Introduction

This poster details a qualitative study undertaken as part of a Masters degree to explore the lived experiences of registered critical care nurses who have provided end of life care (EOLC) to dying patients and their families within an intensive care unit (ICU). Providing EOLC in the ICU can be stressful for ICU nurses who are rapidly confronted with the last transition from curative to EOLC (Puntitilo et al., 2001; Hopkinson et al., 2005; Thacker, 2008). Furthermore some ICU nurses may not consider themselves to be suitably equipped for dealing with EOLC as a result of insufficient training in this area (Hanson et al. 2009). Therefore authors such as Chapman (2009) insist that EOLC must emerge as a fundamental area of ICU expertise, requiring an equal level of knowledge and competence to all other areas of intensive care practice.

Aim

To explore the lived experiences of registered critical care staff nurses who have provided EOLC to dying patients and their families within an ICU.

Methods

A qualitative research design using a phenomenological approach was selected. The study took place within 1 ICU in the West of Scotland and sampling was purposive. In accordance with this research design and approach, the data were collected using semi structured, in-depth interviews. This approach allowed the researcher to guide the conversation and ensure that the content of the interview was relevant to the phenomenon being researched.

Participants

The target population was all registered ICU staff nurses within one ICU. The study group was selected using a non-probability, convenience sampling process. Inclusion criteria stipulated that participants should hold Band 5 or Band 6 registered ICU staff nurses, work full or part time, regularly working within ICU and having cared for a dying patient and supported their relatives within the last 2 years. Any nurses who felt uncomfortable or distressed when discussing EOLC was excluded.

Recruitment

All participants were recruited from the researcher’s own work place. Potential participants were identified and recruited via a handwritten participant invitation letter and participant information sheet. In total, 40 potential participants were identified, 20 agreed to take part and 5 were selected on the basis of their availability at the times interviews were being conducted.

The Interviews

The semi structured interviews were held in a small comfortable room in the hospital. The topic guide was compiled from the main themes in the nursing literature, and the researcher’s knowledge of EOLC. The 8 questions in the topic guide were used to direct the interview and to allow the participants to talk about their experiences of EOLC. The interviews lasted between 30 and 45 minutes and were terminated when they appeared to have reached an acceptable conclusion. They were audio taped using a digital voice recorder and transcribed verbatim prior to analysis.

Analysis

The transcripts were analysed using thematic content analysis. Burnard’s (1991) 14 Step framework was used to guide the analysis. The strengths of this approach are that it provides a systematic approach to data analysis which is replicable and reliable.

Summary of Study Findings

It is apparent from the interviews that EOLC remains inconsistent within this ICU. Consequently it could be surmised that the data from this study implies, that in order for consistent care to be provided, EOLC integrated care pathways should be utilised to their full potential along with delivery of optimal EOLC.

Discussion

This small study highlighted evidence that issues pertaining to EOLC in ICU, as identified in the literature remains current and problematic. The findings in this study did not find anything new, but serves to keep such issues in the public domain as ones that still need to be addressed.

Conclusion

There are several conclusions that can be drawn from the findings of this study. Fundamentally all patients at the end of their lives should have the right to high quality compassionate and dignified care. This opinion is reiterated, not only within the present EOLC literature and throughout the findings of this study, but also within government policy in the UK. Yet despite considerable evidence to suggest that more effective EOLC would be beneficial to patients, families and staff, there continues to be numerous barriers, which prevent this being achieved.

5 Key Points

1. End of life care pathways appear to have some value, although the current situation, nationally, is unclear.

2. High calibre communication in relation to EOLC in the ICU is a key factor in providing successful EOLC.

3. There are numerous aspects of the intensive care environment that impede the delivery of optimal EOLC.

4. Educational support at both local and national levels is required in order to equip ICU nurses to adequately manage the dying process.

5. Providing EOLC to dying patients and their families is potentially one of the most distressing components of the ICU nurse’s workload.

Findings

On completion of Burnard’s (1991) 14 Step framework, a total of 51 essential categories were derived from the collated transcripts. These resulted in the emergence of 5 main themes, which covered all 51 categories. The 5 main themes were; (1) Integrated Care Pathways i.e. the Liverpool Care Pathway (LCP), (2) Communication, (3) The Intensive Care Environment, (4) Education and Training and (5) Staff Distress.

Integrated Care Pathways - the LCP

- "Now that the LCP is used I feel EOLC has a better structure, I think there's more dignity being put on patients now that we have implemented the LCP."

- "My experience is the nurses in this unit are somewhat bewildered as how best to use the LCP and therefore this affects the continuity of EOLC."

Communication

- "Good communication for the patient and the families is extremely important so they know the plan and so they know exactly what is involved when someone dies, even all the fine intricate details, like removing tubes and doses."

- "I find it difficult when the consultant disagrees about patient management decisions. For example one consultant makes plans in the morning and then the afternoon consultant changes them, this can lead to families getting conflicting messages and I’ve seen families being given false hope because consultant makes conflicting decisions."

The Intensive Care Environment

- "It’s a complicated task to teach end of life skills, it is very difficult to be able to offer all different types of comfort."

- "It’s not always the most peaceful environment in ICU although we do strive where possible to rectify the noise pollution. The lack of single rooms and lack of relative’s rooms in this intensive care unit is detrimental to end of life provision which means dying patients and their relatives do not have the privacy they need."

Education and Training

- "I have learned through repeated exposure of dealing with dying patients and their families. I have also learned from watching other more experienced nurses and doctors. It’s a complicated task to teach end of life skills, it’s very difficult to be able to teach all the different types of situations and all different types of comfort."

- "I feel as a nurse in the caring profession we are expected to know how to deal with such diverse ethically challenging situations, with really no education or training."

- "It’s hard dealing with so many dying patients. It’s heartbreaking, upsetting and exhausting, sometimes it’s an occupational hazard unnecessarily."

- "There have been numerous occasions when I’ve been really upset and to be honest not well supported, you are just left to get on with it."

Staff Distress

- "There’s been numerous occasions when I’ve been really upset and to be honest not well supported, you are just left to get on with it."

References


