



Position Statement

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Palliative and End-of-Life (EOL) Care in the Emergency Department

Description

The scope of practice for emergency nursing encompasses the care of patients and their families throughout the continuum of health and the lifespan. Emergency nurses commonly care for patients with advanced, serious illnesses or injuries or who are nearing the end of their lives.¹ This places emergency nurses in a unique position to change the focus of assessment from chief complaint and acuity to care that includes palliative and end of life (EOL) care.²⁻⁵ Challenges to providing palliative and EOL care in the emergency department (ED) include time constraints, lack of space, lack of staffing, prioritization of patient care, ED design, and the lack of formal education and resources on the topic of palliative and EOL care.²⁻¹¹ Other challenges include the incongruity between the goals of emergency care and those of EOL care and the emotional burden the emergency nurse experiences when caring for the dying, particularly when resources are deficient.^{2,3}

Multiple definitions of palliative and EOL care exist in the literature. The World Health Organization has defined palliative care as an approach that improves the quality of life of patients, and their families facing the issues associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.¹² One definition of EOL care is the care of terminally and critically ill patients in their final days and hours of life.⁴ Family has been defined in many ways. For the purposes of this publication, the term “family” includes heterosexual or same-sex partners, with or without children, married or not, single-parent households, extended family members, and cohabitating couples, among others.^{13,14}

Palliative care is not solely reserved for patients at the EOL. Palliative care is provided from the moment of diagnosis, concurrently with curative or disease-modifying therapy, as well as when illness is in its most advanced stages. In fact, early integration of palliative care measures may reduce ED visits and hospitalizations by 50%, which is a quality indicator for palliative care.⁵ Other sources further explain it as care that includes optimizing the quality of life; giving attention to emotional, cultural, social, and spiritual needs of the patient; involving family; preserving patient autonomy and rights; providing pain management; and supporting patient and family medical decision-making.^{4-8,14} Additional alternative care practices that enable patients and family members to better manage the EOL experience include Allowing Natural Death (AND) and Physician Orders for Life-Sustaining Treatment Paradigm (commonly referred to as POLST, the program name and implementation process varies by state).¹⁵⁻¹⁷ Emergency nurses should be familiar with their state-specific form and process based on this paradigm. Integral to the core of these approaches is thoughtful, perceptive, open, compassionate, and respectful communication of the individual's goals of care.



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ENA Position

It is the position of the Emergency Nurses Association (ENA) that:

1. Emergency nurses perform an essential role in providing life-sustaining treatment as well as providing palliative and EOL care.
2. Emergency nurses support family presence during assessment, treatment, resuscitation, and EOL care based on institutional policies and assist with developing such policies if they are not in place.
3. Emergency nurses lead and manage collaborative efforts with physicians and other members of the healthcare team, including the palliative care team, to endorse philosophies that support quality palliative and EOL care in the emergency department.
4. Emergency nurses receive training, education, and mentorship on the topics of palliative and EOL care.
5. Emergency nurses assess, identify, and provide appropriate interventions to patients and families that may potentially benefit from this specialized approach to care.
6. Emergency nurses be aware of the effects that ethical dilemmas and moral distress have on each member of the care team, and work to address and resolve the ethical dilemmas and moral distress.
7. Emergency nurses use ethical principles including the involvement of their institution's ethics committee to assist in navigating through ethically challenging situations.
8. Emergency nurses lead or participate in performance improvement projects to improve palliative and EOL care of individuals as well as to improve processes of care within and across healthcare agencies.

Background

The skill set and knowledge base required of the ED nurse is comprehensive and encompasses the life span of the patient. The primary commitment to the patient requires the ED nurse to maintain competency in lifesaving and life-sustaining treatment as well as provide palliative and EOL care.^{1,18,19} When surveyed, ED nurses cited a renewed passion in the caring aspect of the nursing profession and the enhancement of their personal growth and development.³ The American Nurses Association (ANA) and the Hospice and Palliative Nurses Association (HPNA) issued a joint position paper calling for nurses to "lead and transform palliative care."²⁰ The joint position statement states, "Every nurse should have the knowledge, skills, and abilities to provide primary palliative nursing"^{21(p5)} in their basic skill set. Similarly, in a mixed methods study, emergency nurses reported high levels of comfort and confidence with the



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technical and logical aspects of providing EOL care but state there needed to be clearer practice guidelines to improve EOL skills.² Managing death and dying is a common practice for emergency nurses, yet the delivery of EOL care in the ED requires further study,² in particular, how to manage the evolving family unit and emotional challenges facing caregivers.

Families are defined by the people within the family themselves. The family is undergoing social and cultural change within the definition itself.¹³ The Health Resources & Services Administration has defined the family as "...a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family."^{14(p1)} The traditional definition is self-limiting and restricted to legal and blood relation, while the subjective definition enables the members of that family unit to define the term "family member."^{13,14,22} The inclusion of the family at the bedside of the EOL and palliative care patient can be challenging in terms of space² and resources in the busy setting of the ED. It is important that emergency nurses be directly involved with future planning of the physical space to advise more room be included for families at the bedside during resuscitation and EOL care with privacy and workflow,^{2,8} as the number of patients expected to present with EOL considerations is expected to increase due to the aging population and longer lifespans.⁴

The emergency nurse is often the person who spends the most time involved in direct care of the patient and their families. Thus, they may be the first to recognize and acknowledge the personal decision-making priorities identified by patients and families.^{4,9} The emergency nurse is an integral member of the healthcare team and has a commitment to patients and families to serve as the patient advocate in the collaborative healthcare team.^{1,23} It is necessary for the ED nurse to collaborate with the healthcare team, including emergency physicians and the palliative care team, to meet the needs of the EOL and palliative care patient. Resources to help improve the emergency nurses' comfort and communication skills are listed in the resources section.

As an entry point to healthcare, the ED is distinctively positioned to identify the needs of the patient and their families. However, in recognizing the needs of the patient and caring for those receiving palliative or EOL care, emergency nurses can become exposed to varying degrees of moral distress.^{2,3,11,18,22} In addition, emergency nurses may experience frustration at their inability to meet their patient's needs, particularly in situations where typical interventions or approaches to disease treatment appear to be doing more harm than good—by adding stress, potentially suffering without meaningful gain in survival, function, or quality of life, thus creating an ethical dilemma for the emergency nurse.^{2,30} Given these potential consequences of caring for those receiving palliative or EOL care, it is important for emergency nurses to be aware of the effects that ethical dilemmas and moral distress may have on each member of the healthcare delivery team.^{3,30} Resolving these ethical dilemmas and moral distress may require EDs to implement a more formalized approach, such as incident debriefing or the involvement of an ethics committee to help in navigating through ethically challenging situations.^{23,30,31}

The ED is a chaotic environment that challenges the emergency nurse to prioritize the care of the EOL and palliative care patient.² Family and patient wishes can have a significant influence on emergency care providers' decisions whether to provide palliative or curative care. This can create a distressing situation, especially when there is an expectation for heroic measures.^{2,19} Specialized training has increased the



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emergency nurse's comfort level with and ability to initiate conversations centered around the need to initiate and provide EOL and palliative care in the ED.² A consistent theme in the current research is the emergency nurse's request for more formalized education on the topic of EOL and palliative care to increase their confidence and ability to provide this needed specialization.^{4,5,7,10,18} Current education available to emergency nurses includes the national curriculum, *Education in Palliative and End-of-Life Emergency Medicine (EPEC-EM)*,²⁴ created to educate emergency nurses, physicians, social workers, and others about emergency-specific palliative and EOL care, and the *End of Life Nursing Education Consortium (ELNEC)*²⁵ curricula.

Identification of patients and families that may benefit from the implementation of EOL and palliative care can be difficult for nurses and physicians in the ED setting. Traditionally focused on intervening in emergent resuscitative efforts, a change in mindset is required to more effectively identify patient and family needs, especially given the aging of the U.S. population.^{20,21,26,27} Due to the steady rise in life expectancy and prevalence of EOL comorbidities, in combination with an increased volume in patients, there is a need for early identification and intervention in the ED.⁵ One method used to assist with identifying patients who may benefit from palliative or EOL care includes the use of screening tools. For example, the Surprise Question (SQ) screening tool has demonstrated effectiveness in the early identification of the symptomatic heart failure patient.²⁸ After evaluating a patient, the ED physician answers the question "would you be surprised if this patient died in the next 12 months?"²³ The benefit to the patient and family of early implementation of EOL and palliative care measures are increased comfort, improved pain management, and decreased ED use and hospitalizations for symptom control.^{5,19-29} The ED nurse, as an important member of the healthcare team, can provide a critical service to patients and families by discussing the SQ with the emergency physician after assessing patients and families.

The lack of pathways and protocols to facilitate the initiation of EOL and palliative care is one that emergency nurses can impact directly through their participation in unit and facility-based committees dedicated to performance improvement.^{5,22} The focus of EOL and palliative care is symptom management and comfort, and the protocol or pathway should reflect this. When appropriate, it is important that ED nurses advocate for EOL and palliative care for their patients and families. A collaborative approach optimizes patient care and the transition to comfort or palliative care, reducing the stress and uncertainties associated with the progression of end-stage illness. A systematic approach to the care of the EOL patient in the ED with a defined pathway or protocol facilitates best practice care.^{5,17,22}

Resources

American Association of Colleges of Nursing. (2019, May). *End-of-Life Nursing Education Consortium (ELNEC) fact sheet*. Retrieved from <https://www.aacnursing.org/Portals/42/ELNEC/PDF/ELNEC-Fact-Sheet.pdf>

American College of Emergency Physicians. (n.d.). Palliative care toolkit for EM providers. Retrieved from <https://www.acep.org/how-we-serve/sections/palliative-medicine/news/april-2015/palliative-care-toolkit-for-em-providers/>



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American Nurses Association, Hospice & Palliative Nurses Association. (2017). *Call for Action: Nurses Lead and Transform Palliative Care*. Retrieved from <https://www.nursingworld.org/~497158/globalassets/practiceandpolicy/health-policy/palliativecareprofessionalissuespanelcallforaction.pdf>

Ariadne Labs. (2017). Serious illness conversations guide. Retrieved from https://www.ariadnelabs.org/wp-content/uploads/sites/2/2017/05/SI-CG-2017-04-21_FINAL.pdf

National Coalition for Hospice and Palliative Care. (2018). *Clinical practice guidelines for quality palliative care* (4th Edition). Richmond, VA: Author. Retrieved from https://www.nationalcoalitionhpc.org/wp-content/uploads/2018/10/NCHPC-NCPGuidelines_4thED_web_FINAL.pdf

National POLST Paradigm. (2019). What is POLST? Retrieved from <https://polst.org/professionals-page/?pro=1>

References

1. Emergency Nurses Association. (2017). *Emergency nursing: Scope and standards of practice* (2nd ed.). Des Plaines, IL: Author.
2. Wolf, L. A., Delao, A. M., Perhats, C. D., Clark, P. R., Moon, M. D., ... Lenehan, G. (2015). Exploring the management of death: Emergency nurses' perceptions of challenges and facilitators in the provision of end-of-life care in the emergency department. *The Journal of Emergency Nursing*, 41(5), e23–e33. <https://doi.org/10.1016/j.jen.2015.05.018>
3. Zavotsky, K. E., Chan, G. K. (2016). Exploring the relationship among moral distress, coping, and the practice environment in emergency department nurses. *Advanced Emergency Nursing Journal*, 38(2), 133–146. <https://doi.org/10.1097/TME.0000000000000100>
4. Gloss, K. (2017). End of life care in the emergency departments: A review of the literature. *Emergency Nurse*, 25(2) 29–38. <https://doi.org/10.7748/en.2017.e1707>
5. Revels, A., Goldberg, L., & Watson, J. (2016). Caring science: A theoretical framework for palliative care in the emergency department. *International Journal for Human Caring*, 20(4), 206–212. <https://doi.org/10.20467/1091-5710.20.4.206>
6. Wang, D. H. (2016). Beyond code status: Palliative care begins in the emergency department. *Annals of Emergency Medicine*, 69(4), 437–443. <https://doi.org/10.1016/j.annemergmed.2016.10.027>
7. Anderson, W. G., Puntillo, K., Boyle, D., Barbour, S., Turner, K., Cimino, J., ... Pantilat, S. (2016). ICU bedside nurses' involvement in palliative care communication: A multicenter survey. *Journal of Pain and Symptom Management*, 51(3), 589–596.e2. <https://doi.org/10.1016/j.jpainsymman.2015.11.003>
8. Shearer, F. M., Rogers, I. R., Monterosso, L., Ross-Adjie, G., & Rogers, J. R. (2014). Understanding emergency department staff needs and perceptions in the provision of palliative care. *Emergency Medicine Australasia*, 26(3), 249–255. <https://doi.org/10.1111/1742-6723.12215>
9. Beckstrand, R., Corbett, E. M., Macintosh, J. L. B., Luthy, K. E., Rasmussen, R. J. (2019). Emergency nurses' department design recommendations for improved end-of-life care. *Journal of Emergency Nursing*. 45(3) 286–294. <https://doi.org/10.1016/j.jen.2018.05.014>
10. Beckstrand, R. L., Rasmussen, R. J., Luthy, K. E., & Heaston, S. (2018). Emergency nurses' perception of

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- department design as an obstacle to providing end-of-life care. *Journal of Emergency Nursing*, 38(5), e27–e32. <https://doi.org/10.1016/j.jen.2011.12.019>
11. Tse, J. W., Hung, M. S., & Pang, S. M. (2016) Emergency nurses' perceptions of providing end-of-life care in a Hong Kong emergency department: A qualitative study. *Journal of Emergency Nursing*. 42(3) 224–232. <https://doi.org/10.1016/j.jen.2015.10.025>
 12. World Health Organization. (2018). Definition of palliative care. Retrieved from: <https://www.who.int/cancer/palliative/definition/en/>
 13. Amato, P. R. (2014). What is a family? *National Council on Family Relations Report Magazine: Early Childhood*. Retrieved from <https://www.ncfr.org/ncfr-report/past-issues/summer-2014/what-family>
 14. Health Resources & Services Administration. (2017). Definition of family. Retrieved from <https://www.hrsa.gov/get-health-care/affordable/hill-burton/family.html>
 15. Norton, C. K., Hobson, G., & Kulm, E. (2011). Palliative and end-of-life care in the emergency department: Guidelines for nurses. *Journal of Emergency Nursing*, 37(3), 240–245. <https://doi.org/10.1016/j.jen.2010.02.019>
 16. National Consensus Project for Quality Palliative Care. (2018). *Clinical practice guidelines for quality palliative care* (4th ed.). Retrieved from https://www.nationalcoalitionhpc.org/wp-content/uploads/2018/10/NCHPC-NCPGuidelines_4thED_web_FINAL.pdf
 17. Allen, J. (2010). The POLST: Advocating for assisted living residents' end-of-life wishes. *Geriatric Nursing*, 31(3), 234–235. <https://doi.org/10.1016/j.gerinurse.2010.04.008>
 18. Knox, C. (2005). Allow natural death: A more humane approach to discussing end-of-life directives. *Journal of Emergency Nursing*, 31(6), 560–561. <https://doi.org/10.1016/j.jen.2005.06.020>
 19. Cooper, E, Hutchinson, A, Sheikh, Z, Taylor, P, Townend, W, & Johnson, M. J. (2018). Palliative care in the emergency department: A systematic literature qualitative review and thematic synthesis. *Palliative Medicine*, 32(6), 1443–1454. <https://doi.org/10.1177%2F0269216318783920>
 20. American Association of Colleges of Nursing. (2017). *Call for action: Nurses lead and transform palliative care*. Retrieved from <https://www.nursingworld.org/~497158/globalassets/practiceandpolicy/health-policy/palliativecareprofessionalissuespanelcallforaction.pdf>
 21. Bell, D., Ruttenberg, M. B. & Chai, E. (2018). Care of geriatric patients with advanced illnesses and end-of-life needs in the emergency department. *Clinical Geriatric Medicine* 34 453–467. <https://doi.org/10.1016/j.cger.2018.04.008>
 22. Chan, G. K. Trajectories of approaching death in the emergency department: Clinician narratives of the transitions to the end-of-life. (2012). *Journal of Pain and Symptom Management*, 42(6), 864–881. <https://doi.org/10.1016/j.jpainsymman.2011.02.023>
 23. Chan, G. K. (2008). End-of-life care models and emergency department care. *Academic Emergency Medicine*, 11(1), 79–86. <https://doi.org/10.1197/j.aem.2003.07.019>
 24. Northwestern Medicine, Feinberg School of Medicine. (2019). EPEC: Education in palliative and end-of-life care. Retrieved from <https://www.bioethics.northwestern.edu/programs/epec/curricula/emergency.html>
 25. American Association of Colleges of Nursing. (2019). About ELNEC. Retrieved from <https://www.aacnnursing.org/ELNEC/About>
 26. Lowery, D.S., & Quest, T. E. (2015). Emergency medicine and palliative care. *Clinics in Geriatric Medicine*.



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- 31(2), 295–303. <https://doi.org/10.1016/j.cger.2015.01.009>
27. McEwan, A., & Silverberg, J. Z. (2016) Palliative care in the emergency department. *Emergency Medicine Clinics of North America*, 34(3), 667–685. <https://doi.org/10.1016/j.emc.2016.04.013>
28. Mogul, A. S., Cline, D. M., Gabbard, J., & Bryant, C. (2018). Missed opportunities: Integrating palliative care into the emergency department for older adults presenting as level 1 triage priority from long-term care facilities. *The Journal of Emergency Medicine*. 56(2), 145–152. <https://doi.org/10.1016/j.jemermed.2018.10.020>
29. Aaronson, E. I., George, N., Ouchi, K., Zheng, H., Bowman, J., Monette, D., ... Jackson, V. (2019). The surprise question can be used to identify heart failure patients in the emergency department who would benefit from palliative care. *Journal of Pain and Symptom Management*, 57(5), 944–951. <https://doi.org/10.1016/j.jpainsymman.2019.02.007>
30. Hogan, K. A., Fothergill-Bourbonnais, F., Brajtman, S., Phillips, S., & Wilson, K. G. (2016). When someone dies in the emergency department: Perspective of emergency nurses. *Journal of Emergency Nursing*, 43(3), 207–212.
31. Hajibabae, F., Joolae, S., Cheraghi, M. A., Salari, P., & Rodney, P. (2016). Hospital/clinical ethics committees' notion: an overview. *Journal of Medical Ethics and History of Medicine*, 9, 17.

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