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

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Disclosure and Objectives

- Dissertation - Binghamton University; Author: Roberta Rolland
- I have no relevant financial or nonfinancial relationships to disclose.
- Partial funding by Omicron Alpha Chapter
- Current Employer: Upstate Medical University

Learner objectives

- Upon completion of this presentation, the learner will be able to:
  - Identify the concepts and components of Rural Nursing Theory,
  - Apply the components of Rural Nursing Theory to ER nurses’ experiences transitioning from curative to end-of-life care,
  - Discuss strategies to support rural ER nurses caring for patients and families at end-of-life.
Transitioning Curative to End of Life

- “fewer than one percent of Emergency Room (ER) visits result in death,"
  - nearly a quarter of a million deaths occur in ERs annually (CDC, 2013, p. 29)

- curative efforts exhausted - focus of care changes to end-of-life

- intense physiologic focus to intense psychosocial focus
Obstacles and Barriers

Obstacles:
- Family/friends calling the nurse for updates as opposed to the designated family member
- Knowing the patient or family personally
- Conflicting results: Nurses comfort caring for dying (Bailey et al., 2011; Beckstrand et al., 2012)

Barriers:
- Time (Bailey et al., 2011)
- Poor design of the emergency room for end-of-life care (Beckstrand et al., 2012)

Research Question:
- What are the rural influences on rural ER nurses transitioning from curative to end-of-life care?
Rural Nursing Theory

- **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)

- Health belief - what constitutes health among the rural population
  - perform daily activities.

- Isolation - awareness of separation geographically, socially, and professionally

- Distance - mileage and time - perception of distance
  - Access to health is a consequence of distance
Rural Nursing Theory

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** - capacity to provide for one’s own needs - independence, skills, and decision making - self-confidence and self-competence
- **Outsider** - differentness, unfamiliarity, disconnectedness - cultures, practices, and beliefs.
- **Insider** - relationship to a group physically or socially
- **Old-timer** - long established in a place or a position
- **New-comer** - newly arrived and unaware of the history of the area
- **Resources** - property or assets - accessed or resorted to
- **Informal Networks** - family members, friends, neighbors, and coworkers that supply emotional, physical, and social support
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)

Lack of anonymity - visible and identifiable - characterized by diminished personal and professional boundaries

Familiarity - relationship, intimacy, and informality
  - consequence - unwarranted intimate and personal interactions or behaviors

Professional isolation - lack of resources to fulfill professional responsibilities and needs - education, specialized staff, and technology
Primary Study

- Grounded Theory (Corbin & Strauss, 2008)
- Transition Theory (Meleis, 2010)
  - Dynamic Process – one role to another role
  - Phase of disconnectedness - insufficiencies – gaps in education, resources, support

- Trustworthiness was determined using three criteria, credibility, dependability, and confirmability (Polit & Beck, 2012).
- IRB Approval
## Demographics of Participants

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Age (mean years)</td>
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<td>48</td>
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<tr>
<td>RN (mean years)</td>
<td>11.25</td>
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<tr>
<td>Urban ER (mean years)</td>
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<td>1.3</td>
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<tr>
<td>Rural ER (mean years)</td>
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<td>12.6</td>
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<tr>
<td>Total Participants</td>
<td>4</td>
<td>6</td>
<td>10</td>
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## Categories and Sub-processes

<table>
<thead>
<tr>
<th>Categories</th>
<th>Preparing Caring</th>
<th>Immersion</th>
<th>Making Sense</th>
<th>Changing Gears</th>
<th>Reflecting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus</td>
<td>Preparing self</td>
<td>Giving your all</td>
<td>Building a bigger picture</td>
<td>Customizing needs</td>
<td>Judgment</td>
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<tr>
<td>Feeling</td>
<td>Hope</td>
<td>Detached emotion</td>
<td>Frustration</td>
<td>Relief</td>
<td>Delayed emotion</td>
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<tr>
<td>Conflict</td>
<td>Readiness</td>
<td>Distraction</td>
<td>Knowing</td>
<td>Consensus</td>
<td>Coping</td>
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</tbody>
</table>
Caring Driven - where the needs are
Preparing Caring

Theoretical Statement 1
► If I don’t, who’s going to . . . I can do it so I need to do it.

Theoretical Statement 2
► You have to know them (resources) out here in the rural setting because, if you don’t, you can get in trouble very quickly.

Theoretical Statement 3
► Maybe 90% of the time it’s people that we know.
Immersion

Theoretical Statement 1
- 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.

Theoretical Statement 2
- 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.

Theoretical Statement 3
- The family was helping (in the ER) because they were hunting with him and they ended up bringing him in.
Making Sense

Theoretical Statement 1
- Time is brain, time is heart, time is everything.

Theoretical Statement 2
- The biggest resource we have is the staff that stays here, that gains the knowledge, every nurse here because sometimes you’re alone.

Theoretical Statement 3
- With that gentleman, it was like I couldn’t do anything right.. What else could you do?”
Changing Gears

Theoretical Statement 1
- 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.

Theoretical Statement 2
- Somebody had to see what the family’s needs were at that time.

Theoretical Statement 3
- 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

Theoretical Statement 1
► He wanted help and we didn’t get their soon enough.

Theoretical Statement 2
► 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.

Theoretical Statement 3
► It was really hard seeing my neighbor die.
Discussion

- Rural concepts and characteristics - most evident in the first category preparing caring

- *Familiarity and connectedness* - common components throughout all categories.

- Conflicts within the model influenced nurses transitioning from curative to end-of-life care
  - Familiarity and resources

- *Resources* - streamline effective care

- *Self-reliance*, knowledge, and experience

- Gaps - education, staff resources, personal and professional support
Education

- Pivotal point of transitioning –
  - recognizing aggressive curative efforts were exhausted
  - less experienced delayed transitioning to the end-of-life care role
- Strengthen assessment and end-of-life skills to better identify patient and family needs during critical situations and prepare for end-of-life care
- Formal education
- Informal education – conferences, seminars, professional development
- Healthcare facility
  - Orientation.
  - annual face-to-face
- Barriers and obstacles with education
- Distance, time, and financial constraints (Penz et al., 2007)
  - Teleconferences and streamlining workshops
Resources

- Staff Resources - affected all phases of transitioning in various capacities with educational, professional, and personal support.
  - Challenge in most acute care settings (ANA, nd)
  - Smaller and more remote hospitals face a greater challenge

- Technology – mixed perspectives
  - 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.

- Remains an area to explore.
Mentoring

- Newer nurses
  - supportive relationship focused on knowledge, professional practice, and career development (Mills, Francis, & Bonner, 2007)

- Culture –
  - Nurse managers (Turner & Goudreau, 2003)

- Educating management and staff
  - skills and strategies to mentor newer nurses
  - create a climate of support - retention of staff and optimizing care (Rush et al., 2013)
Conclusion

Limitations
- Human recall (Hassan, 2005)
- Homogenous sample of Caucasian participants

Implications for Nursing
- Enduring presence at the bedside and vigilant to patients’ needs
- Moved through the phases of caring driven in a forward manner according to what was needed next.
- Influenced by conflicts that could cause a more difficult or problematic transitioning process
- Identified barriers as insufficiencies
  - Supplementation with education, staff resources, and mentoring

Future Research
- Further explore the effect of education, staff resources, and mentoring on rural nurses transitioning from the curative care role to end-of-life care
- Research involving rural populations - produce valuable data
  - General policies and recommendation to better suit the structure of rural health care systems
References

Thank you