Exploring the Critical Care Nurse's Role in Compassionate End-of-Life Care

A literature review using Benner's domains of Critical Care Nursing Practice

Author: Samantha Brammar (Critical Care Sister, Sheffield Teaching Hospitals NHS foundation Trust) | Acknowledgements: Michaela Brown (Senior Lecturer Adult Nursing)

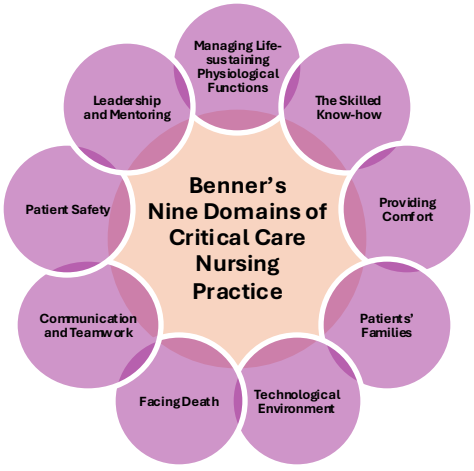
Managing end-of-life care (EOLC) and the withdrawal of life-sustaining treatment (WLST) is an inevitable part of critical care (CC) nursing[1]. As death often follows quickly after the WLST[2], this review explores the nurse's role in providing compassionate EOLC and supporting a 'good death' in the intensive care unit (ICU).

Design: Critical Literature Review with Systemised Search

-Qualitative focus, guided by Benner's CC Nursing Domains[3,4].
-Researcher's CC experience informed framework.

Search Strategy – *PEO Framework/Databases/Criteria*

Population: CC, Intensive Care, ICU, ITU, CCU.
Exposure: Nurse.
Outcome: End-of-life Care, Dignified Care, Good Death.
-Databases: CINAHL Complete, MEDLINE, ScienceDirect.
-Boolean Operators and Snowball Sampling used.
Inclusion Criteria: Peer-reviewed, Adult CC, English, 2019-2024.
Exclusion Criteria: Peads/Neonatal, Organ Donation, Older Studies.



Study Selection: *PRISMA*

-Preferred Reporting Items for Systematic reviews and Meta-Analyses[5].

Records Identified (n = 268) → Records Screened (n = 216) → Full-Text Studies Assessed (n = 29) → Studies Included (n = 7)

-7 Studies met the criteria[6,7,8,9,10,11,12].

Appraisal & Reflexivity

-Used JBI appraisal checklist[13].
-Ensured rigour, transparency, reflexivity.

Data Analysis

-Thematic Analysis (Aveyard method)[14].
-Themes mapped to Benner's nine domains.

Findings and Results: Six Themes - *EOLC is multifaceted, aligning with Benner's domains.*

Communication
- Good communication and teamwork enable compassionate EOLC.
- Poor communication risks ignored patient wishes and overtreatment.
- Nurses use verbal/non-verbal methods.
- Advocacy and early MDT discussions are crucial.

Role within the MDT
- Nurses manage WLST processes and comfort care.
- Provide essential basic care (e.g., hygiene, repositioning).
- Control over WLST supports smooth care delivery.
- Coordinate MDT-family meetings.
- Staffing and workload impact care quality.

Family Support
- Focus shifts to family once EOLC begins.
- Build trust and reassure families emotionally.
- Communicate consistently to avoid conflict.
- Involve families in decision-making.

Self-Awareness
- Accepting death supports better EOLC.
- Nurses value EOLC but must manage emotions.
- Self-care is essential.
- Guidelines aid complex decisions.

Education
- Novice nurses need more EOLC training.
- Mentorship and reflective practice build confidence.
- ICU culture should embrace death as natural.

Environment
- Calm, personalised environments aid dying with dignity.
- Remove tech where possible to create peace.
- Adapt ICU space to meet EOLC needs.
- COVID-19 highlighted tech-based family connections.

Barriers

Emotional toll of EOLC and WLST responsibility.
Interprofessional tensions and lack of role clarity.
Inadequate EOLC education/training.

Possible Solutions

Reflective Practice.
Staff Allocation.
Specialist Training.

Conclusions

-CC nurses are essential to holistic, high-quality EOLC.
-ICU death is not a failure but a critical moment requiring compassionate care.
-Further research and guidelines are needed to improve practice and outcomes.

End-of-life care in CC is not a failure, but compassionate practice– Requiring clarity, teamwork and ongoing support.

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