"Resuscitate and Push": End-of-Life Care Experiences of Healthcare Staff in the Emergency Department – A Hermeneutic Phenomenological Study

Jonathan Bayuo[1*] RN, Emmanuel Kwadwo Anago[2] RN, Frank Bediako Agyei[2] RN, Yakubu Salifu[3] RN, Prince Kyei Baffour[4] RN, Collins Atta Poku[5] RN

[1]School of Nursing, The Hong Kong Polytechnic University, Hung Hom- Kowloon, Hong Kong

Email: jonathan.bayuo@connect.polyu.hk

[2]Department of Nursing, Faculty of Health and Medical Sciences, Presbyterian University College, Ghana

Email: archbishopake@gmail.com

[2]Department of Nursing, Faculty of Health and Medical Sciences, Presbyterian University College, Ghana

Email: frankagyei89@gmail.com

[3]Division of Health Research, Faculty of Health and Medicine, Lancaster University, Lancaster, United Kingdom

Email: y.salifu@lancaster.ac.uk

[4]Conquest Hospital, East Sussex Healthcare NHS Trust, East Sussex, United Kingdom

Email: princekyeibaffour@yahoo.com

[5]Department of Nursing and Midwifery, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana

Email: attapokucollins@yahoo.com

* Corresponding author

Jonathan Bayuo
School of Nursing
The Hong Kong Polytechnic University
Email: jonathan.bayuo@connect.polyu.hk/

Abstract

Objective: Care in the emergency department focuses significantly on delivering lifesaving/ life-sustaining clinical actions, often with limited attention to health-related suffering even at the end-of-life. How healthcare staff experience and navigate through the end-of-life phase remains minimally explored. Thus, this study aimed to uncover the lived experiences of emergency department staff at the end-of-life.

Methods: van Manen's hermeneutic phenomenological approach was used. Nineteen healthcare staff were purposively recruited and interviewed. Interviews were audio-taped, transcribed verbatim, and thematic categories formulated. The existential lifeworld themes (corporeality, relationality, spatiality, and temporality) were used as heuristic guides for reflecting and organizing the lived experiences of participants.

Results: The overarching category, *'resuscitate and push'*, was captured as corporeality (resisting death and dying); relationality (connectedness to the *body of the patient;* and lacking support for family and self); spatiality (navigating through a *liminal space* and lack of privacy for patients); and temporality (having limited to no time for end-of-life care and grieving). The end-of-life space was unpleasant. Although participants experienced helplessness and feelings of failure, support systems to help them to navigate through these emotions were lacking. Grief was experienced covertly and concealed by the entry of a new patient.

Conclusion: End-of-life in the emergency department is poorly defined. In addition to shifting from the traditional emergency care model to support the streamlining of palliative care in the department, staff will require support with navigating through the *liminal space*, managing their grief, and developing a better working relationship with patients/ families.

Keywords: End-of-life; dying and death; Emergency Department; Palliative Care

Introduction

Advances in medicine have inevitably enhanced longevity albeit increasing attendance to the emergency department (ED) in the last days or hours of life.[1] The ED is often the first point of call for critically ill persons and their families which creates a need to ensure the availability of support for patients at the end-of-life, their families, and staff. Death in the ED can be classified in two ways: spectacular (occurs in persons with injuries or acute illness) and subtacular (occurs in terminally or advanced illness).[2] Irrespective of the pathway followed, patients and their families may experience distress as they navigate through the rapid processes in the ED at the end of life.[3]

End-of-life (EOL) care is an essential aspect of palliative care focusing on dignified care in the final moments of life.[4] Although conceptually different, palliative care is sometimes used interchangeably with EOL care,[5] particularly in trauma care.[6,7] The importance of providing high-quality EOL care is well documented and recent studies have highlighted the need for such service across varied patient population, including the ED.[1,8-10] Palliative/ EOL care does not seek to only relieve physical symptoms, but also, to respond to the psychosocial and spiritual needs of patients and their families to attain a dignified death and offer bereavement/ post-bereavement support to families [11] and healthcare staff.[12]

The ED is a highly specialized clinical unit requiring swift clinical decision with focus on acute care, resuscitation, and trauma care.[13] Care in the ED is underpinned by the philosophy of actively treating the patient, usually with limited attention to health-related suffering.[11,14,15] Initiating EOL care in this setting may therefore appear to be at odds with the culture of emergency care. This assertion notwithstanding, it has been observed that palliative care (PC) delivery, including EOL in the ED, is feasible and may improve the quality-of-life experience.[16,17] Besides being one of the gateways into the hospital, the ED may be considered a safe environment to provide symptom relief.[11,14]

In developed settings, PC/ EOL care curricula are gradually being introduced in emergency medicine training [18] albeit several challenges such as time constraints, role

uncertainty, limited training and education, complex healthcare processes, and addressing family concerns persist.[19] Low-and-middle-income settings (LMICs) on the other hand are already faced with competing health interests with a significant disease burden which may limit the availability of PC even to persons with advanced illness in other clinical units beyond the ED.[20,21] Irrespective of the setting, studies exploring the delivery of EOL care in the ED have observed a perceived incongruence between goals of ED and EOL care among staff which causes emotional burden following the death of the patient.[2,22-24] Thus, although ED staff are regularly exposed to death and dying, their attitudes and actions suggest a desire to avoid the occurrence of death by moving the dying patients as soon as practicable.[23] Although these studies highlight potential challenges regarding death and dying in the ED, they do not offer insight into how healthcare staff experience and navigate through EOL care in the ED.

The burden of health-related suffering has been projected to increase with a significant proportion occurring in LMICs.[25] This may imply a need for PC/ EOL care to be fully integrated into health systems, including traditionally non-palliative care settings such as the ED in both developed and developing settings.[12,26,27] Moving towards this direction requires an in-depth exploration of how ED staff experience and navigate through care at the EOL to underpin the development of context-specific services.[4,28] Thus, this study sought to uncover the EOL care experiences as lived by ED staff.

Methods

Study design

van Manen's hermeneutic phenomenological approach was employed to understand the lived experiences of providing EOL care in the ED.[29] Hermeneutic phenomenology is essentially the study of the lifeworld with emphasis on the world as lived by a person[30] and useful in illuminating sensitive phenomena such as EOL.[31,32] The study is reported according to the Consolidated criteria for reporting qualitative research (COREQ) checklist.[33]

Study setting

The study was conducted at the Agogo Presbyterian Hospital, Ghana. The hospital is a large district facility functioning as the second largest hospital in the Ashanti Region of Ghana.

Participants, sampling, and sample size

In all twenty-five (25) ED staff were approached out of which nineteen (19) agreed to participate. Healthcare staff were eligible to participate if they had been working in the ED for a minimum of 6 months. ED staff on annual or study leave during the study period were excluded. To capture a broad range of experiences, we included a variety of participants based on their professional discipline (nurses, physicians, and physician assistants). Following ethical approval, the study was advertised, and potential participants were encouraged to contact the team to discuss their participation. Potential participants were also approached face to face. Some potential participants declined to participate due to heavy work schedules, disinterest in the phenomenon and on leave during the study period. Recruitment continued until no new analytical information was noted.[34]

Data collection

Semi-structured interviews were undertaken.[30] Considering the sensitive nature of EOL issues and the need to clarify meanings, follow-up interviews were conducted around 3-14 days following the initial interviews.[35] All interviews were conducted from July 2020 to January 2021. Field notes were maintained throughout the process.[36] Following recruitment, an agreeable date and time were set for the interviews. Interviews were held in the presence of a member of the research team and each participant separately. The interviews were conducted by two research nurses (JB & EKA). All interviews were conducted in English with occasional use of the local dialect (Asante Twi) by some participants. A topic guide developed by the research team and piloted among two ED staff was used for the data collection. It is worth mentioning that following the pilot,

minor corrections were made to the topic guide and the pilot data were not added to final dataset.

Sample interview questions include: "how has it been providing care in your unit?" "how has it been providing end-of-life care in your unit?" "how do you experience bereavement and what does it mean to you?" "how do you experience death and the immediate period following death in your unit?" All interview proceedings were audio-recorded with the participant's permission.

Data analysis

All audio recordings were transcribed verbatim into MS Word alongside their corresponding field notes. Statements in the local dialect were interpreted to English by and meanings confirmed with participants. Interview and follow-up discussions were merged to form a single transcript for each participant. The transcripts were anonymized, exported them to NVivo version 11 for data management, and analysed following van Manen's analytic-reflective methods and paying attention to the field notes.[30,37] The analytic strategies involved extracting thematic categories and reflecting on the meanings using the existential lifeworld themes.[30]

Each interview transcript was analyzed independently by two team members (JB & EKA). The transcription, reading, and re-reading processes helped to be immersed in the data. Following transcription there were line-by-line and wholistic readings of each transcript concurrently with highlighting the meanings embedded in the text. The statements reflecting participant's experiences with EOL care were highlighted and their thematic meanings noted. The emerging essential themes that reflected the same meaning were grouped as thematic categories. Following the formulation of the thematic categories, the lifeworld themes (corporeality, relationality, spatiality, and temporality) were employed as guides for reflecting on the meaning of the EOL experiences.[29,30,38] Throughout the analytic process, the team adhered to hermeneutic alertness[30] and maintained an analytic memo.[39] The professional background of all team members

(palliative care, emergency/ critical care, and general nursing) helped to interpret the data from diverse lenses and to enhance credibility.

Trustworthiness

Lincoln and Guba's framework (credibility, confirmability, dependability, and transferability) was applied to ensure trustworthiness.[40] The semi-structured interviews enabled in-depth understanding of the lived experience to attain credibility. The interviews were conducted by two graduate nurses who had received additional research training in qualitative interviewing. Analysis of the interview data was undertaken by two graduate nurses with ongoing team consultation. Audit trails were maintained, and member checking by all participants was also ensured as we proceeded with data analysis to facilitate confirmability and dependability. It is worth mentioning that though majority (n=17) were satisfied with transcripts, two participants made changes to their interpretations of the emotions that emerged immediately preceding the death of a patient.

Ethical Considerations

Permission was initially obtained from the Registry of the Presbyterian University College, Ghana. The study was approved by the Institutional Review Board of the hospital (APH/ADM/RES-135/20). Each participant was taken through the information sheet and if they agreed to participate, they were given two consent forms to sign. The service of a clinical psychologist was obtained, in case any participant experienced distress during or after the interview.[41] However, no distress was observed or reported.

Results

Nineteen (19) healthcare staff aged between 25 to 59 years participated in the study. The participants included 14 nurses (RN001 - RN0014), 3 physicians (PHY001 - PHY003), and 2 physician assistants (PA001 – PA002). Most of the participants were Christians (n= 15). The duration of work in the clinical unit ranged from 1year to 14years

with a mean duration of 6years. The initial interviews lasted from 45 to 70 minutes. The follow-up interviews lasted from 8 to 15 minutes.

Lifeworld themes and thematic categories

The findings were organized using the existential lifeworld themes with six thematic categories that capture the EOL experiences in the ED. The overarching category was *'resuscitate and push'* (see figure. 1).

Lived body (corporeality)

Lived body describes how participants perceived their bodies relative to the experience. The finding that emerged covering this existential lifeworld theme is resisting death and dying.

Resisting death and dying

Participants experienced working in the ED as being situated in the sphere of providing urgent lifesaving care to varied patient groups (trauma and non-trauma). Care in the ED targeted the urgent needs of the '*body'* of the patient to restore physiological stability. The ED was not considered a '*place'* suited for EOL. The focus of the ED staff was to '*resuscitate and push'* the patient to another ward within the hospital or refer to another hospital for specialist management:

> *"The place is an emergency unit, so we treat... when the person comes in and is in need of immediate care, we just give it, after that we transfer them to the ward for further treatment, so with the triage we just deal the emergency situation."* (RN006)

The unpredictable nature of the ED and rapid patient flow was noted to be stressful albeit with a sense of fulfilment so long as patients are successfully resuscitated and '*pushed'* to the next clinical unit, usually the ward. Healthcare staff in the ED therefore put in significant efforts and determination via implementing active treatment strategies/ resuscitative efforts to resist death. The determination to preserve life also emanated from a belief that patients wished to be kept alive at all costs. Besides, participants felt

situated within a socio-cultural context in which discussing death before it occurred was particularly challenging and as such ED staff worked towards avoiding it altogether:

> *"Okay, you see, technically, we do not manage those that need the palliative care because the patient has to be alive, so we provide all the necessary emergency care. The patient doesn't even last that long in our care and then we transfer"* (RN0011)

> *"Our culture is even in a way that we cannot talk about such issues when the relatives can see the patient is still alive. They do not want to hear or accept such news even though it may be the reality. They do not want to hear that their relative may not survive. We do not usually talk about such issues and we do what we can"* (RN0014)

The situatedness of the healthcare staff in the sphere of preserving life made EOL appear '*foreign'* and incongruent with the focus of care in the ED:

> *"You resuscitate the patient for more than 2 hours, sometimes they even come to the point where heart stands still. You resuscitate again to revive the patient, and when you expect the patient to pick up and then recover, suddenly, they go down again and all your efforts to revive patient does not yield any result. Looking at the energy and the skills, everything put into caring for the patient and still you lose that patient, it becomes emotional. It really weighs you down."* (PA002)

Lived relation (relationality)

The existential lifeworld describes the relatedness expressed between healthcare staff to the patient and family in the ED. The findings that encapsulate relationality are connectedness to the *'body of the patient'* and lacking support for family members and self.

Connectedness to the 'body of the patient'

Irrespective of the number of hours or days spent by the patient, it was uncovered that a connection formed between the ED staff and the '*physical body'* of the patient. This enabled the ED staff to identify and attend to the bodily alterations of the patient via active treatment/ resuscitation. The significant focus on the physical alterations affecting the body with limited to no attention to other spheres of the patient was still present at the EOL. Occasionally when ED staff perceived a pending death, the focus shifted to prayers:

"...you're just giving care to the patient but once you interact with the patient, there is a bond so you can care for them." (RN002)

"...and we believe that God is in control of everything. So let us keep praying as we continue managing the disease even when the prognosis doesn't look too good." (PA001)

Lacking support for family members and self

The nature of work in the ED leaves limited to no room to support family members. The focus on urgently resuscitating and pushing the patient led to the development of only a superficial relationship between the ED staff and family members. Competencies to actively engage with family members such as EOL communication were generally lacking among participants. Family presence during resuscitation at the EOL was not permitted as it was perceived that family members would either be distressed or be a source of distraction:

"That has always been one of the challenges. Especially when the patient is about dying and then relative is around, you must tell the person, "Please, will you excuse me?" (PHY002)

ED staff however sought to engage family members more following the patient's death as they attempted to break the death news and offer post-bereavement support which was often challenging:

"After the patient dies, we call the family aside and tell them, you see, this is the diagnosis the patient came in with, these are the pros and cons, these are the signs and symptoms, and this was the prognosis. So, after educating them to that extent they begin to realize that the patient's condition was very poor and that the condition was even fatal during admission." (RN0010)

The connectedness with the patient was also short-lived which seem to end following death. ED staff did not have support as they experienced grief. The arrival of a new patient to the ED 'covered' their grief experience and facilitated a rapid move from the EOL sphere to continue with the 'resuscitate and push' to the ward mode:

"But sometimes you know the stress and toil you went through caring for a patient and the following day you come, and the patient is gone, and you feel like, what didn't I do right. Yeah, but of course because they do not keep so long the bond is short, because there's always another person to care for." (RN009)

Lived space (spatiality)

Lived space describes the place in which humans move and find themselves. The findings associated with this existential lifeworld there are navigating through a '*liminal space*' and lack of privacy for patients.

Navigating through a liminal space

Healthcare staff in the ED experienced EOL care as a transition to an unfamiliar space. The sense of fulfilment diminished, hopes of attaining recovery were quashed, and stress associated with being in an unfamiliar space increased as participants navigated through the EOL and witnessed patients in distress. The notion of 'resuscitate and push' to the ward was gradually felt within the unfamiliar space as 'resuscitate and push' to the morgue. To avoid the latter, ED staff attempted to do their best within the '*liminal space*' of EOL but experienced feelings of helplessness when futility became apparent. The '*liminal space*' became unpleasant as the death often occurred suddenly. Participants felt a sense of failure and reflected on the preceding events following the death of the patient to identify any missed opportunities:

> "*It is so painful. You see them struggle in bed and at that time you want to do all you can. Seeing the patient dying in the emergency unit is so difficult. It is very painful when putting extra effort and you are very hopeful that the patient will come back and he dies, it becomes very emotional to us.*" (PHY002)

> "*So many things come into your mind… was there something that you could have done to avoid the situation, did you do all that had to be done, so many things come to mind and then later on you just realize that maybe you did all that you could and then it really had to happen and then it happened or even missed out on something that could have been done, like did not do my best.*" (RN003)

Sadness and grief emerged albeit latent. The intensity of grief was observed to be dependent on the age of the patient (death of a younger person evoked more intense emotions as compared to older persons), and the resuscitative efforts instituted to resolve the identified bodily alterations. Finding oneself within the EOL sphere further led to a recollection of personal bereavement experiences in the past to enable participants to

make sense of the current event as being a part of humanity although painful and unexpected:

> "Most of the time it depends on the condition of the patient and there are certain patients that you put in extra effort and sometimes looks like you will get the patient back but sometimes too it deals with the young ones. I lost a sickle cell patient some time ago who was young, we did our best thinking of putting him somewhere but died. When it happens, it can be emotional, but you get an elderly patient who is in his/ her 90's who has suffered a lot, I am not saying it is something we all wish for, but it depends on the age and the effort to put in place at that particular time for the patient." (PA001)

> "I take it personal because I lost my father in the same way so when I see people in those conditions, I don't joke with them." (RN005)

Navigating through the 'liminal space' also required breaking the death news to family members who may or may not be present at the time of death. Irrespective of how many deaths one had witnessed in the past, breaking the death news remained an uncomfortable task most often handled by the ED nurses. The task of breaking the death news became even more challenging when the death occurred suddenly:

> " Mm, as a health personnel, you've seen it several times, but you're still involved, I mean you never get used to it [breaking death news] …. Mm that's another errm, for us doctors, most of us leave it [breaking death news] to the nurses." (PHY001)

> "It has always been the challenge of the health professional, breaking the news. Telling the family about the death is very difficult and very painful, physically stressful and emotionally stressful as well especially with patients who die suddenly." (RN008)

Lack of privacy for patients

The ED design was described as an open environment with patients put together to facilitate observation. Although ED staff attempted to provide privacy by using screens, it was considered inadequate. Resuscitation was often carried out in the open and even when screens are provided, participants felt other patients could perceive the happenings behind the screens. Patients who died suddenly often lacked privacy in their spaces creating distress in other patients present:

"...so, when the patient is dying of course you know, we mostly screen, we screen, it is not mostly complete screening but, we screen, and then keep the relatives outside." (RN0014)

"With our setup here, we do not have a separate ward for those who die, or a separate place where we care for the dying, so they are all mingled in one place and just using a screen to prevent them. Sometimes the screen is not even there 24/7. We take it when we need it. So, they also do not feel comfortable, like their privacy has been looked down upon." (PA002)

Despite the limited to no privacy for patients at the end of life, family members were offered privacy during the breaking of the death news. ED staff actively sought to create these spaces to offer an avenue for release for family members:

"We usually call the relatives to the office or any private room or any comfortable place before telling them what happened to their relative" (RN007)

Lived time (temporality)

Temporality refers to the time passage in relation to the EOL experience. Temporality was experienced as having limited to no time for EOL care and grieving. s

Having limited to no time for EOL care and grieving

Time in the ED was often short with every passing second considered significant in determining outcomes. The success of resuscitation is timebound and futility is often determined following a period of resuscitation with no positive response. Death may also occur within a brief period to the shock of ED staff. Given the significant focus on resuscitation in the ED, comfort care was often not a priority or streamlined in the resuscitation process. Additionally, ED staff felt they were not trained to fit into the EOL care space. Patients who died suddenly often received no comfort care. However, patients whom the ED staff perceived to be dying may receive comfort care in managing their physical pain, which was inadequate:

"Yes, I'll advocate for that we need specialists. We need people who are specialized in caring for people with that need because to me, as an emergency nurse, our interests and training is not in the ones at that stage [end of life] but rather, those having the acute condition we are managing so if I put these two people, I will leave the one who needs that palliative care to attend to somebody who needs

urgent care that is not palliative. So, if we have such a specialist here, it will be better." (RN0014)

"Oh, some go through and we give some pain medication, but they will still be in pain. But for others they will just be there and then the next time you check upon them they are gone." (RN001)

Further to the above, ED staff *'covered'* their grief and there was limited to no time to express it or achieve closure as they moved on quickly to continue the 'resuscitate and push' mode with new patients coming in:

"Sometimes you can even forget you are a professional, if you don't hold yourself, you will join them, but we just move on to the next patient." (PHY001)

Discussion

Guided by the existential lifeworld themes, this study sought to uncover the EOL experiences of ED staff. The findings highlight a phenomenon of *'resuscitate and push'* mode of work in the ED with a significant focus on resisting death. The EOL was experienced as an unpleasant *space* with ED staff navigating through it using the *'resuscitate and push'* strategy. Additionally, comfort care was not a priority and ED staff felt they were not suited to offer this form of care. Care only focused on some physical needs of the patient with limited space and time to consider other domains and family needs at the EOL. Although ED staff may experience helplessness, grief, and feelings of failure within the *liminal space* of EOL, support systems to help them to navigate through these emotions were lacking with a quick turn to the next patient. Grief was experienced covertly and *covered* by the entry of a new patient. The findings suggest that EOL is poorly defined although death is a reality in the ED. There is a need for a paradigm shift from the traditional ED model to support the streamlining of palliative/ EOL care in the ED to enable staff better support patients at the EOL and their families. Additionally, ED staff will also require support with navigating through the *liminal space*, managing their grief/ achieving closure, and developing a better working relationship with patients/ families.

Undoubtedly, the ED is mostly associated with heroic lifesaving actions.[2,42] Yet, the ED, in recent times, is becoming a setting that increasingly attends to persons at the EOL.[43-45] Being one of the gateways to the hospital, the ED may be a safe place that can facilitate the delivery of palliative/ EOL care.[2,20,46] Despite this assertion, the need to resist death often with limited attention to health-related suffering is a reality noted in the current study with EOL experienced as an unpleasant space in which the ED staff generally lacked the expertise to navigate through. The phenomenon of defying death has been reiterated in previous studies as ED staff focused significantly on resuscitation and were unable to offer EOL care though it may have been the most dignified course of action.[1,2,47] This phenomenon may be due to the rapid nature of work in the ED,[46] staff perception that the ED is a wrong place to die,[48] challenges with identifying patients who may benefit from palliative care,[49] or general lack of expertise among ED staff.[50] Evidently, the findings affirm a critical need to equip all ED staff, not just ED physicians, with primary palliative care skills which can be employed to ensure that even in the rapid ED environment, persons who require EOL have access to what is available.[51] Screening/ prognostication tools, EOL care protocols, and care pathways that can facilitate collaboration/ referrals to specialist palliative care services, where available, are also urgently needed in the ED.[52]

Further to the above, the current study noted the availability of limited to no support for family members and ED staff at the EOL. Interestingly, participants sought to engage the family more following the death of their patient. Often the fast-paced ED environment leaves only limited time to support family members, provide updates regarding the state of the patient, or even grief over a loss. For families, this development may lead to frustration as it they may find it difficult to navigate through the busy ED environment.[53] Even though ED staff may have only a limited time with the patient, the lack of support as they navigate the EOL *liminal space* and grief may increase their risk for work-related stress and burnout.[54] Thus, as ED staff are trained to develop better working relationships with families, they also need avenues of release to achieve closure following an episode of death in the ED. *Covering* the grief with the next patient

presenting at the ED may not a healthy way of managing grief. As attempts are made to develop and implement bereavement support programmes for families,[55] there is a need to also consider tailor-made grief programmes for ED staff.[56,57]

Communication is central in the practice of EOL and has been consistently ranked as a major need for families of persons at the end-of-life.[13,58,59] The heavy ED workload can hinder communication with family members only for healthcare staff to appear later to break the death news. Effective communication may also be hindered in an ED environment where there is inadequate privacy to discuss sensitive EOL issues.[60] As noted in the current study, breaking the death news is often a difficult task for ED staff, particularly, if the death occurred suddenly. Families may often miss the opportunity to see, touch, speak and say good-bye to their loved ones. Besides, they were not permitted to be present during resuscitation, which may escalate their sense of uncertainty. The death news may therefore appear abrupt for family members even when death was an expected outcome. Studies in the intensive care unit have highlighted similar concerns noting that family members are often in a state of uncertainty which was worsened by poor communication.[12,27] Thus, ED staff will require training in communication skills which should focus on initiating goals of care discussion with families (and patients where applicable), providing regular updates to families, interprofessional communication, and breaking death news.[46] Where possible, collaboration with palliative care specialists may help to support ED staff in ensuring a family-centred approach to care.

Strength and limitations

The strength of this study lies in the use of the phenomenological orientation to understand the meaning of EOL care in the ED. Some limitations are however noteworthy. Firstly, although the findings are comparable to existing literature, some findings may be unique to the study context. Also, the study included more nurses than other ED staff which although reflects the professional distribution at the study setting may have given greater voice to nurses.

Conclusion

In conclusion, the study findings highlight poorly defined EOL in the ED. ED staff experienced the EOL as an unpleasant space during which the 'resuscitate and push' approach was still in use with focus on meeting some physical needs of the patient. Often, there was limited attention to other spheres of the patient, family needs, and the ED staff own needs. Critical gaps therefore exist to work towards building capacity in the ED and ensuring the availability of support for ED staff at the EOL.

Authors note.

JB, FBA, and EKA conceptualised the study; JB & EKA conducted data collection; all authors participated in data analysis, writing up, and critical review of the final draft.

Data availability statement

The data that support the study findings are available on reasonable request from the corresponding author on jbayuo88@gmail.com.

Conflicts of interest

The authors declare no conflicts of interest.

Funding

No specific funding obtained.

References

1. Dawood M. End of life care in the emergency department. *Emergency Medicine Journal.* 2020;37(5):273-278.
2. Bailey CJ, Murphy R, Porock D. Dying cases in emergency places: caring for the dying in emergency departments. *Social science & medicine.* 2011;73(9):1371-1377.
3. Mughal A, Evans C. Views and experiences of nurses in providing end-of-life care to patients in an ED context: a qualitative systematic review. *Emergency Medicine Journal.* 2020;37(5):265-272.
4. Tse JWK, Hung MSY, Pang SMC. Emergency nurses' perceptions of providing end-of-life care in a Hong Kong emergency department: a qualitative study. *Journal of Emergency Nursing.* 2016;42(3):224-232.
5. Nauck F, Jaspers B. Is palliative care synonymous with end of life care. *European Journal of Palliative Care.* 2003;10(6):223.
6. Bayuo J, Bristowe K, Harding R, et al. The role of palliative care in burns: a scoping review. *Journal of pain and symptom management.* 2020;59(5):1089-1108.

7.   Smith AK, Fisher J, Schonberg MA, et al. Am I doing the right thing? Provider perspectives on improving palliative care in the emergency department. *Annals of emergency medicine.* 2009;54(1):86-93. e81.

8.   Mierendorf SM, Gidvani V. Palliative care in the emergency department. *The Permanente Journal.* 2014;18(2):77.

9.   Adams V. Access to pain relief: an essential human right. A report for World Hospice and Palliative Care Day 2007. Help the hospices for the Worldwide Palliative Care Alliance. *Journal of pain & palliative care pharmacotherapy.* 2008;22(2):101-129.

10. Radbruch L, De Lima L, Knaul F, et al. Redefining palliative Care—A new consensus-based definition. *Journal of pain and symptom management.* 2020;60(4):754-764.

11. Grudzen CR, Stone SC, Morrison RS. The palliative care model for emergency department patients with advanced illness. *Journal of palliative medicine.* 2011;14(8):945-950.

12. Bayuo J, Bristowe K, Harding R, et al. "Hanging in a balance": A qualitative study exploring clinicians' experiences of providing care at the end of life in the burn unit. *Palliative Medicine.* 2021;35(2):417-425.

13. Norton CK, Hobson G, Kulm E. Palliative and end-of-life care in the emergency department: guidelines for nurses. *Journal of Emergency Nursing.* 2011;37(3):240-245.

14. Grudzen CR, Stone SC, Mohanty SA, et al. "I want to be taking my own last breath": patients' reflections on illness when presenting to the emergency department at the end of life. *Journal of palliative medicine.* 2011;14(3):293-296.

15. Mosenthal AC, Murphy PA. Trauma care and palliative care: time to integrate the two? *Journal of the American College of Surgeons.* 2003;197(3):509-516.

16. Wilson JG, English DP, Owyang CG, et al. End-of-life care, palliative care consultation, and palliative care referral in the emergency department: a systematic review. *Journal of pain and symptom management.* 2020;59(2):372-383. e371.

17. Hendin A, La Rivière CG, Williscroft DM, O'Connor E, Hughes J, Fischer LM. End-of-life care in the emergency department for the patient imminently dying of a highly transmissible acute respiratory infection (such as COVID-19). *Canadian Journal of Emergency Medicine.* 2020;22(4):414-417.

18. Paterson B, Duncan R, Conway R, Paterson F, Napier P, Raitt M. Introduction of the Liverpool Care Pathway for end of life care to emergency medicine. *Emergency Medicine Journal.* 2009;26(11):777-779.

19. Wright RJ, Lowton K, Robert G, Grudzen CR, Grocott P. Emergency department staff priorities for improving palliative care provision for older people: A qualitative study. *Palliative medicine.* 2018;32(2):417-425.

20. Hasson F, Nicholson E, Muldrew D, Bamidele O, Payne S, McIlfatrick S. International palliative care research priorities: A systematic review. *BMC palliative care.* 2020;19(1):16.

21. Abu-Odah H, Molassiotis A, Liu J. Lessons Learned from Countries That Have Introduced Palliative Care Services into Their National Health System: A Narrative Review. *Journal of Palliative Care.* 2021:0825859721989557.

22. Beckstrand RL, Collette J, Callister L, Luthy KE. Oncology nurses' obstacles and supportive behaviors in end-of-life care: providing vital family care. Paper presented at: Oncology nursing forum2012.

23. Decker K, Lee S, Morphet J. The experiences of emergency nurses in providing end-of-life care to patients in the emergency department. *Australasian Emergency Nursing Journal.* 2015;18(2):68-74.

24. Gloss K. End of life care in emergency departments: a review of the literature. *Emergency Nurse.* 2017;25(2).

25. Sleeman KE, de Brito M, Etkind S, et al. The escalating global burden of serious health-related suffering: projections to 2060 by world regions, age groups, and health conditions. *The Lancet Global Health.* 2019;7(7):e883-e892.

26. Abu-Odah H, Molassiotis A, Liu J. Challenges on the provision of palliative care for patients with cancer in low-and middle-income countries: a systematic review of reviews. *BMC palliative care.* 2020;19:1-16.

27. Bayuo J, Bristowe K, Harding R, et al. "Managing uncertainty": Experiences of family members of burn patients from injury occurrence to the end-of-life period. *Burns.* 2021.

28. Chan GK. End-of-life and palliative care in the emergency department: a call for research, education, policy and improved practice in this frontier area. *Journal of Emergency Nursing.* 2006;32(1):101-103.

29. Van Manen M. Phenomenology in its original sense. *Qualitative health research.* 2017;27(6):810-825.

30. Van Manen M. *Researching lived experience: Human science for an action sensitive pedagogy.* Routledge; 2016.

31. Manen Mv. Phenomenology of practice. *Phenomenology & Practice.* 2007;1(1):11-30.

32. Errasti-Ibarrondo B, Jordán JA, Díez-Del-Corral MP, Arantzamendi M. van Manen's phenomenology of practice: How can it contribute to nursing? *Nursing inquiry.* 2019;26(1):e12259.

33. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care.* 2007;19(6):349-357.

34. Moser A, Korstjens I. Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *European Journal of General Practice.* 2018;24(1):9-18.

35. Read BL. Serial interviews: When and why to talk to someone more than once. *International Journal of Qualitative Methods.* 2018;17(1):1609406918783452.

36. Laverty SM. Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International journal of qualitative methods.* 2003;2(3):21-35.

37. Heinonen K. van Manen's method and reduction in a phenomenological hermeneutic study. *Nurse researcher.* 2015;22(4).

38. van Manen MA. On ethical (in) decisions experienced by parents of infants in neonatal intensive care. *Qualitative Health Research.* 2014;24(2):279-287.

39. Saldaña J. *The coding manual for qualitative researchers.* sage; 2021.

40. Lincoln YS, Guba EG. But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New directions for program evaluation.* 1986;1986(30):73-84.

41. Draucker CB, Martsolf DS, Poole C. Developing distress protocols for research on sensitive topics. *Archives of psychiatric nursing.* 2009;23(5):343-350.

42. Stone SC, Mohanty S, Grudzen CR, et al. Emergency medicine physicians' perspectives of providing palliative care in an emergency department. *Journal of palliative medicine.* 2011;14(12):1333-1338.

43. Olusegun-Joseph A, Akande O, Otrofanowei E, Nwoye E, Olopade O, Ajuluchukwu J. Medical mortality in an emergency department in Nigeria: the transition is obvious! *African Health Sciences.* 2021;21(1):172-179.

44. Yates M, Barrett A. Oncological emergency admissions to the Norfolk and Norwich University Hospital: an audit of current arrangements and patient satisfaction. *Clinical Oncology.* 2009;21(3):226-233.

45. Amado-Tineo JP, Oscanoa-Espinoza T, Vásquez-Alva R, Huari-Pastrana R, Delgado-Guay MO. Emergency department use by Terminally Ill patients: a systematic review. *Journal of pain and symptom management.* 2020.

46. Cooper E, Hutchinson A, Sheikh Z, Taylor P, Townend W, Johnson MJ. Palliative care in the emergency department: a systematic literature qualitative review and thematic synthesis. *Palliative medicine.* 2018;32(9):1443-1454.

47. Kongsuwan W, Matchim Y, Nilmanat K, Locsin RC, Tanioka T, Yasuhara Y. Lived experience of caring for dying patients in emergency room. *International nursing review.* 2016;63(1):132-138.

48. Marck C, Weil J, Lane H, et al. Care of the dying cancer patient in the emergency department: findings from a N ational survey of A ustralian emergency department clinicians. *Internal medicine journal.* 2014;44(4):362-368.

49. George N, Bowman J, Aaronson E, Ouchi K. Past, present, and future of palliative care in emergency medicine in the USA. *Acute medicine & surgery.* 2020;7(1):e497.

50. McNamara R. Emergency palliative care. *Emergency Medicine Journal.* 2020;37(5):260-261.

51. Tan A, Durbin M, Chung FR, et al. Design and implementation of a clinical decision support tool for primary palliative Care for Emergency Medicine (PRIM-ER). *BMC medical informatics and decision making.* 2020;20(1):13.

52. Jennerich AL, Jöbges S, Slabbert M. Advancing palliative care in intensive care and emergency medicine. In: *Compelling ethical challenges in critical care and emergency medicine.* Springer; 2020:119-125.

53. Salifu Y, Almack K, Caswell G. 'My wife is my doctor at home': A qualitative study exploring the challenges of home-based palliative care in a resource-poor setting. *Palliative medicine.* 2021;35(1):97-108.

54. Hartog CS, Reinhart K. Staff and family response to end-of-life care in the ICU. *Current Opinion in Anesthesiology.* 2018;31(2):195-200.

55. Cooper JJ, Stock RC, Wilson SJ. Emergency department grief support: A multidisciplinary intervention to provide bereavement support after death in the emergency department. *The Journal of emergency medicine.* 2020;58(1):141-147.

56. Marcella J, Kelley ML. "Death is part of the job" in long-term care homes: Supporting direct care staff with their grief and bereavement. *Sage Open.* 2015;5(1):2158244015573912.

57. LeBrocq P, Charles A, Chan T, Buchanan M. Establishing a bereavement program: caring for bereaved families and staff in the emergency department. *Accident and Emergency Nursing.* 2003;11(2):85-90.

58. Kenney AE, Bedoya SZ, Gerhardt CA, Young-Saleme T, Wiener L. End of life communication among caregivers of children with cancer: A qualitative approach to understanding support desired by families. *Palliative & Supportive Care.* 2021:1-8.

59. Jung MY, Matthews AK. A Systematic Review of Clinical Interventions Facilitating End-of-Life Communication Between Patients and Family Caregivers. *American Journal of Hospice and Palliative Medicine®.* 2021;38(2):180-190.

60. Lawler J. *Behind the screens: Nursing, somology, and the problem of the body.* Sydney University Press; 2006.

Figure 1: EOL experiences in the ED.

Lived body (Corporeality)

1. Resisting death and dying

Resuscitate and push

Lived relation (Relationality)

1. Connectedness to the 'body of the patient'

2. Lacking support for family members and self

Lived time (Temporality)

1. Having limited to no time for EOL care and grieving

Lived space (Spatiality)

1. Lack of privacy for patients

2. Navigating through a liminal space