts. Although he did recognize the presence of the family, consistent with urban nurses, his focus was on the patient.

*They were there when we first started. We turned and said, “This is what’s going on. You can stay if you want to.” They all went out because they wanted to. I think more they wanted to get out of our way so we could do everything we could do. Because of it being such a small ER, it’s a small room. They didn’t want to be in our way. They wanted us to be able to do everything we could, so they stepped out.*

Urban ER nurses struggled more with distraction and disruptive family members or visitors. Other staff was usually called in to address such issues. Rural ERs typically did not have additional staff on hand and was perhaps sensed by families and visitors. In other situations, *lack of anonymity* led to distraction where family members contacted the nurse instead of the designated contact person for the family.

Emotions and familiarity were discarded and set aside. Edgar explained,

*Getting chest tubes, trying to get the blood out of his chest, his heart starts beating again and we are getting a blood pressure...I think you are in the heat of it technically and you don't allow that emotional aspect of, wow, this is somebody's son. This is somebody's boyfriend. This is somebody's brother.*

**Making Sense.** The third category, making sense, focused on the nurse's perception and effectiveness of aggressive efforts. The nurse's prior experience and knowledge influenced nurses transitioning through this pivotal phase. Nurses gathered information to support aggressive curative efforts or were such efforts exhausted. Trigger factors allowed nurses to step back and reassess the situation. Time and *distance* were a trigger factors and indicated survivability. Melissa conveyed, "time is brain, time is heart, time is everything."

Bill explained the importance of experienced *recourses*, "The biggest resource we have is the staff that stays here, that gain the knowledge, every nurse here because sometimes you're alone." Eric spoke of a seasoned nurse, who had the knowledge and experience to build a bigger picture of the situation at hand,

*She said that she could see it coming. But I didn't see it. . . I really didn't realize the extent of it. I just had this belief that we were going to get him back. This is just a quick temporary thing.*

*Familiarity* influenced personal conflict and frustration. Bill illustrated with a gentleman he had known coded. Although the gentleman had a history of cardiac disease, knowing the patient influence an internal conflict to exhausting efforts, “But then, with that gentleman it was like I couldn't do anything right. You felt like okay I should be doing something more. What else could you do?”

**Changing Gears.** The fourth category, changing gears, the nurses focused care on palliative and end-of-life needs. One nurse depicted, “It's almost like I flip a switch in myself. CPR, IVs, breathing for the patient, all that other stuff . . . You don't need that anymore. Your focus is changing.” Nurses may have internally transitioned to consider end-of-life needs while still physically performing curative measures. Although Bill was formally involved in resuscitation efforts, he saw them as not effective. His personal focus then changed to include the family, “I made the decision this person is not going to live. . . . Number one, somebody had to see what the family's needs were at that time.” Nurses staged the environment to help comfort the families and ease them through the death of a loved one. Eric explained,

So my focus at that point was making it look like what they (the family) are going to remember the rest of their lives. I don't want them to see him naked covered in vomit. I want them to see him lying in a bed, peaceful, with his eyes closed.

Nurses expressed relief when all persons were in consensus. *Familiarity* influenced the consensus to exhaust efforts and implement end-of-life care. Expanding on Bill's earlier experience, familiarity conflicted with consensus,

*I've been in so many codes. I think each one is different. I think the one with \_\_\_\_, I had a real emotional tie to that as a friend and people that I work with so it's like I wanted do more and more and a lot more.*

Both rural and urban nurses struggled when patients were younger in age. Curative efforts typically extend for a longer period of time yet, familiarity compounds the situation. Eric delayed transitioning when a code was called a young gentleman with acute bacterial meningitis, "He was at the store last Tuesday. Now he's dead in front of me."

**Reflecting.** Nurses reflected and judged the various stages of the patient encounter that all that could be done was done. Melissa explained, "I think not knowing that you didn't do something that you could have done would have been way worse to know." Time and *distance* was usually out of the nurse's control however; it impacted how nurses judged the outcome. Edgar recalled a situation where distance was a factor with a man calling 911 in respiratory distress, "He wanted help and we didn't get their soon enough. . . It took about over ten minutes to get there and his heart stopped."

Eric recognized strengths and *resources* of the rural hospital that all could be done within their capabilities.

*I always feel that we're limited at what we can do because we are a small size but what we can do we do very well. And that is attributed to us all getting along so well and being able to go to each other when we need to.*

Cody had worked in a rural and urban ER. Although he valued the close relationship of the rural hospital, he reflected about a patient when resources were limited,

*There were times when I worked at the smaller hospital where I felt we barely got through the night . . . We barely provided care that we are supposed to. And that's not our fault, because we do everything we can, but it's just we were poorly staffed or we got slammed. You do the best you can. You go home feeling, "Ok, this sucks." I didn't do the best I could because we didn't have the resources. We could have helped that patient a 100 times better. Here (in a larger urban hospital), I'm sure it happens but, it's far less because there's better staffing and there's more ancillary help, more help just in general.*

Emotions were typically delayed until after their shift or later at home. Judy relayed,

*I guess I put up a strong front in front of people but it's...it hurts really bad you know when you go home you are like, Oh God, how could that have happened? Oh God, these poor people. How are they going to get through this?' But, we all get through it.*

Again, *familiarity* played a role. Gabrielle shared that her personal coping mechanism where she was able to calm herself was getting more difficult as time passed due to the personal connection with patients.

*Once you have your adrenaline and when the adrenaline stops it's like calm. I was calm. But the more I go in nursing; I find the more years I've done it and the more experiences I have, I find that I am losing the calm. That once it wears off that I'm more upset and I find it harder to control my feelings.*

Judy expressed her feelings of familiarity influencing coping. "I'm disconnected because I am not related to them. It was really hard seeing my neighbor die. It was really hard seeing this

mother, who I know, her child die.” Gabrielle expressed the importance of closure when taking care of a patient for an extended length of time, “We follow them from the ER to the floor and I know if I’m off and I’ve been taking care of this patient I attend the calling hours.” Bill was comforted that he was able to be there to care for friend who died in the ER, “And I just remember the wife hugging me and saying I’m glad we were there, It was like ...I don’t know.”

## **Discussion**

Rural concepts and characteristics were most evident in the first category *preparing caring*. The concepts of *familiarity* and *connectedness* were common components throughout all categories. Conflicts within the model influenced nurses transitioning from curative to end-of-life care. Familiarity and resources were evident among such conflicts. Nurses in this study agreed that *resources* are imperative to streamline effective care however, the perception of resources varied. *Self-reliance*, knowledge, and experience were essential for the rural ER nurse. Mentoring newer nurses will help build confidence and independence.

Three areas of concern resulted from this study. Gaps in education, staff resources, and personal and professional support may affect rural nurses transitioning from curative to end-of-life care. Addressing these areas will assist rural nurses caring for patients and families at end of life.

**Education.** Nurses gained information from several sources. Nurses need a strong foundation of knowledge and access to information to make critical decisions while planning appropriate care to best serve patients and families in crisis. A pivotal point of transitioning was when nurses recognized aggressive curative efforts were exhausted. Patient care then required a different focus considering end-of-life needs. Nurses shared they were thinking of the patient’s

and family's end-of-life needs before aggressive efforts were formally discontinued. Nurses who were less experienced delayed transitioning to the end-of-life care role.

Critical situations in the ER can change abruptly; therefore, the nurse's focus must also change to effectively plan the care for patients where death is imminent. Formal education including the elements of end-of-life care in curriculum is essential to effectively and efficiently transition from the curative care role to the end-of-life care role. End-of-life care essentials are a necessity with orientation to any healthcare facility. Encouraging staff to attend conferences and seminars on end-of-life care is vital for current information and imperative with professional development. In addition, annual face-to-face in-services should be mandated to ensure staff is current with end-of-life care issues.

Rural nurses face barriers and obstacles with education. Continuing education will help strengthen assessment and end-of-life skills to better identify patient and family needs during critical situations and prepare for end-of-life care. Penz and colleagues (2007) recognized the barriers to continuing education activities among rural nurses include distance, time, and financial constraints. Scheduling time to travel to conferences can be difficult with limited staffing (Penz et al., 2007). Technological advances allow for teleconferences and streamlining workshops. Such opportunities are encouraged to bring the current education to remote areas.

**Staff Resources.** Nurses held staff resources in high regard. Nurses typically recalled what staff was available during a specific event and its impact on their experience. Staff resources affected all phases of transitioning in various capacities with educational, professional, and personal support. Norton and colleagues (2011) advocate for ER nurse-to-patient ratios 1:1 or 1:2

when a nurse is caring for a patient at end-of-life. In addition, the authors recommend a multidisciplinary team be available for family, spiritual, and social needs (Norton et al., 2011).

This study revealed the importance of staff resources for nurses to allocate adequate time and various tasks to best address patient and family needs. In addition, personal support for both seasoned and novice nurses were found important for coping. Achieving adequate staffing has been a challenge in most acute care settings (American Nurses Association, nd). Smaller and more remote hospitals face a greater challenge with staffing where support staff were commonly on-call and may not be readily available. Strategies to address staff resources remain an area to explore.

**Mentoring.** Nurses in this study recalled how they, as newer nurses, felt overwhelmed and unprepared when caring for a patient where curative efforts were exhausted. Nurses empathized with newer nurses having difficulty with traumatic events. Arbour and Wiegand (2014) acknowledged the various roles nurses assume when curative efforts are discontinued. The authors stressed the importance of mentoring to educate and prepare newer nurses to employ such complex roles.

Mentoring newer nurses involves a supportive relationship focused on knowledge, professional practice, and career development (Mills, Francis, & Bonner, 2007). Mentoring influences several areas including clinical decision-making skills (Seright, 2011), feelings of professional isolation, and psychosocial support (Medves, Edge, Bisonette, & Stansfield, 2015). Such factors impact performance and retention of staff resources. Supporting newer nurses with mentoring will subsequently create new mentors for future nurses.

## **Limitations**



Human recall is a limitation that can threaten the accuracy of data (Hassan, 2005). The researcher must consider the data reported as truth; however, it is realistic to acknowledge human error or gaps in memory. Other limitations included the homogenous sample of Caucasian participants and only two settings within one state.

### **Implications for Nursing**

The nurse is an enduring presence at the bedside and vigilant to patients' needs. Nurses moved through the phases of *caring driven* in a forward manner impelled by what was needed next. Conflicts foster a more difficult or problematic transitioning process. Establishing and strengthening support mechanisms will countervail the influence of conflicts on nurses transitioning roles in the ER. Rural nurses in this study identified knowledge and resources as barriers with end-of-life care in the ER setting. Meleis (2010) referred to such barriers as insufficiencies. Supplementations with education, staff resources, and mentoring may help nurses transitioning their role from curative to end-of-life care.

### **Future Research**

Future research is needed to further explore the effect of education, staff resources, and mentoring on rural nurses transitioning from the curative care role to end-of-life care. General policies and recommendation may not suit the structure of rural health care systems. Research involving rural populations will produce valuable data to assist and support nurses caring for dying patients and their families in rural communities.

### **Conclusion**

Emergency room nurses are exposed to a fast pace setting where patients often present in a life threatening crisis. Education, resources, and support are essential components for nurses

caring for patients and families facing death (Bailey et al., 2011). Education, staff resources, and mentoring may help nurses transition smoothly and effectively to the end-of-life care role. Continued research in this area will further clarify the needs and effective measures to support rural nurses caring for patients and families at end-of-life.

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