Emergency Nurses' Perceptions of Providing End-of-Life Care in a Hong Kong Emergency Department: A Qualitative Study

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CE Earn Up to 9.5 CE Hours. See page 292.

Introduction: Provision of end-of-life (EOL) care in the emergency department has improved globally in recent years and has a different scope of interventions than traditional emergency medicine. In 2010, a regional hospital established the first ED EOL service in Hong Kong.

Methods: The aim of this study was to understand emergency nurses' perceptions regarding the provision of EOL care in the emergency department. A qualitative approach was used with purposive sampling of 16 nurses who had experience in providing EOL care. Semi-structured, face-to-face interviews were conducted from May to October, 2014. All the interviews were transcribed verbatim for content analysis.

Results: Four themes were identified: (1) doing good for the dying patients, (2) facilitating family engagement and involvement, (3) enhancing personal growth and professionalism, and (4) expressing ambiguity toward resource deployment.

Discussion: Provision of EOL care in the emergency department can enhance patients' last moment of life, facilitate the grief and bereavement process of families, and enhance the professional development of staff in emergency department. It is substantiated that EOL service in the emergency department enriches EOL care in the health care system. Findings from this study integrated the perspectives on ED EOL services from emergency nurses. The integration of EOL service in other emergency departments locally and worldwide is encouraged.

End-of-life (EOL) care is an important component of palliative care (PC) and aims to provide patient care during the last stage of life. The scope of care has shifted to include making dying patients as comfortable as possible by minimizing invasive and life-prolonging therapies and helping patients and their families adapt to mourning. Health professionals not only provide treatment to relieve symptoms and control pain but also respond to the psychosocial and spiritual needs of patients and families and emphasize dying with dignity.[1–3]

The World Health Organization has estimated that the proportion of the world's population that is older than 60 years will double from 11% to 22% between 2000 and 2050.[4] The Hong Kong (HK) government estimates that the population older than 65 years will increase from 13% to 30% between 2011 and 2041.[5] Although people now have longer life spans, quality of dying and death issues have been overlooked. Large numbers of people are expected to be treated in emergency departments during the EOL stage, increasing the demand for EOL services.[6]

Death in an emergency department can be classified as either unexpected or expected. Bailey, Murphy, and Porock[6] categorized these trajectories into 2 groups: spectacular, which refers to unexpected death in an emergency department and usually involves trauma or acute illness, and subtacular, which

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refers to expected death and advanced or terminal illness. Traditional emergency medicine training focuses on acute medical treatment, lifesaving resuscitation, and trauma care,[1,7] but the subtacular trajectory is commonly found in emergency departments.[6] Foreseeing a service gap in outpatient PC services,[3,8] a review of the ED EOL service is recommended to deal with the aging population and the increase in dying and terminally ill ED patients.

Emergency nurses are key to EOL services.[6,9] ED health professionals have generally been found to be lacking in EOL knowledge but are trained to provide immediate response to patients' health conditions.[1,6] Although some emergency nurses have indicated that they consider an emergency department to be an unsuitable setting for a good death, there is a need for EOL care.[10] Many studies focus on how health professionals perceive the effectiveness of pain and symptom control at EOL.[1,3,11] The ENA generated a position statement for emergency nurses in EOL care, stating that the goals of EOL services are to minimize patients' suffering due to pain and other symptoms, consider their cultural and religious beliefs, and promote dying with dignity.[2] In numerous studies, emergency nurses encountered difficulties in providing EOL care in emergency departments because of a lack of EOL knowledge and training,[1,12] difficulty handling relationships between families and health care professionals,[1,11,13] and EOL-related ethical and social concerns.[17] However, few studies have examined emergency nurses' experiences in providing EOL services.

In the United States, curricula in PC and EOL care in emergency medicine have been established for health professionals, including nurses who work in emergency departments.[14] Numerous emergency departments in the US and in European countries have established EOL services to provide appropriate care to dying patients.[15]

In 2010, the largest regional acute hospital in HK, the Queen Elizabeth Hospital (QEH), initiated an EOL service in the emergency department with the aim of providing high-quality care for EOL patients (defined as patients with advanced medical diseases or those for whom death is imminent) and their families to meet the demand for ED EOL services. The QEH was the pioneer emergency department in HK to initiate the ED EOL service for patients and their families. After 2011, this special service was extended to medical unit inpatients when the ED EOL service is not engaged by ED patients.

The aim of this study was to explore the perceptions and reflections of emergency nurses with experience in providing EOL care. Although numerous studies regarding ED EOL care have been performed, this study provides an initial understanding of the HK situation.

Methods

This qualitative study was conducted in the largest regional acute hospital in HK. A total of 195,280 patients visited the emergency department in 2013/2014; approximately 36% (67,236 patients) required hospital admission and 0.22% (406 patients) died in the emergency department.[16,17] A multidisciplinary team including emergency physicians, nurses, a clinical psychologist, a chaplain, and a social worker were involved and cooperated in service provision under the ED service. The service included a spacious single private room, named *Osiris*, and an emergency nurse who had previously received basic training for ED EOL service in the emergency department and was assigned to provide and arrange one-on-one psychosocial and spiritual care.

Ethical approval for the study was granted by the ethics committees of the university and hospital with which the researchers are affiliated. Sixteen registered nurses with at least 6 months' experience in providing EOL care in an emergency department since service commencement were recruited. The Table provides the demographics of the participants.

Semi-structured, face-to-face interviews were conducted using guiding questions to encourage the participants to verbalize more of their personal experiences and perspectives regarding the ED EOL service. For example, the participants were asked, "Could you share with me the most memorable case(s) that you experienced in the ED EOL service?" Participants were encouraged to share their experiences and views regarding EOL care anonymously (without the use of personal identifiers) to ensure privacy and confidentially. Prior to the interview, the research purpose, methodology, voluntary participation, and dissemination of research findings were explained to all participants during the consent process. All the participants had the right to withdraw from the study at any time without penalty or disclosure of the personal identifiers. None of the participants withdrew from the study. Interviews were audio recorded and transcribed verbatim. Transcripts were collated with the researchers' field notes and distributed to the researchers with the recordings to facilitate discussion, confirmation, and validation of the themes and subthemes.

Content analysis was conducted. Similar key units were grouped into subthemes and categorized into 4 interrelated themes. Data saturation occurred after 16 individual interviews. Multiple meetings were held among the researchers to ensure credibility. An audit trail was created to ensure confirmability and allow others to trace the course of the study and verify decisions made regarding the procedure. Reflective commentary was maintained to allow

TABLE
Demographic characteristics of participated nurses.

Characteristic	Participating nurses (N = 16) *f*(%)
Gender	
Male	8 (50)
Female	8 (50)
Ranking	
Advanced practice nurse	1 (6.25)
Registered nurse	15 (93.75)
Years as a nurse	
1-5	2 (12.5)
6-10	10 (62.5)
11-15	3 (18.75)
>15	1 (6.25)
Years as an emergency nurse	
1-5	8 (50)
6-10	7 (43.75)
11-15	0 (0)
>15	1 (6.25)

evaluation of the study and its development. One of the researchers (JWKT) works with participants with whom familiarity had previously been established, to ensure credibility, and the other 2 researchers had amassed rich experience in emergency nursing and EOL research. To prevent bias, reflexive reviews and discussions among the researchers regarding the transcripts and themes were performed regularly.

Results

With respect to emergency nurses' perceptions of providing EOL care in emergency departments, 4 main themes emerged, within which 10 subthemes were identified; these themes and subthemes are described in the following sections.

THEME 1: DOING GOOD FOR DYING PATIENTS

Subtheme 1: Estimating the Duration of Stay and EOL Care

Participants understood that when patients were referred to the EOL service, they have entered the last stage of life. Care priorities shifted to maximize quality of life during the patients' remaining time; this was considered suitable care as opposed to active and invasive life-sustaining interventions. As Nurse E stated, "We all know that they [EOL patients] are terminally ill and will not respond to current interventions…they don't need to suffer with controversial and invasive treatment…letting them pass away comfortably."

Participants stated that duration of stay was difficult to estimate for EOL patients. They also revealed that care and service delivery were influenced by changes in duration of stay and altered accordingly, which made patients' actual needs difficult to meet. One participant (Nurse A) raised concern regarding the effectiveness and quality of care with a short duration of stay: "Once a patient's condition has become incurable and they are sent to us [the ED] from the medical ward for EOL care, following assessment and consultation with the EOL team physician… the patient passed away within 15 minutes in the [Osiris] room… nothing we had planned for the patient and his family could be done."

Subtheme 2: Promoting Desirable Locations for EOL Care

Participants appreciated the renovated private single room provided for patients and their families during their final moments. Patients and their families were relaxed in a private, peaceful environment without disturbance. Nurse O commented, "It [the Osiris room] is a good place for dying patients, compared to the medical ward. It is just like upgrading from economy to business class on the plane…he [the EOL patient] has suffered for a long time, let him be more comfortable in the EOL room with his family accompanying him."

Religious rituals could be performed according to patients' and families' wishes in the spacious room for EOL patients and families. The participants believed that this addressed patients' psychosocial and spiritual needs. Nurse B noted, "With the EOL protocol, er…we can refer to religious parties when necessary…[the room] is allowed to play some religious background music; like, if they are Buddhists, Buddhism music could be chosen, which helps [them to] release their emotions and makes them feel peaceful and calm…. Although they might be unconscious, I speak to the patients, and let them know that I am staying with them."

Subtheme 3: Providing Comfort and Care to Meet the Needs of EOL Patients

Almost all participants expressed a belief that the ultimate goal of EOL care was to provide comfort for dying patients, using various interventions. Opioid-type medications were commonly used for pain relief, particularly in patients with malignancies. Participants expressed concern regarding the

benefit-risk balance of increasing medication dosage. Some participants believed that large doses of opioid medication would accelerate the dying process, whereas others believed that higher doses could offer effective pain relief. Nurse C said, "The physicians visit the EOL patients and order a morphine infusion, which helps them control pain continuously, making them look peaceful and comfortable."

Participants all valued the effective administration of medications for respiratory symptoms and provision of sedation during the final moments of life. Some participants expressed concern regarding physicians' decisions to withhold all types of medication, as some medications provided effective symptom control, and patients' physical needs could be neglected. Nurse M commented, "Buscopan is effectively used to reduce sputum…as these patients suffer from respiratory secretion…. Withholding all medications? I have another view on that…for example, with fever, rectal Panadol [Paracetamol] would be used, as it helps the patients; whichever drug relieves their symptoms, I support its use…."

Some participants wondered whether other interventions, such as repositioning and turning, would relieve symptoms more effectively than increasing medication dosages.

THEME 2: FACILITATING FAMILY ENGAGEMENT AND INVOLVEMENT

Subtheme 4: Realizing Family Involvement in Choosing Intervention Options

Most participants had negotiated with patients' families regarding which intervention options to use during EOL care. In particular, feeding issues were a source of conflict between patients' families and health care professionals. One participant had bargained with families over the amount of milk fed to patients via a nasogastric tube. Participants understood that wishes being rejected could affect families during their bereavement and grieving; therefore, they attempted to educate families regarding EOL issues. Nurse L noted, "Some families insist on continuing to feed [the patient] as usual, request that the amount is decreased but not withheld…we have to compromise with the families on the amount of milk the patient can tolerate, from a half to a quarter [of the full] amount…. I understand the frustration of the families when their opinions are ignored, so I would not neglect to show them how tolerant the patient is."

Some participants understood that the reasons for such bargaining were concern and love. In balancing the best interests of patients against the wishes of families, they endeavored to allow families to decide or participate in providing optimum intervention for dying patients. Nurse D noted, "So far, they [the families] would agree to give the patients [opioid-type] medication…initially, they might not accept the interventions; er…spend time and communicate with them to consider the best interests of the patients, but not to prolong suffering or pain…to let [the] patient pass away more peacefully…."

Subtheme 5: Supporting the Family in Expressing Their Concern and Love to the EOL Patient

A few participants had encountered families who repeatedly requested various types of support for patients. Although some nurses felt exhausted by frequently answering families' questions, they understood that their requests were an expression of concern and love. Nurse L commented, "The family kept pressing the call bell every 15 minutes, as they noted that the patient was complaining of chest pain. They wanted me to get the glyceryl trinitrate [TNG] tablet for the patient, but the physician had already signed off the pills! They were family; they just wanted to help and were concerned about the patient's comfort."

Some participants appreciated family members' involvement in caring for EOL patients. They encouraged and assisted family members in helping EOL patients by showing them how to wash patients' faces or bodies, which could represent connection and love. Nurse O said, "I would ask if they wanted to help the patients with mouth cleansing. Actually, they don't know how to, so we encourage and teach them…I believe it could help to show their love to the EOL patients."

Subtheme 6: Balancing Family's Needs and Patient's Interests and Dignity While Dying During the Final Farewell

Most participants acknowledged the need for family presence and company during the final stage of life. The meaning of the final farewell was essential, as it could influence family members' grief and bereavement. According to Nurse P, "Allowing them to stay with the dying patient is important…if you do not allow it, they would feel something missing in their lives…this could help [them] to get through the grieving process well."

Some participants considered the needs of the EOL patients to be more important than family members' requests for a final farewell. They were conflicted in balancing patients' best interests against the Chinese cultural belief in unconditional filial piety and prolonging the dying process:

> "At the time, the family requested to…prolong the patient's life, as they wanted the eldest son, who was

flying back from another place, to see the patient… before his death" (Nurse J).

"The families insisted in delaying the interventions after transgeneration unity for a final farewell, such as increasing the opioid infusion dosage, they mistakenly believed that [it] would accelerate dying…this could be due to their belief in Chinese filial piety which all descendants should be present at the patient's final moment of life, it is a blessing and completeness of life for the dying patient" (Nurse I).

THEME 3: ENHANCING PERSONAL GROWTH AND PROFESSIONALISM

Subtheme 7: Reflecting on the Meaning of Life and Death

Although death was encountered frequently in the emergency department, caring for EOL patients prompted some participants to reflect on the meaning of death. Nurse M noted, "Death is unavoidable…. I didn't think about it much before…. With the chance of caring [for] EOL patients, I found there was strong bonding within families…they [the family members] worried and also suffered throughout the process. Death is not a personal issue and attaches to families…. I would definitely treasure my family and life more…."

Participants experienced an opportunity to reflect on the meaning of life and death after observing bonding between patients and their families during EOL care.

Subtheme 8: Revitalizing Participants' Passion for Nursing as a Caring Profession

Participants stated that most ED work was task oriented, but caring for EOL service users was different, allowing them to reinforce their competencies and maintain their professional knowledge and skills, particularly those involving therapeutic relationships and their patient advocacy role in communication with other health professionals. Nurse I noted, "It allowed me to reflect…why I wanted to be a nurse at the beginning…umm…I worked for a few years in the ED, my passion has "cooled" with busy and heavy daily routines… when families expressed their deep sense of gratitude for my work, I was motivated, and [it] inspired [me to remember my] reasons for being a nurse, and [I] would continue to accomplish my mission of being a nurse."

Participants experienced various difficulties in delivering EOL care. They expressed a need to improve communication and counseling skills and considered consolidation of these skills important. As Nurse D noted, "The communication and counseling skills are important in EOL care…. I think there is a need for emergency nurses to strengthen these skills…especially [in] caring [for] the families."

Striving for professionalism was stimulated by positive feedback and encouragement during the provision of EOL care; the participants shared this earnestly. For example, Nurse O said, "Although I struggled [with] the purpose of providing EOL care in ED…er…the appreciation from families motivated and encouraged me to rethink…working as a nurse in ED is not just based on the guidelines…."

THEME 4: EXPRESSING AMBIGUITY TOWARD RESOURCE DEPLOYMENT

Subtheme 9: Manpower Constraint and Service Priority in an Emergency Context

Participants stated that, even as delegated EOL case nurses, their time was occupied with other work. A few gave the EOL service the lowest priority relative to other clinical duties. They explained that this was because of insufficient manpower in the emergency department, which meant that they could not provide appropriate one-on-one EOL care. Nurse D commented, "Even as the delegated nurse for [the] EOL service, if an acute pulmonary edema [occurred and the] patient's condition deteriorated, I would go to care [for] the APE [acute pulmonary edema] patient first and put their [EOL families'] requests aside."

Because of manpower shortages, some participants questioned the further development of EOL in the emergency department. Participants appreciated the patient benefits of EOL care and acknowledged the need for ED EOL services, but they also recognized restrictions and limitations due to manpower shortages and a lack of resources. For example, Nurse F said, "There is an urge to have enough resources and manpower when considering expansion of EOL services."

Subtheme 10: Effectiveness of Resource Utilization in Emergency Contexts

Resources, such as spacious single rooms and designated teams of staff caring for one EOL patient, were provided in all cases. However, some participants questioned whether resources for ED EOL services were used effectively and met current patient demands and needs. For example, Nurse I said, "We have all EOL facilities ready, a spacious room, a delegated nurse and physician…sometimes I wonder if that is too much to care only one single EOL patient and family at a time…how about serving 2 to 3 patients at the same time?.... I believe it is workable."

Participants understood that resources required for EOL patients differed from those of other ED patients. They questioned whether resources could be used more efficiently by serving more than one EOL patient at a time. Some questioned

whether the service could provide care for a number of EOL patients simultaneously to benefit all patients.

Discussion

Findings in this study describe how emergency nurses perceive the relationship of ED EOL care with the patient, family, and themselves. The participants in this study expressed their ambiguity about the ED EOL service. To emergency nurses, the emergency department was a place for active medical treatment, resuscitation, and saving lives, and they stated that patients' needs should not be neglected.[1,9,18] The goal of EOL care differs from those of other types of ED care, and it takes time for emergency nurses to transit. Once patients' EOL stage has been determined, care can be tailored to better meet their needs in the final stage of life. Participants understood that prognosis was important in planning suitable and meaningful EOL care.

Elements of psychosocial and spiritual care for EOL patients should focus on their fear of death, concerns surrounding physical symptoms, reflection on the meaning of life, and dying with dignity.[19] Religious and spiritual comfort was recognized as necessary for Chinese EOL patients.[20] Participants understood the importance of spiritual care in reducing patients' fear of dying, and some religious rituals were performed without violating hospital or ward regulations and policies.

Three principles of care need to be considered when a patient is dying: identifying the underlying causes of symptoms, treating symptoms seriously, and maintaining the balance between patients' best interests and invasive investigation.[6,20] Consistent with previous studies,[6,9,13,18,20] participants recognized the benefits of pain and symptom control and believed this to be an essential component of EOL care. Almost all participants agreed that invasive investigation should be eliminated to ensure minimal suffering. Five of the 16 participants expressed concerned regarding the balance between dose increases and optimum medication effectiveness.

Conflict over intervention opinions and patients' best interests could occur between emergency nurses and patients' families or physicians. Participants stated that feeding was a key concern and can prompt such conflict. The idea that "mortals treat eating with heavenly importance" is essential in Chinese culture, in which patients, particularly children, should not suffer from hunger, because it constitutes the commission of a sin by the family.[21,22] Therefore, dying patients should be fully nourished prior to death. Family members' requests regarding feeding can provoke disputes and lead to stress in health care professionals. Seven out of the 16 participants understood that such conflict occurred because of the belief in filial piety in Chinese culture and represented a final opportunity for family members to care for their loved ones, as discussed in the literature.[21,23]

Participants described being challenged by the intensive help-seeking behavior of EOL patients' families. Although some nurses felt exhausted by responding to such requests, the majority applauded this behavior and believed that it demonstrated family members' concern and eagerness to help their loved ones. Similar literature suggested that this behavior may occur as a means via which family members fulfill their information and psychosocial needs when the patient reaches the EOL stage.[24]

Family presence is essential for family members and patients in EOL care.[25] Williams and colleagues[26] found that families appreciated nurses' acceptance of their presence, guidance in preparation for death, and encouragement in exchanging final farewells. Family members find it easier to endure grief and bereavement if they have expressed their love and final thoughts to their loved ones.[27] Recent studies found that Chinese people considered transgenerational unity essential to family connection.[19,28] Participants understood that accepting the family's presence would benefit family members during their grief and bereavement, but 3 of the 16 participants questioned whether patients' best interests should be prioritized over family presence.

Participants accepted the opportunity for reflection on life and death throughout EOL care provision. One participant mentioned that caring for EOL patients prompted deep thought regarding the meaning of life and death, connection, and family love. Because of advances in medical technology, death is often avoidable for a time; therefore, ED health care professionals can experience a sense of loss when it occurs.[27] This can affect EOL care provision in emergency departments if emotional and psychological issues affecting health professionals are overlooked.[6,9,29,30] Transition from traditional emergency care to EOL care is dependent on how emergency nurses approach their therapeutic relationships with patients.[14,15,29] Anxiety and fear can impede effective therapeutic relationships between emergency nurses and patients. Emergency nurses providing EOL care frequently face issue surrounding death; therefore, it is essential that emergency nurses manage their emotional and psychological needs, which can improve the quality of care and alleviate nurses' work-related stress.

Ten of the 16 participants verbalized the idea that holistic care was essential to their ED EOL care, which

echoed the existing literature. Patient comfort and emotional support were important elements in holistic care for EOL patients,[31,32] which explained their modification of traditional EM care approaches and practices. Participants in the study mentioned that their care was focused more on humanity than on disease and intervention. Participants opted to create a peaceful atmosphere to help EOL patients and their families face issues surrounding the last chapter of life.

Although some nurses in other countries have expressed reluctance or unwillingness to provide EOL care within emergency departments, with adequate training to improve their competencies, emergency nurses can provide high-quality EOL services.[4,11,29] Fourteen of the 16 participants in this study accepted their roles and supported the establishment of this service in the emergency department, because they agreed with and appreciated the advantages it provided to patients and believed it could fill the service gap in emergency medicine. Emergency nurses should take the opportunity to enrich their skills via EOL care training and contribute to the health care system using their professional competencies.

Emergency nurses expressed a lack of competency in communication surrounding EOL issues, particularly in breaking bad news and supporting families during the EOL stage.[26] Good communication with patients' families would allow nurses to determine care needs and provide the help required by families to manage grieving and accept sudden or unexpected death.[28,33,34] Although there is limited time to provide care to the patients and families, and also a hesitation to discuss death with families in the emergency department, participants in the study believed that good communication could strengthen bonding between nurses and families, facilitate care delivery, and fulfill family members' needs during grief and bereavement. Obstacles discouraged emergency nurses from working in EOL services,[1,10–13] but the participants in this study expressed different views than those reported in other studies. They admired and wanted to work with EOL care users but were concerned about whether the service could be improved and developed under conditions of resource constraint and insufficient training.

Participants indicated that careful consideration of staffing and resource allocation for ED EOL services is required. Staffing was an important factor in meeting increased demand for ED services. A nursing association reported that because of the shortage of nurses, the nurse-to-patient ratios in public hospitals in HK ranged from 1:10 to 1:23 for morning and night shifts,[35] which was far below those of Australia and European countries, where the ratios ranged from 1:3 to 1:6.[36,37] As a means of supporting ED EOL services, participants mentioned restriction of nursing time for EOL patients and families as a result of staffing shortages and expressed concern about whether existing resources could be used more efficiently to meet the increasing demand for EOL services, particularly with respect to psychosocial and spiritual support. With sufficient manpower, delegated nurses could provide better psychosocial and spiritual support to EOL patients and their families. In addition, support from ancillary services, such as social workers and chaplains, is important, because this could help nurses to fulfill EOL patients' psychosocial and spiritual needs,[9,18] which also require attention and fulfillment.

The health care system faces an aging population and increased demand for EOL services, but the provision of EOL services and support from the HK government policies is inadequate.[38] According to the HK government statistics, the proportion of people aged 65 years or older is expected to increase to 30% of the overall population by 2041.[4] ED EOL services can fulfill the need for EOL care under these circumstances and play an important role in caring for patients who die unexpectedly, encounter life-threatening traumatic injuries, or experience an acute exacerbation of illness that does not respond to therapeutic interventions. ED EOL services could eliminate unwanted and unnecessary hospitalization and benefit other health care users and the health care system.[39] This study demonstrates that the emergency nurses perceived benefits of instituting EOL care in the emergency department with appropriated dedicated resources and policies.

Limitations

Currently only one hospital in HK implements an EOL service within the ED through use of a standard protocol. Therefore, participants in this study all worked for the same unit. The findings reflected the perceptions of emergency nurses in this unit, which might not be generalizable.

Implications for Emergency Nurses

The findings in this research encourage the improvement of existing training for ED health professionals and emergency nurses with regard to knowledge relating to EOL care and care for EOL patients and families. Communication and counseling skills are an important training area for the emergency nurses. With reference to research findings, emergency nurses can understand the meaning of providing specific comfort and care interventions for EOL patients and their families, especially the family's involvement in intervention decision and the expression of concern and love for the EOL patients. Caring for EOL patients and the families in the emergency department evoked the passion of emergency nurses for nursing as a profession. Perspectives

from different caregivers and receivers in the ED EOL service are areas for further research, which can enrich the provision of the ED EOL service.

Conclusion

ED EOL services are neglected despite an increased need for such services. Although these services have been implemented for a few years at a local hospital in HK, this study provides an in-depth description of the perceptions of the emergency nurses with experience in the area. Four themes and 10 subthemes were identified. These findings provide insights into service improvement, which could benefit EOL patients in emergency departments. There is a need for further research examining the perspectives of patients and caregivers, including families, other health care professionals, and hospital administrators, which could refine and support future EOL development in emergency departments.

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