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A Phenomenological Study of Lived Experiences of Transport Nurses Experiencing Patient Death

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Abstract

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ADN, College of Southern Idaho, 2005

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Experiencing a patient death can directly affect the well-being of health care professionals; however, this phenomenon and the effects of patients' deaths are not well understood in the transport setting. Transport nurses work in unique settings with complex patients and significant autonomy in determining the plan of care; therefore, the experiences of other health care professionals may not be applicable in this environment. The purpose of this qualitative study was to explore the lived experiences of transport nurses who have experienced patient death using Husserl's life-world and phenomenological philosophies as a theoretical framework. Semistructured interviews were completed with 8 transport nurses who had experienced a patient death in their care using video-conferencing and verbatim transcription of the interviews. Data analysis was manually coded and categorized into themes based on Moustaka's modification of the Van Kaam methods of analysis of phenomenological data. Key findings included 5 themes. Findings from this study indicate that patient death, particularly unexpected death, takes an emotional toll on transport nurses. Most transport nurses indicated that they did not have formal debriefing or support from the transport program following patient death. Transport nurses relied on their partners for feedback and support following patient death. Recommendations based on this research include promoting education regarding the psychosocial effects of death in the transport environment and formal debriefing following an unexpected death. Results from this study can be used to promote positive social change by improving the experiences of transport providers following a patient death, which may lead to improved retention and nurse satisfaction.

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Dedication

This study is dedicated to transport professionals everywhere. May you care for yourselves the way you selflessly care for others.

Acknowledgments

Words cannon express how grateful I am to my friends and family for the years of support and encouragement you have shown me on this doctoral journey. Mom and Dad, your love and words of encouragement kept me going and pushed through the tough times. Christian, you have been my rock and voice of reason when I wanted to give up. I love you all and can’t thank you enough for helping me complete this dissertation.

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Chapter 1: Introduction to the Study

Introduction

The transport nurse's work environment is not in a traditional hospital intensive care unit (ICU) or emergency department (ED) but rather an airplane, helicopter, or ambulance. Their work is an essential component to the care of the critically ill and is heavily relied on to transport patients to specialty or tertiary care facilities that may be a long distance from the location of injury or outlying facility in which the patient presented (Reimer, Alfes, Rowe, & Rodrigues-Fox, 2018). Transport nurses are often involved with two types of transports: interfacility and scene. Interfacility transports facilitate moving patients from one health care institution to another based on the level of care needed that is not available at their current location. Scene calls typically entail flying directly to the scene of an accident or incident and providing emergency or critical care. Depending on the area of service and training of the crewmembers, care is provided across the lifespan to include infants, children, adolescents, adults, and older adults.

Inherent to the job of a registered nurse is frequent exposure to death and dying (Peters et al., 2013; Wilson, 2014). Part of a nurse's obligations is to alleviate pain and suffering. Kondo and Nagato (2017) described that a nurse's duty at end of life lies in having a presence during the death of a patient, which can often be arduous and emotionally taxing. The environment in which a transport nurse provides care is unique, and therefore it is possible that the way transport nurses experience and process a patient's death is different from nurses in other settings. As physical space, supplies, and personnel are limited in a transport environment, patient care can be complicated and often critical (Dias, Ferreira, & de Carvalho, 2017), therefore affecting how transport nurses deal with, and are affected by, patient death.

After experiencing the death of a patient, the ability to debrief the incident may be overlooked or done expeditiously as the team must remain in service and may be dispatched on another call where they must be prepared to immediately provide critical care for the next patient. Immediate debriefing may be ineffective because personnel on site may be limited to only the involved transport crew, often consistently solely of a nurse, paramedic, and pilot. In addition, there is no one available to facilitate a debriefing or relieve the crew from duty to allow for a formal debrief to occur. Creative approaches may be needed to facilitate effective debriefing in the transport environment.

Further, Peter et al. (2013) suggested that the nurse’s role in a patient death is often exhausting and compels nurses to be reflective on how they both deal with and process death. The potential social implications for this study are to bring an awareness to transport nurses and their administrators of how patient death is experienced in this environment and examine how those experiences may have an emotional effect on their work and personal lives. Advancing understanding of how transport nurses experience patient death may lead to the implementation of education or resources that may help nurses gain support in coping with the death of a patient.

In this chapter, I will discuss the background of the study including the current gap in the literature it addresses, the problem statement, and purpose statement. In addition, I will discuss the primary research question, theoretical framework, nature of the study, definitions, assumptions, scope, delimitations, limitations. I will conclude Chapter 1 with significance of the study and an introduction to Chapter 2.

Background

Patient death is an event often experienced by nurses and may affect how they provide care in the future (Peters et al., 2013). Peters et al. (2013) also emphasized the need for education and skills acquisition to be able to deal with death and associated emotions such as fear and facing the reality of death. Furthermore, Peters et al. suggested that nurses experiencing a patient death may, unbeknownst to them, be emotionally affected, which, in turn, can negatively affect their performance of future patient care. Unlike a hospital or clinic setting with ancillary resources and physician availability, transport nurses rely solely on one other team member to provide critical care treatment. In addition to patient care duties, medical transport team members are responsible for ensuring crew and patient safety during transport. Medical decision making relies on standing orders and protocols that dictate the type of care provided. This level of autonomy and critical thinking places more accountability on a transport nurse (Brand, Cesario, Symes, & Montgomery, 2016), which may lead to feelings of personal responsibility in the event a death occurs.

In a study aimed at describing the lived experiences of Spanish nurses working in an ICU and how they face patient death, Valerde-Garcia et al. (2016) suggested that nurses are more apt to experience emotional encumbrances due to patient death. Valerde-Garcia et al. recommended that further research be conducted to explore the lived experiences of other health care professionals who experience death. Understanding how transport nurses perceive, and process, patient deaths can provide insight into strategies that may be used to facilitate the grieving process and improve the outcomes of nurses who experience loss of life in the transport setting.

This study addressed a gap in the evidence by providing critical insight into the transport nurses’ experience, as the environment they work in and care they provide is different from nursing roles in a traditional hospital setting. Findings from this study may impact positive social change by improving preparation of nurses for end of life care. It may also guide transport providers in developing strategies to support nurses following a patient death in this unique setting and be used by transport nurses, administrators, and other transport providers to gain an understanding of how those working in this complex environment may be impacted by patient death. This may lead to social change within organizations where transport nurses may share their experience to help create both social support and effective coping strategies for addressing patient deaths.

Problem Statement

Transport nurses are often present during patient deaths. Death is an inevitability that all human beings share and an experience that can present individuals with difficult choices and emotions. In a review of the literature, I found no studies related to the lived experiences of civilian transport nurses who encountered patient death. Although there is some research on hospital-based nurse experiences with patient death, it is not directly transferable to the transport environment. Most of the research on nurses’ experiences with death has been completed with ICU and emergency nurses (Bayuo, & Agbenorku, 2018; Hogan et al., 2016).

Transport nurses may experience death differently from nurses and health care providers in other settings due to several factors including autonomous care, limited space and resources to perform care, and lack of available human and physical resources to support the grieving process post patient death. During a review of the literature, there were no studies identified that explored the lived experiences of transport nurses or the characteristics of transport nursing that might influence how they process patient death. Anecdotal experience indicates that transport nurses may experience grief in solitude, may feel responsible for the patient death, and may feel compelled to not show emotion following a patient death.

My study was based on research findings regarding the lived experiences of patient death experienced by medical professionals including prehospital providers, physicians, and nurses. I found no literature regarding the lived experiences of patient death experienced by transport nurses, a phenomenological study may lead to awareness among transport nurses, administrators and employers to create dialogues in which to discuss how patient death may impact personnel both professionally and personally. This study filled the gap in understanding from the transport nurses' perspective on the lived experiences of patient death.

Purpose of the Study

My purpose in this qualitative study was to build on the existing literature of phenomenological studies regarding the lived experiences of other health care professionals, including nurses, who experience patient death (Velarde-Garcia et al., 2016) by exploring the lived experiences of transport nurses who have experienced patient death. To address this gap in the current evidence of transport nurses' experiences, I conducted a qualitative phenomenological study using semistructured interviews. Findings from this study may then be used by transport nurses, administrators, and other transport providers to gain an understanding of how those working in this unique environment may be affected by patient death. This may lead to social change within organizations where transport nurses may share their experience to help create both social support and effective coping strategies for addressing patient deaths.

Research Question

The following research question guided the study: What are the lived experiences of transport nurses who have experienced patient death while providing patient care during transport or transfer of care?

Theoretical Framework of the Study

The theoretical base for this study included life world and the phenomenological philosophies of Husserl, which aim to describe and shed light on phenomena as described by an individual's lived experience (Barrientos & Holmberg, 2018). Because this framework can address all manner of lived experiences faced by an individual, its use provided a lens to examine the phenomenon of transport nurses who face patient death in a manner that has not been previously conducted. Use of the life world approach aided in achieving understanding of both meaning and implications of patient death on personal and professional lives as expressed by the lived experiences of transport nurses. Furthermore, Husserl (2014) suggested innate knowledge both stems from and thrives on experience. By having an increased understanding of the lived experiences of transport nurses who face patient death, knowledge gained may be shared with others to influence positive social change by helping to foster social support and create effective coping strategies after a patient death.

Nature of the Study

In this qualitative inquiry, I used a phenomenological methodology that I intended to explore the lived experiences of transport nurses. Phenomenological research questions grow out of strong interest in understanding a problem or topic while working to understand the full crux and meaning of a human experience (Moustakas, 1994). Furthermore, Patton (2014) suggested that a phenomenological framework allows the researcher to inquire the meaning, structure, and core of lived experiences for a certain person or group of people. As the research and interview questions involved examining the lived experiences of patient death among transport nurses, a phenomenological approach was the most appropriate as it allowed for the description of the “live world,” or the lived experiences of an individual. Miles, Chapman, and Francis (2015) suggested that phenomenology analyzes the words of others and creates the essence of experience or themes to elucidate understandings of human experience. As participants recalled their experiences, the phenomenon of interest being studied clarified, which may offer both breadth and depth to the complex experiences and allows for the researcher to interpret the phenomenon within the context it was described (Miles et al., 2015).

This study initially took place throughout the intermountain west contingent on the location and availability of participants. As no participants were recruited in the intermountain west, nationwide recruitment was completed. I conducted interviews by Zoom as agreed on by both myself and the participants. I chose a purposive sampling method to allow for diverse sampling of participants to obtain varying experiences. I conducted semistructured interviews to allow participants the opportunity to share their lived experiences and allowed me as the researcher to probe further into their answers to capture the essence of their experiences with patient death.

Definitions

Key terms used frequently throughout the study were *transport nurse/nursing*, and *death*. These key terms are listed and defined to mitigate misunderstanding:

Death**:** Death has been described as the irreversible end of both respiratory and circulatory function, including both brain and brain stem activity (Lewis, Cahn-Fuller, & Caplan, 2017). Similarly, Moschella (2016) described death as the total loss of the ability of the brain to initiate spontaneous breathing and have a capacity for self-awareness resulting in the loss of one's soul.

Transport nurse/nursing: A registered nurse with a background in emergency and/or critical care nursing that provides patient care in a helicopter, ambulance, airplane, or watercraft. Transport nurses are able to take risks and use deliberate practice which includes progressive performance improvement and acquisition of knowledge to become an expert in their field (Snow, 2014). The Air and Surface Transport Nurses Association (ASTNA) (2018) defined *transport nursing* as "the unique and expanded role for a professional nurse, encompassing the air and surface medical transport of critically ill and injured patients" (para. 4).

Assumptions

The primary assumption for this study was that transport nurses would be interested in participating in this study. In addition, the participants who agreed to be interviewed provided candid, honest answers during the semistructured interviews that represented their lived-experiences of patient death to the best of their ability. To ensure honest and candid answers, I ensured participants that their identities would not be linked to the answers they provided during the interview. A secondary assumption for this study was that the lived experiences of transport nurses experiencing patient death would be similar to the responses of other health care professionals who experienced patient death.

Scope and Delimitations

The scope of this study included transport nurses recruited from transport programs throughout the United States. Inclusion criteria required all participants to have a minimum of 3 years' experience as a transport nurse and experienced at least one patient death while in the role of transport nurse. Exclusion criteria included less than 3 years of experience as a transport nurse or not having experienced at least one patient death in while in the role of transport nurse. There were no exclusions based on mode of transport which included helicopter, airplane, or ambulance. All participants agreed to be audio recorded and have their interviews transcribed verbatim. Prior to the interviews, I obtained informed consent, which advised the research participants of both the potential risks and benefits this study afforded (Rudestam & Newton, 2015).

Additional noted boundaries of this study directly related to the chosen theoretical framework. Because experiencing a patient death is a subjective experience, I chose

Husserl’s live world and tenants of phenomenology as it allows knowledge to ascend and flourish from the experiences of individuals (Husserl, 1994). Pao-Feng’s (2013) middle-range theory of caregiver stress has the potential to carry over to nursing as nurses are often the primary caregiver in many settings. The lens in which to explore the lived experiences of transport nurses who experience patient death resonates with Pao-Feng’s theory; however, its focus is on objective burdens as the primary stimulus (Pao-Feng, 2003). This middle-range theory was not chosen for the study, as the life-world theory provides a subjective outlook on the experiences of individuals and allows the researcher to be a casual observer (Husserl, 1970/1954).

Limitations

Bias may often be a significant limitation in qualitative research. As a transport nurse, my personal biases could potentially affect the interviews conducted and how the data obtained is analyzed. Having cared for patients that have died during transport, personal experiences coincide closely with this study and may create significant empathy for the research participants. To address issues of bias, I created interview questions prior to conducting the interviews that were read verbatim as to not digress and inadvertently interject personal thoughts or experiences. Patton (2014) advocated for qualitative researchers to consider their role as the main data collector and being a human being in that role requires vigilant reflection on personal bias. Patton also suggested the concept of empathetic neutrality that allows for researchers to maintain emotional distance while still allowing for a judgement-free connection to be made with research participants.

Another potential limitation that may have affected my study was transferability. Ravitch and Carl (2016) posited that transferability is a way in which researcher may keep depth related to content while allowing that content to be applicable and transferable to a larger setting. Research participants had varying experiences, therefore creating difficulties in generalizability to the transport community. I mitigated this by providing thick descriptions of the participants experiences and working environment as to allow for transferability (Rudestam & Newton, 2015).

Significance

My research filled a gap in understanding the lived experiences of transport nurses who are affected by patient death. My study was significant as no other studies have been identified that have collected data on this unique nursing population and how their lived experiences affect both their personal and professional life. The results of my research were significant and provided much-needed insight into the lived experiences of transport nurses. Findings from my study may facilitate awareness into how transport nurses are affected by patient death, which may result in negative behaviors such as fear, hopelessness, and terror (Lavoie et al., 2016). The insight gained from my qualitative study will provide knowledge and understanding for transport nurses, their administration, and other like-minded transport professions to create a dialogue that may influence positive social change by helping to foster social support and create effective coping strategies following a patient death.

Summary

In this chapter, I provided introductory information on the lived experiences of transport nurses experiencing patient death. In Chapter 2, I will present literature review strategies that I used in describing the chosen theoretical framework and literature review.

Chapter 2: Literature Review

Introduction

My purpose in this qualitative study was to build on the existing literature of phenomenological studies regarding the lived experiences of health care professionals, including nurses, who experience patient death and provide insight specifically related to the lived experiences of transport nurses. To address this gap in the current evidence of transport nurses’ experiences, I conducted a qualitative phenomenological study using semistructured interviews.

Nurses are a key player in health care delivery and can often be exposed to death and dying. In a study examining the lived experiences of pediatric burn nurses involved in patient death, Kellog, Baker, and McCune (2014) described how working in an ICU often entailed dealing with the death of a child. It was suggested that although nurses adapt to handle experiences of patient death, their feelings are often overlooked, and they are not provided with resources to address their grief. Kellog, Baker, and McCune recommended that nurses providing care to children or other populations facing patient death should be encouraged to verbalize their experiences. Furthermore, they recommended that those in positions of education and management facilitate the development of support programs to assist nurses in verbalizing their experiences and addressing their grief. However, the strategies used in hospitals or clinics may not be viable in the transport environment.

Zheng, Lee, and Bloomer (2017) conducted a study examining how nurses cope with death. Although experiencing a patient death was perceived as a personal experience, nurses were often left to cope alone and find their own sources of support. A lack of confidence in how to deal with patient death often affected their overall quality of nursing care (Zheng et al., 2017). Further research was recommended in aiding organizations in both examining and creating strategies for nurses to explore how nurses cope with death. To better understand the educational needs of nurses caring for patients who have died, de Swart and Fouché (2017) explored the experiences of nurses providing postmortem care in an ICU. They discovered that nurses often felt the need to emotionally detach themselves from the experiences they had with the patient prior to death, as most reported personal blame for the patient's death. Ultimately, de Swart and Fouché recommended debriefing after a patient death and providing educational offerings for nurses to learn how to cope with their feelings.

In the following sections, I will describe the literature search strategies that I used to provide evidence of the need for this study. A description of the theoretical framework in which my study was grounded will be discussed as well as an exhaustive review of the literature and transition into Chapter 3.

Literature Search Strategy

To gain a firm grasp and global view of the phenomenon of the lived experiences of health care professionals experiencing patient death, a comprehensive review of the literature was conducted that examined the lived experiences of death from a global perspective and progressing to the perspective of health care providers and finally nurses. I used the following library databases and search engines for the literature search: *ProQuest Nursing and Allied Sciences*, *CINAHL & MEDLINE*, *CINAHL Plus*, *MEDLINE, Ovid Nursing Journals, ProQuest Health and Medical Collection, PubMed, ProQuest Dissertations and These Global,* and *ProQuest Nursing and Allied Source.* While accessing these databases, a combination of terms where used to identify relevant literature that could present an accurate portrayal of both the history and current state of the lived experiences of patient death. I used the following key search terms in the literature search strategy: *patient, death, lived experience, nurse, healthcare, qualitative, phenomenology,* and *grief. I also changed Nurse* to *flight nurse* and *transport nurse* to maximize search results.

To ensure that articles I found were based on relevancy to the chosen phenomenon, initial search dates were narrowed to a period of 2013 to 2018, which supports best practice. To date, I found no literature that examined the lived experiences of transport nurses encountering patient death, despite altering the search terms in each database and examining from 1998 to the present, further justifying the need for this study. I expanded the literature review to other areas of nursing including ED and ICU, other health care providers, and global perspectives that would have a higher likelihood of experiencing patient death. I expected research in the areas of critical care, pediatrics and emergency nursing; however, I found a surprising amount of data on noncritical care areas including oncology and palliative care. Additional searches with a focus on nurses in the military found a lack of description in types of patients cared for by Navy nurses (Blackmon et al., 2018). Although initial training requirements assisted in helping nurses provide care in a physical setting with a high rate of morality (Blackman et al., 2018), I found no evidence of the effect of patient death on nurses.

A surprising dearth of research existed during this literature review, even among nontransport nursing professions. Although much of the information focused on subjects leading up to death, like the dying patient and end-of-life care, I found little examining the lived experiences of nurses who had experienced patient death. This lack of literature reiterates the need for further exploration into the lived experiences of transport nurses experiencing patient death. In this chapter, I will outline the current literature available on this phenomenon throughout disciplines in health care and among similar nursing areas. This emphasizes the need for further study to fill a gap in understanding the lived experiences of transport nurses endure when experiencing a patient death.

Theoretical Foundation

A theoretical framework provides a lens in which to view research and outcomes. The theoretical base for my study will include life world and the phenomenological philosophies of Husserl, which aim to describe and shed light on phenomena as described by an individual's lived experience (Barrientos & Holmberg, 2018). Because this framework can address all manner of lived experiences faced by an individual, its use may provide a lens to examine the phenomenon of transport nurses who face patient death in a manner that has not been previously conducted. Use of the life world approach aided in achieving understanding of both meaning and implications of patient death on personal and professional lives as expressed by the lived experiences of transport nurses. Furthermore, Husserl (2014) suggested innate knowledge both stems from and thrives on experience. By having an increased understanding of the lived experiences of transport nurses who face patient death, knowledge gained may be shared with others to influence positive social change by helping to foster social support and create effective coping strategies after a patient death.

Husserl is credited as the principle philosopher and creator of phenomenology (Dorney, 2014). A leading tenant in Husserl’s phenomenology is the lifeworld theory which aims to explore and describe the lived experiences of human beings. According to Husserl (1970/1954), the life-world has always existed through the course of time and prior to the era of what is defined as science today. It is neither objective nor logical, but rather subjective and experiential. The contrasting difference between objectivity and subjectivity of the life-world is that the former supports logic rather than experience, while the latter is distinguished by actual experience (Husserl, 1970/1954). Human beings are subjects who place value in, experience on, and relatability to its purpose in the world (Husserl, 1970/1954). Hanna, Wilkinson, and Givens (2017) described phenomenology, including Husserl’s phenomenology, as a means to acquire knowledge of one’s self, their consciousness, and the world around them. The world in which humans live provides meaning based on experiences bore (Husserl, 1970/1954). Husserl posited that individuals have the capability of self-reflecting on both actions and deeds (Husserl, 1970/1954). These reflections, however, do not stop with the individual or their own lived experiences. As ego-subjects, human beings have the capability of getting to know one another through observation (Husserl, 1970/1954). These observations may include observing the acts of thinking and experiencing, while remaining neutral without participating in those thoughts or experiences (Husserl, 1970/1954). The analogy of observing a living organism provides a poignant example of human interaction. It describes how only so much can be learned and understood by casual observance, in this case viewing a living organism (Husserl, 1970/1954). A deep analysis of both the history and environment in which an organism comes from and the accomplishments achieved which shape the essence of being can give one another a true reflection of who and what they are (Husserl, 1970/1954).

In Husserl’s (1970/1954) early work on phenomenology and the life-world, the researcher expressed concern for a person’s ability to use this theory as a fundamental framework in which to provide subjective investigation, as person’s scientific inquiry historically involved a certain level of objectivity. Husserl argued that through the phenomenological reduction of objective science, it is possible to see the life-world as a long-standing subject matter already integrated into objective science (Husserl, 1970/1954). Fact or truth may inherently be considered objective, but Husserl argued that fact or truth may be seen differently in the eyes of others which set off with the purpose of encouraging reflective thinking as a means of encouraging others to see the life-world as a pure theory (Husserl, 1970/1954). The practical application of life-world allows individuals to see that human beings are directly cognizant of their surrounding world, how they live in that world, and how having experiences can directly affect their surroundings (Husserl, 1970/1954).

As qualitative research has become more commonplace and accepted in the scientific community, tenets of phenomenology like those of Husserl have become more frequent as a scientific method of inquiry. An extensive search of the literature produced minimal results showing the life world theory as a theoretical framework for the lived experiences of patient death from a global or health care provider perspective. However, in an article examining the experiences of nursing students taking part in reflective seminars, Lindberg, Karlsson, and Knutsson (2018) adopted the lifeworld approach based upon Husserl's phenomenology to describe how reflection in practice can lead to both caring and thoughtfulness. Those reflections could then help highlight deficiencies in care and provide awareness of the value of caring for patients.

Similarly, Long, Thanasilip, and Doutrich (2018) conducted a qualitative phenomenological study of death acceptance among cancer patients. As my study aimed to present subjective data on the lived experiences of these individuals that had not previously been researched, Husserlian phenomenology was used as a framework for the study (Long et al., 2018). Death acceptance was noted to be a very subjective topic and proved difficult to quantify due to its multifaceted complexities (Long et al., 2018). Although the authors were not facing the experience of death, their choice of framework allowed them to witness the subjective behaviors and feelings recanted by those participating and provided an in-depth look into their lives and experiences in hopes to inspire other care providers and family members to understand the meanings of facing death.

Anecdotal experience suggests that the ability to research and understand the subjective, lived-experiences of others may allow researchers to gain and understanding of those who have experienced the death of a patient. Although studying death and the affects it has on health care workers including nurses, limitations exists due to a lack of personal experience. By adopting the tenets of Husserl including phenomenology and the life-world, my study resulted in firsthand knowledge of the phenomenon of the lived experiences of transport nurses who have experienced patient death through the subjective experiences of others.

Research in nursing has utilized other frameworks to study the effects of disease processes and care provided by nurses. Lenz, Suppe, Gift, Pugh, and Milligan (1995) presented their seminal work on the middle-range theory of unpleasant symptoms. Grounded in studies examining unpleasant symptoms of patients suffering from dyspnea and fatigue, the authors proposed three categories of factors: physiologic, psychologic, and situational (Lenz et al., 1995). The convergence of one or more of these symptoms resulted in experiences of distress including varying durations, intensity, and quality (Lenz et al., 1995). In an update of their theory, Lenz, Suppe, Gift, and Milligan (1997) noted the existence of physiologic antecedents that were present in conjunction with unpleasant symptoms. Overall, these affected function, cognition, and physical performance (Lenz et al., 1997). Nurses have the potential to experience similar unpleasant symptoms that may potentially affect their personal and professional lives (Lenz et al., 1997). Although this theory offers an objective look of measurable factors negatively affecting function (infection, nutrition, cardiovascular health), cognition, and physical performance (Lenz et al., 1997), it lacks the ability to understand the lived experiences of how individuals experience these symptoms subjectively.

Based on the Roy Adaptation Model, Pao-Feng’s (2003) seminal work on the middle range theory of caregiver stress hypothesized that a focal stimulus, or environment stimuli such as the objective responsibility of being a caregiver, facilitates responses in how the caregiver can adapt. In the absence of stress, however, objective responsibility and stressful life events will have no influence on how a caregiver adapts (Pao-Feng, 2003). In this context, objective burden was described as providing care to the chronically ill which could include extended periods of time providing care (Pao-Feng, 2003). This objective burden of caregiving is the impetus behind caregiver stress, and the higher amount of stress someone experiences will negatively affect their ability to cope including impaired functioning, decreased self-esteem, decreased job satisfaction, and less marital fulfillment (Pao-Feng, 2003).

Pao-Feng’s middle-range theory of caregiver stress was the conceptual framework behind Dr. Juana Ferrerosa’s (2013) dissertation describing objective relationships when caring for older adults. These included overall caregiver traits, objective burdens of the caregiver, and perceived caregiver health and strain among workers caring for older adults. Although clear, objective data were provided indicating the potential hazards of being a care provider, it too lacked the ability to understand a person’s lived experiences when caring for older adults.

My research filled a gap in understanding the lived experiences of transport nurses who are affected by patient death. My study was significant as no other studies have been identified that have collected data on this unique nursing population and how their lived experiences affect both their personal and professional life. The results of my research provided much-needed insight into the lived experiences of transport nurses. Findings from my study facilitated awareness into how transport nurses are affected by patient death, which may result in negative behaviors as described by Lavoie et al.

(2016). The insight gained from my qualitative study provided knowledge and understanding that may influence positive social change by helping to foster social support and create effective coping strategies following a patient death in the transport setting.

Literature Review Related to Key Variable and Concepts

Death from a Global Perspective

As a universal event, death may be experienced as a participant or bystander, and by its nature is genuinely individualized and subjective (Banjar, 2017). Death is an inevitability all human beings share. The United Nations (2017) reported that in 2015, eight deaths per 1000 people occurred worldwide, totaling over 56 million deaths for the year.

Death and grief have been studied with a phenomenological lens among several populations with many commonalities in the evidence (Bayuo, & Agbenorku, 2018: Hogan et al., 2016). Studies have shown that the death of a child can create by both physical and psychological hardships for the parents, leading to avoidance and taking on additional tasks to evade dealing with associated grief (Björk, Sundler, Halström, & Hammarlund, 2016; Abdel Razeq & Al-Gamal, 2018). Maternal death has been shown to decrease quality of life among spouses and children ranging from mental health issues including lack of concentration, to a lack of nutrition for infants who were breastfeeding (Zhou et al., 2016). Chu (2015) conducted a phenomenological study of the lived experiences of Chinese adults who have lost a loved one and found that grief is a process of healing and giving meaning to someone’s death may foster hope for the future.

Although death is individualized, those experiencing loss share common attributes in how their grief is handled either positively or negatively (Chu, 2015).

Death and the Health Care Provider

Pre-Hospital Providers.

The lived experience of death may be a solitary event in a person's life, but health care providers have the potential of experiencing multiple deaths throughout their careers. On the forefront of health care are pre-hospital providers including emergency medical technicians (EMT's), paramedics, and fire fighters. Although the basic skills and equipment necessary to treat critically ill patients are readily available, many providers lack the tools to effectively deal with the death of a patient, especially children (Cope, 2015). Health care providers in pre-hospital roles often face constant exposure to death which may lead to thanataphobia, or the fear of one's own death (Brady, 2015). Often brought about by "existential slaps," or cues of mortality, health care workers may show signs of psychological distress as manifested by avoidance, irritability, or burnout (Brady, 2015). Recognition of these cues and their subsequent manifestations can be difficult to identify and address, yet Brady (2015) advocates for educating personnel to assist in mitigating any associated distress.

Although identifying how patient death affects a health care provider may prove beneficial in providing education in mitigating stress, health care providers often lack the skills necessary to cope in the event of a patient death. Fernández-Aedo, Pérez-Urdiales, Unanue-Arza, García-Azpiazu, and Ballesteros-Peña, (2017) conducted an exploratory qualitative study examining emotional responses of pre-hospital personnel after performing cardiopulmonary resuscitation that resulted in death. Fernádez-Aedo et al. suggested that health care providers often lack coping skills following a traumatic or stressful situation and dealing with the death of others may have direct implications on the how they perform future patient care.

Three themes emerged indicating that although feelings of sadness over the death of a patient existed, solace was taken noting that exhaustive measures had been provided to the best of their ability (Fernádez-Aedo et al., 2017). The first theme noted was that after experiencing the death of a patient, providers often turned to their peers for comfort and understanding which was shown to build professional relationships and comradery (Fernádez-Aedo et al., 2017). This differs from a study examining how paramedic students coped with death and found family as an asset over peers in the coping process (Williams, 2013). Second, those experiencing the death of a patient found difficulty in discussing the events surrounding the death with the family members of the patient (Fernádez-Aedo et al., 2017). Finally, greater emotional effect was noted after taking part in the resuscitative efforts and death of a child or young person (Fernádez-Aedo et al., 2017).

Physicians.

As primary care providers for patients in ranging aspects of health care, physicians are often present in the event of a patient death, yet their experiences can differ depending on their roles. The trend I noted in the literature among physicians shows a dichotomy between patient deaths in palliative care and pediatric oncology and proves interesting as I noticed differing reactions and emotional responses to patient death. For instance, Arnold, Lloyd, and von Guten (2016) conducted a qualitative, retrospective analysis of visual representations of patient death expressed by palliative care physicians at the end of their fellowship. Through visual cues including drawings and pictures, Arnold et al. discovered that although exposure to patient death and working with family members may occur frequently, reflections do no generally reveal pain and suffering, but rather a sense of empathy and community as persons having a shared experience.

In another qualitative study examining the experiences of death and dying among palliative medicine specialists, Zambrano, Chur-Hansen, and Crawford (2014) discovered three overlapping themes that included being with the dying, being affected by patient death, and adjusting to the effect of death and dying. Although the cumulative effect of being exposed to several deaths over a short period of time had emotional influences, physicians found comfort in the ability to attend the funerals of their patients which afforded them the opportunity to reflect upon their own mortality (Zambrano et al., 2014). Ultimately, physicians attempted to make meaning of their patient's death by keeping perspective of death as being a part of the life process and knowing that the rewarding work they accomplish outweighs the emotional burdens that may accompany constant exposure to death (Zambrano, et al., 2016).

While death may prove difficult to handle in any regard, the death of a child can prove emotionally difficult for any individual involved in their care. In a study examining the challenges of a child's death and what makes it difficult among pediatric oncologists, Granek, Bartels, Scheineman, and Barrera (2015) described the increased amount of contact with both the dying patient and their families. Challenging scenarios were identified as the sudden death of a child, ceasing of futile medical treatments and death brought about as a side effect of medical treatment (Granek et al., 2015). In Westernized civilizations, Granek et al. described that the occurrence of death among children is often less, yet its infrequency creates difficulty in accepting those deaths and knowing the child would never grow up to adulthood to achieve their goals and dreams. This often brought about emotions of disappointment, sadness, and injustice (Granek et al., 2015).

Irrespective of the patient type or circumstances surrounding a patient death, the lived experiences of patient death among physicians can affect their own lives and the ways in which they interact with patients and family members. In a phenomenological study of the lived experiences of physicians dealing with iatrogenic patient death, Whitehead (2014) discovered five underlying themes that included physicians accepting patient death as part of their job, expectations and responsibilities of providing care, questions of competency, memorable patient deaths, and taking action versus being present during the death of a patient. Often these expectations surrounded the physician’s ability to “know everything,” and when death did occur they questioned their own competency as a physician (Whitehead, 2014). It was interesting to note the difference between acute care physicians versus palliative care physicians and their role in patient death. Whitehead described how acute care physicians were of the mindset of taking action of tasks they needed to perform, while palliative care physicians were of the mindset of being present during the process of death. This dichotomy of roles proved interesting in how physicians react and handle the death of a patient, either acting to prolong it or being present and allowing it to happen.

Nurses.

Nurses are frontline workers providing patient care in many settings which often affords opportunities to be present and involved in the death of a patient. Although no studies were identified in the literature regarding the lived experiences of transport nurses experiencing patient death, studies were found in similar areas where death occurred frequently. Nursing units such as the ED and ICU were expected in the literature and presented data on the experience of patient death. Information was also found in settings involved in pediatrics which included critical care, oncology, and the newborn ICU (NICU). Although each area of nursing presented its unique challenges when facing patient death, several themes were noted across the literature including the importance of peer support, administrative support, and education on death and dying.

Peer Support

The tasks of nursing and providing patient care is not a solitary undertaking and often requires a team approach to provide care. In the event of a patient death, many nurses turn to their peers for support. Although the literature reflected death in several patient populations including adults and children in both the ED, ICU, and oncology, a general theme existed focusing on peer support. The ability to share experiences with peers is vital in processing the incident of a patient death and being able to return to the bedside and resume care for others (Hogan et al., 2016; MacDermott & Keenan, 2014). The use of “black humor” was described by Wilson (2014) as a means for peers to deal with the incident of patient death in a joking, jovial manner. Regardless of nurse's role in a patient death, failed attempts of resuscitation affect individuals differently, but peer support can help facilitate coping among each other (Lindsay & Heliker, 2018; Khalaf et al., 2017).

In an exploratory descriptive study examining the coping mechanisms of nurses in burn ICU, Bayou and Agbenorku (2018) posited that death may often lead to feelings of sadness and lack of accomplishment. Teasing one another to lighten the mood and the use of humor were found to be an effective coping strategy in dealing with patient death (Bayou & Agbenorku, 2018). Regardless of which strategy staff may use, implications for nursing practice included creating an environment where nurses could receive support and talk about their experiences (Bayou & Agbenorku, 2018). Creating an environment where nurses can share their experiences often contributes to the well-being of the individual and overall strengthening and support of the team (Bacon, 2017; Parola, Coelho, Sandgren, Fernandes, & Apostolo, 2018). Anderson, Kent, & Owens (2015) suggested the sharing of experiences, especially first-time exposure to a patient death, was found to facilitate a sense of "team" among nurses. Trusting bonds between nurses rather than family members are often relied upon when dealing with fluctuating emotions surrounding patient death (Fernández-Aedo, Pérez-Urdiales, Unanue-Arza, García-Azpiazu, & Ballesteros-Peña, 2017). This is contrary, however, to the findings of Forster and Hafiz (2015) who suggested that discussing experiences surrounding death with other nurses may in fact worsen feelings of grief.

Individuals often process death on a personal level that may often not be witnessed by others as described by Zheng et al. (2017). In a descriptive qualitative study examining the grief of nurses following a child's death, MacDermott and Keenan (2014) explained both the necessity and need for peer support not only after a death, but anytime an individual may need help with the grieving process as not all nurses may grieve the same.

Education

Regardless of how a nurse may process the death of a patient, the need for education surrounding death and dying may be a useful tool assisting in the coping process. While nursing peers can provide solace for many individuals experiencing a patient death, a lack of knowledge and education in to how to provide that help could hinder the healing process. In a phenomenological study examining the experiences of emergency personnel after the failed resuscitation of a child, Lindsay and Heliker (2018) recognized the importance of peer support yet found that many individuals needed ongoing support far past the incident including education in how to provide self-care. In their phenomenological study of the experiences of grief among Jordanian nurses following a patient death, Khalaf et al. (2017) concluded that participants stressed the need and importance of teaching nurses in how to deal with patient death, especially new staff. This could be accomplished by implementing educational modules that address grief and the bereavement process early on during a nurse's orientation (Khalaf et al., 2017). Educating nurses on patient death does not need to wait until they start working as a nurse, but rather early on in nursing school curriculums (Shorey, André, & Lopez, 2017).

Far beyond the classroom lies nurses in several health care settings that may potentially benefit from education surrounding patient death. ED nurses not only find end of life education of value, but they also see the value in incorporating this education into nursing guidelines that could help influence their practice (Wolf et al., 2015). Patient death can be difficult for any nurse regardless of their specialty. However, education may be even more important for those nurses working in rural areas. They often feel powerless due to a lack of staff, resources, and have a higher likelihood of knowing the patient as they may feel powerless in the event of a patient death due to lack of resources, minimal staff, and dealing with the death of someone they know (Beckstrand, Rohwer, Luthy, Macintosh, & Rasmussen, 2017).

Administrative Support

Whether or not nurses have education in how to handle the death, it may become moot if a lack of administration support exists. Bacon (2017) described the negative effects of perinatal death including hypervigilance and the long-term effects on how nurses may care for patients. Ultimately, administrators and managers can gain insight and a fundamental understanding into the nurses' experience and therefore create education that facilitates support and guidance (Bacon, 2017). Bacon found this evidence to coincide with other disciplines who experience both sudden or expected death. MacDermott and Keenan (2014) described the importance of administrative support and presence in their descriptive qualitative study examining grief after the death of a child with an intellectual disability. MacDermott and Keenan concluded that with correct level of administrative support, nurses can manage their grief in a way that allows them to be better care providers for both children and their families in the future.

A surprising lack of literature was found discussing how exactly administrative personnel can provide support, although its need was heavily stressed. Conte (2014) described the lived-experiences of nursing dealing with the death of pediatric oncology patients and found that nurses often had to continue to carry on with their work and care for others despite a patient dying. Conte described the challenges in processing death that many nurses face and concluded that administrators should adjust staffing if possible to allow for staff flexibility in these situations.

Summary and Conclusions

My literature review provides insight into the experiences health care providers face when challenged with the death of a patient. From a global perspective including physicians, pre-hospital personnel, and nurses, patient death can have an effect. Peer support, education, and administrative support were the major themes surrounding patient death among nurses. Although no literature was found describing these experiences among transport nurses, they parallel the transport environment significantly. As transport nurses deal with patient populations of all ages and can include both emergency and critical care diagnoses, these studies provide key insights that are applicable to transport nursing. Coupled with a small working environment, a limited amount of resources, and higher likelihood of facing the death of a patient, transport nurses may benefit from these studies and their findings as they work in this unique environment.

My research filled a gap in understanding the lived experiences of transport nurses who are affected by patient death. As I was unable to identify literature surrounding this unique population, my research was significant and provided much-needed insight into the lived experiences of transport nurses. My proposed study shed light on the occurrence of patient death experienced in this particular field of nursing and provided new knowledge and insight into how patient death affects the lives of transport nurses both personally and professionally. Positive social change may be affected as communication is fostered and social support created to help transport nurses cope with the death of a patient in their care.

Chapter 3 will utilize a qualitative approach grounded in the work of Husserl's phenomenology and life-world. This will include a discussion of the research design, my role as the researcher, qualitative methodology, and issues of trustworthiness.

Chapter 3: Research Method

Introduction

My purpose in this qualitative study was to build un the existing literature of phenomenological studies regarding the lived experiences of health care professionals, including nurses, who experience patient death and provide insight specifically related to the lived experiences of transport nurses. In this chapter, I will discuss the research design and rationale, the role as researcher, methodology, and issues of trustworthiness.

Research Design and Rationale

The following research question guided the study: What are the lived experiences of transport nurses who have experienced patient death while providing patient care during transport or transfer of care? The research design chosen for this study was a phenomenological design, suggested by Patton (2014) as a framework permitting researchers to query the experiences of a person or group of persons, to understand both meaning and structure of those experiences. My goal in this study was to explore the lived experiences of transport nurses experiencing death. To further explore this phenomenon, a qualitative phenomenological approach was chosen using semistructured interviews. Ravitch and Carl (2016) depicted semistructured interviews as a means for researcher to have an instrument in which to guide the interview, while allowing for situation-specific questions to be asked for follow-up and clarification.

The emphasis of phenomenological research is a person’s experience articulated by researchers in a way that captures the essence of experience as closely as possible (Rudestam & Newton, 2015). The rationale behind choosing this research design was the intent to capture the true essence of the lived experiences of transport nurses that experience death. Ravitch and Carl (2016) suggested a phenomenological approach used by researchers stem from the interest of individuals' lived experiences of a certain phenomenon. This provided detailed descriptions that captured the crux of the event of patient death that transport nurses face on a regular basis.

Role of the Researcher

For the research study, the primary researcher and data collector was me. With direct contact and deep involvement in the experiences of research participants, personal and ethical dilemmas were a common concern. This requires researchers to automatically identify any potential biases, personal values, or their own experiences that may affect the analysis of their results (Creswell, 2014). As a transport nurse who has experienced patient death, personal lived experiences have provided motivation to review the literature and complete this research study, therefore potentially creating issues of bias. Being so close to this topic will required taking on the role of researcher rather than transport nurse so that a comprehensive understanding of the lived experiences of others may be had. I was an active participant in the data collection process, which entailed one-on-one, semistructured interviews with transport nurses.

I addressed ethical issues including confidentiality by providing written and verbal assurances to all research participants that any identifying factors including their name and transport program were omitted from the data analysis. Rather, I provided participants with a number that was used as an identifier. All identifying material including names and contact information were kept separately from the actual data collected.

As a transport nurse, I have close personal and professional relationship to this study. To avoid potential ethical issues that may have arisen from my close relationship to this study, there were no personal, work-related, or supervisory relationships with the research participants. This included not recruiting participants who are personal colleagues. Furthermore, no information regarding the personal experience of patient death or working as a transport nurses were shared. Rather, I informed them that this study was being completed by a registered nurse conducting doctoral dissertation research. The rationale for not sharing a true identify was to prevent research participants from feeling obligated to share or withhold more information based on a relationship of being a fellow transport nurse. Furthermore, sharing my personal experiences was avoided to preclude them from becoming the focal point of the interview or having an influence over their answers.

Other ethical issues include strong emotional responses that may have arisen from reflecting upon past experiences. These responses may have caused turmoil resulting in anxiety, fear, or sadness. Prior to conducting the interviews, IRB approval was obtained to ensure ethical treatment of all research participants. I provided participants with information regarding free psychological assistance that could be accessed in the event that the interview causes emotional distress. Free mental health resources including hotlines and lists of local mental health professionals could be found at mentalhelp.net. I also encouraged participants to refer to their employer’s employee assistance program

(EAP) for further resources, if such were available. I also informed participants that they could end the interview at any time without fear of repercussions or potential effect on the study.

Methodology

I chose a qualitative, phenomenological approach for my study to capture the essence of human experience surrounding patient death as experienced by transport nurses. Other methodological approaches I considered for this study but did not chose were grounded theory and narrative inquiry. Clute (2017) suggested that a grounded theory approach facilitates the advent of theoretical principles through analyses completed by researchers. Furthermore, Rudestam and Newton (2015) described grounded theory studies as inductive and as data are collected, themes develop. Although grounded theory is a noteworthy option for qualitative research, it does not align with the research. Rather, an exploration of the experiences of death in transport nurses through the lens of the seminal work of Husserl was chosen which is aimed at exploring the experiences of others. A narrative approach was also considered but appeared to provide a significant limitation in data collection. A story told by research participants in a narrative inquiry typically epitomizes fact, and often do not match their lived experiences (Patton, 2014).

Participants Selection Logic

For my qualitative phenomenological study, research participants were recruited through purposive sampling and snowballing. Patton (2015) posited that selecting information-rich cases that may provide depth is the rationale behind purposeful sampling. The inclusion criteria for participants included three years of experience as a transport nurse having experienced the death of a patient and the willingness to be audio and/or video recorded. Three years of experience was chosen as it would likely lead to a transport nurse dealing with the death of a patient at some point in their practice. There were no limitations on age, years of experience over three years, or patient population served as this would ideally allow for a well-rounded look at the experiences of transport nurses. Exclusion criteria included less than three years of experience as a transport nurse, not experiencing the death of a patient as a transport nurse, and not willing to be audio and/or video recorded. Additionally, no research participants with whom I had a preexisting personal or working relationship were chosen, as Creswell (2014) stressed the importance of not selecting research sites in which outcomes may provide personal interest. Creswell regarded this action as limiting objectivity and may solicit questions of conflict of interest or undo power over participants.

An email/flyer containing the information of my study was emailed to all the transport programs in the intermountain west region. Due to a lack of participant response, an IRB addendum was obtained with permission to recruit nationally. The same email/flyer was sent via email to several transport programs in the west coast region, mid-west region, and east coast region. See Appendix B for the recruitment email/flyer. For my study, interviews were conducted until thematic saturation was achieved. Participants expressing interest in this study were given both a phone number and email address in which to contact me. For my research study, eight research participants were recruited. Patton (2014) explained that although no statute for the sample size in qualitative research exists, a greater depth of experience may be achieved by a rather small number of people. Patton also stressed that small samples that are genuinely in-depth have the capability of providing great understanding of the phenomenon of interest. As I found no literature on this particular phenomenon of interest, anecdotal evidence in similar areas of nursing would suggest that thematic saturation may possibly occur in eight to ten interviews.

Instrumentation

The instrumentation for my study included a semistructured interview in which questions were asked to answer the research question: what are the lived experiences of transport nurses experiencing patient death while providing patient care during transport or transfer of care? As researchers working to thoroughly capture and describe a person's experience of a phenomenon, it was necessary to recruit participants for in-depth interview who have had explicit experiences with the phenomenon of interest being studied; participants have "lived experience" rather than indirect experiences (Patton, 2015). Ravitch and Carl (2016) posited that a research participant's experience inherently makes them an expert based on those experiences. Ravitch and Carl also suggested that when conducting interviews, the participants experiences far outweigh the importance of the overall data.

All interviews were audio and video recorded utilizing Zoom. This password protected program allows for both parties to communicate via personal computer and allows for both audio and video recording. All recordings were downloaded through the Zoom website and kept on a password protected computer. Additional audio recording was done utilizing Rev, a smart phone app that allowed for audio recording and verbatim transcription. This app was stored on an Apple iPhone that was protected by both a password and facial recognition software All recordings were sent for secure transcription and accessed through password protected email and stored on Dropbox.

Researcher-Developed Instruments

The purpose of my study was to examine the lived experiences of transport nurses experiencing patient death. Semistructured interviews were used during the interviews to allow for both structure and the ability to probe deeper dependent upon participant answers. See Appendix A for the interview protocol. While semistructured interviews utilize open-ended questions, greater depth may be achieved in an interview which makes this method of questioning preferred by health care professionals (Jamshed, 2014).

As no prior literature was found that addressed how patient death is experienced in the transport nurse population, questions created for the interview were based upon anecdotal experiences that transport nurses may have. Creswell (2014) suggested that phenomenological researchers typically prepare some questions in advance but prefer to alter them based on the discussion and how the interview progresses. Content validity was also used to check for accuracy of my research findings, and incorporated factors of trustworthiness consisting of credibility, transferability, confirmability, and dependability (Creswell, 2014). See Appendix B for the recruitment letter/flyer that was sent to transport programs requesting research participants. See Appendix C for the consent form/demographics sheet.

Procedures for Recruitment, Participation, and Data Collection

Recruiting research participants entailed creating a letter with a brief synopsis of my study including contact information. This email/flyer was sent to transport programs in the intermountain west region and throughout the United States in a letter format to be distributed to their respective transport team nurses. Upon being contacted by a transport nurse who interested in participating in the study, an email response was sent to inform them of the interview process. This included a consent along with a Survey Monkey link to complete a demographics form. This allowed for questions to be asked, clarifications made, and feedback solicited prior to continuing with the interview process. Once all questions had been answered and the participants agreed to move forward with the interview.

Once participants consented, a time was agreed upon by both parties in which to complete the interview. Data was collected from eight transport nurses meeting the inclusion criteria with audio and video recording via Zoom and Rev. Semistructured interviews were conducted using a list of predetermined question. All interviews were audio/video recorded and transcribed verbatim (See Appendix C).

Interviews were scheduled for 60 minutes with the understanding that they may run shorter or longer depending on the involvement of the participant. Research participants were informed that they may stop the interview process at any time and for any reason. Prior to each interview, participants were informed they could receive verbatim transcripts of the interview if desired.

Data Analysis

Having chosen a phenomenological approach for my study, Patton (2014) suggested there are key elements in data analysis that must coincide with this chosen method. When analyzing qualitative data, researchers are encouraged to do their best to represent and convey the data given the overall purpose of our study (Patton, 2014). As an interpretive framework, phenomenology works to understand clarify, and arrange the very essence of the lived experiences of a phenomenon of those participants we interview (Patton, 2014). These may include consciousness, intentionality, nomea and noesis, the ability to become aware of our biases (epoche), and phenomenological reduction leading to bracketing to ensure the purity of our data (Patton, 2014). Data is then spread out and each element examined with equality so that it may be organized it in a meaningful way. The final actions draw upon Moustaka's steps to synthesize the meaning and core of the experiences shared by the participants (Patton, 2014)

Considering the options available to analyze data in qualitative research studies, I chose one definitive analytical approach. This approach was Moustaka's (1994) modification of the Van Kaam methods of analysis of phenomenological data. The tenants of this method include first listing every relevant expression to the experience, or horizontalization. Reduction and elimination were then conducted to inquire if the experiences contain necessary components to understand the phenomenon, and if possible, summarize the experience and provide it with a label. Next, experiences were clustered and designated as core themes to the experience. Finally, validation was completed by examining the transcript to ensure that the themes mentioned throughout were attuned to the experience or need to be deleted as they did not hold any real relevance.

The approach to data analysis was carried out as noted above while establishing inclusion criteria to strive for thematic saturation. This was established by using a demographics sheet and flyer sent to potential research participants (See Appendix B & C).

Issues of Trustworthiness

As qualitative research is carried out, it becomes essential to ensure that the data collected and reported on is trustworthy. Creswell (2014) identified the importance of validity in qualitative research to assess for and ensure both accuracy and credibility in a researcher's findings. There are four particular areas in qualitative research that must be addressed to mitigate issues of trustworthiness. These four areas of trustworthiness include credibility, transferability, dependability, and confirmability.

Credibility

Ravitch and Carl (2016) described validity in qualitative research as a methodical process that works to evaluate a study's rigor. This process of credibility may include practices of member checking, triangulation, offering thick descriptions, and the use of peer debriefers (Ravitch & Carl, 2016). Member checking is a way in which participants may assess the validity of their statements to ensure that accuracy was obtained. After each interview, participants were provided with the option to receive a document of their interview to ensure their statements reflected their true feelings regarding their experiences of patient death. At the completion of the interviews, no participants requested a transcript. Triangulation was also completed by having enough participants to reach thematic saturation. This allowed for multiple perspectives to be given in which to validate the study or provide what Cart et al. (2014) described as merging multiple data sources to test validity.

Ultimately, this provided the true essence of experience as recanted by transport nurses experiencing patient death. Reflexive journaling was another technique that was used in which to document personal thoughts and experiences throughout the interview process, therefor adding validity to the study. Triangulation was also conducted by having my dissertation chair, who is a doctoral prepared researcher, independently review the transcripts to validate conclusions and establish consensus in the study findings.

Transferability

A main tenet of transferability is not striving for factual statements, but rather applying to or transferring to similar contexts, while maintaining richness of detail in the context provided (Ravitch & Carl, 2016). Creswell (2014) described how providing thick, rich description allows the reader to share the experiences conveyed by participants descriptions, which may offer a more representative look of their overall experiences. Patton (2014) added that triangulation of qualitative resources allows for the testing of consistency to understand the strength and confidence of the conclusions drawn. For this research study, having eight interviews provided sufficient evidence to reach thematic saturation and ensure transferability. This further justified the need for my study as no research has been conducted examining the lived experiences of transport nurses.

Ultimately, providing extensive detail and thick descriptions, along with examining the consistencies among the data allowed for transferability. Morse (2015) advised that external validity, or applying conclusions to similar circumstances or people, may be accomplished by “decontextualization and abstraction of emerging concepts and theory” (p. 1213).

Dependability

To establish dependability for my study, an inquiry audit was utilized by the dissertation committee chair who reviewed the results of the study and ensure that the data collected truly validates those results and conclusions. Additionally, triangulation in the form of journaling was be used to compare personal observations with the answers given by research participants during their interview (Patton, 2014). Audit trails and triangulation are two qualitative methods that may help ensure dependability in a research study. Mores (2015) suggested the additional use of inquiry audits in which an outside party reviews the research process to ensure “internal linkage” (page number for quote??) of material as the theory develops. Morse also indicated that dependability in qualitative research is the capability for other researchers to achieve the same results in the event the study where to be repeated in the future.

Confirmability

Confirmability in qualitative research helps ensure that the experiences and thoughts found in a researcher’s work is truly those of the participants and not of the researcher. Amankwaa (2016) provided insight into trustworthiness in qualitative research including credibility and objectivity from the researcher to mitigate bias and allow the outcomes to be formed by the participants. Anney (2014) described the importance of a thorough audit trail in qualitative research which includes raw data from field work including notes regarding information from the interviews and researcher observations. Similarly, the technique of reflexive journaling which includes notes from field work and researcher’s personal reflections (Anney, 2014). An audit trail and reflexive journaling were completed from the beginning of the research project, throughout the interviews, and upon data analysis, interpretation, and reporting of the findings. These entries may then be referred to when reflecting upon individual interviews to recall and confirm in-depth moments of the interviews that stood out, rather than making biased assumptions.

Intercoder and Intra coder Reliability

For this phenomenological study, role of primary researcher was assumed by Joshua Wall. As the only researcher for both data collection and data analysis, an intra coder reliability approach was adopted. This approach measures the consistency of the researcher, meaning it will allow for the same results if the coding process is repeated again in the future (Jacinto, Santos, Soares, Sílvia, & Silva, 2016).

Ethical Procedures

Paramount to the success of research is the ethical considerations and accommodations made for research participants. To ensure that all ethical procedures were met, approval from the Institutional Review Board (IRB) at Walden University was obtained. Upon this approval, participants were recruited, and data were collected. To prepare for approval, completion the “Protecting Human Research Participants” certificate through the National Institute of Health (NIH) has been completed. (Certification Number: 2360991).

Ethical concerns surrounding the recruitment of participants may be mitigated in several ways including full disclosure of the purpose of the study, participant benefits, and ensuring participants do not feel pressured or forced to participate (Creswell, 2014). Patton (2014) described the ability to achieve IRB approval lies in the honesty of the purpose of the study and participants giving their full consent. These concerns were mitigated by ensuring full disclosure of the intent of the research along with informed consent signed prior to collecting data. At any time, participants were able to remove themselves from the study without question and would be thanked for their time and contributions. Assurances were also provided that all identifying information including names, transport programs, audio recording, and notes would be kept confidential. This material was also kept on a password protected computer, password protected Dropbox account, and will be destroyed after the amount of time required by IRB approval. Access to these data was limited to myself as the primary researcher and my dissertation committee comprised of three faculty members at Walden University. Printed materials were kept in a locked drawer and a locked office at the home of the primary researcher.

Finally, personal colleagues were not recruited as this may have created discomfort in sharing their personal experiences, or conversely oversharing experiencing that may not be divulged with a non-coworker, therefore diminishing the quality of the interview.

Summary

This chapter has described the primary methodology for my phenomenological study which included the research design, instrumentation, and recruit methods. Furthermore, issues of trustworthiness and ethical consideration met in qualitative research were addressed and mitigating efforts described. My proposal guided the research and assisted in providing a framework to recruit participants, collect data, and report upon the finding. Chapter 4 will provide recruitment and data collection efforts for my study in addition to an in-depth data analysis, results, and evidence of trustworthiness

Chapter 4: Results

Introduction

Transport nurses often experience patient death, and little is known about the effects it may have both personally and professionally. My purpose in this study was to build on existing phenomenological studies examining the lived experiences of medical professionals experiencing patient death, by exploring the lived experiences of transport nurses experiencing patient death. Results from this study shed light on the phenomenon of patient death experienced by transport nurses in a way that has not been previously researched.

Research Question

The research question guiding this study was: What are the lived experiences of transport nurses who have experienced patient death while providing patient care during transport or transfer of care? In this chapter, I will present the results of the phenomenological study to include the setting in which it took place, demographic information, data collection methods, data analysis, evidence of trustworthiness, and the results that address the research question.

Setting

Recruiting for this study took place between December 2018 and February 2019. I contact transport programs in the intermountain west via email with a recruitment letter expressing interest in recruiting research participants for my study. In addition, a recruitment flyer was also included with the letter intended to be posted at each program location to elicit participation. Interested parties were given a contact email and phone number in which they could express interest in participation. Due to a lack of response from transport nurses throughout the intermountain west, recruitment was broadened to transport programs throughout the United States. I contacted programs in the West Coast region, Midwest region, and East Coast region via email with the email/flyer asking for participants to take part in my study. Audio and video recording for the interviews was conducted within the Zoom video-conferencing program. Additional audio recordings were conducted simultaneously utilizing Rev, a smart phone app that recorded the interviews and allowed for verbatim transcripts to be created.

Demographics

I interviewed eight participants for this phenomenological study. Inclusion criteria included a minimum of 3 years of civilian transport nursing experience in a rotor-wing, fixed-wing and/or ground ambulance settings, and experienced at least one patient death as a transport nurse. All modes of patient transport were included and consisted of a mix of rotor-wing, fixed-wing, and ground transport. Patient populations served included adults, pediatrics, neonates, and high-risk obstetrical (HROB) patients. Seven participants were women, and one participant was male. Participant ages ranged from 25 to 65 years of age. Years of experience ranged from 5 years to more than 20 years of transport experience. All participants had experienced at least one patient death during their time as a transport nurse (Table 1).

Characteristics of Participants

Table 1 consists of demographic information of the research participants.

Table 1

Demographic Information of Participants

Demographic information	Number of participants (*n* = 8)
Gender	
Female	7
Male	1
Current age range (y)	
18-25	0
25-35	1
34-45	5
45-55	1
55-65	1
65+	0
Years of experience in transport nursing	
<3	0
3-5	1
5-10	4
10-15	1
15-20	1
25+	1
Experienced a patient death as a transport nurse	
Yes	8
No	0
Method of transport (may choose multiple)	
Rotor-Wing	8
Fixed-Wing	8
Ground	3
Patient population served (may choose multiple)	
Neonates	5

Pediatrics	7
Adults	8
HROB	1

Data Collection

Participants

During the recruitment process, ten participants initially volunteered to participate in the study. Of the ten, eight responded with the signed consent, completion of the demographics survey, and a desire to schedule an interview. All eight participants met the inclusion criteria consisting of a minimum of three years of civilian transport nursing experience in a rotor-wing, fixed-wing and/or ground ambulance setting, and experienced at least one patient death. Two consenting participants were not included in the study due to a lack of response in setting up an interview.

Location, Frequency, and Duration of Data Collection

To obtain data for my study, I completed eight interviews with transport nurses who had experienced a patient death. Prior to data collection, permission to collect data from human subjects was obtained by Walden University's IRB. Approval was granted on December 23rd, 2018, approval number 12-24-18-0124090. After IRB approval was obtained, a recruitment letter and recruitment flyer (Appendix B) were sent to transport programs throughout the intermountain west region. Due to a lack of response, an addendum was submitted to Walden University's IRB requesting to recruit nationally, which was approved and maintained the same approval number. The recruitment letter and recruitment flyer were then sent to transport programs throughout the United States. Once a candidate sent an email expressing interest in participating in the study, I sent a response describing the interview process. Attached to the email response was the informed consent and a Survey Monkey link that took candidates to an anonymous demographics survey. Inclusion criteria was obtained via the demographics survey that ensured participants had been employed as a civilian transport nurse for a minimum of three years and had experienced at least one patient death in either a rotor wing, fixed wing, and/or ground ambulance setting. Once participants gave informed consent and completed the demographics survey verifying inclusion criteria, the interview was scheduled. All interviews were conducted between January 23rd, 2019 and February 18th, 2019. Seven interviews were audio and visually recorded within the Zoom video-conferencing program to allow for future reference. I chose video conferencing for this study, as face-to-face interaction was not possible due to geographic distances between the researcher and participants. Video-conferencing allowed for witnessing emotional responses and body language. Although no notes were taken during the interviews, observations were made when participants discussed difficult aspects of the patient's death and included a loss of eye contact and a pause in their speaking. These observations of emotional responses and body language were noted afterwards during reflective journaling by the researcher. Additional audio recordings were simultaneously obtained using the Rev recording app. Recordings were then transcribed verbatim through Rev. These recording were transmitted confidentially through Rev's password protected app on a password and facial recognition protected iPhone. Completed verbatim transcripts were then sent to a password protected email and were accessed and downloaded onto a password protected computer and stored in Dropbox.

I used open-ended questions for the interview to allow for research participants to share their experiences and keep the interview on topic. This method proved beneficial to keep participants on track when more detailed information was provided on the medical nature of the call rather than their experiences with patient death itself.

During the data collection process, I asked participants about a time when they experienced a patient death and the thoughts and feelings they experienced following the event. I sought further inquiry into how the patient death affected them both personally and professional, along with any changes that occurred related to experiencing that patient death. I also asked participants how the experience of patient death differed or was similar to death in an acute care setting. Finally, I asked participants how the emotions of their coworkers affected them, and the debriefing process after a patient death.

Variations in Data Collection

During the initial recruitment process, no participants from the intermountain west region reached out expressing interest in taking part in this study. An IRB addendum was written and submitted requesting the ability to recruit nationally, which was accepted and maintained the same approval number. The recruitment letter and flyer were sent to several programs throughout the United States and eight participants were ultimately interviewed for this study. Seven participants worked in the mid-western region of the United States, and one participant worked in the western region of the United States.

Due to technical difficulties, one participant was unable to be interviewed through Zoom, so the interview was completed using only the Rev app. Interviews ranged from 12 minutes to 31 minutes in duration. Variations in time of the interviews differed among participants based on the depth of experiences they shared and responses to the questions they were asked. Further probing was required during some of the interviews to clarify statements given or examples that were not clear.

Data Analysis

Coding Process

Data analysis began by reviewing the interview transcripts and completing hand-written, first and second cycle coding, or descriptive and pattern coding (Saldaña, 2016).. With first and second cycle coding were completed, Moustaka's (1994) modification of the Van Kaam methods of analysis of phenomenological data was used in which relevant experiences and expressions, or horizontalization, were listed as it pertains to the research question. Reduction and elimination were then used to decipher pertinent experiences related to the phenomenon of experiencing patient death as a transport nurse. These experiences were then summarized and labeled as core themes to the experience and listed as themes and subthemes. Finally, validation was completed by examining each interview transcript to ensure that the themes were mentioned throughout or deciding whether they were attuned to the experience or needed to be deleted as they may not hold any real relevance (Moustakas, 1994).

Interview questions were used to elicit responses which led to thematic saturation and the discovery of five common themes (See Figure 1). Each interview transcript was first reviewed, and descriptive codes were created and written in the margin. Descriptive coding consisted of summarizing passages of qualitative data with one-word terms or phrases (Saldaña, 2016). A second review of each interview transcript occurred, and pattern codes were created which were written in the margin beneath the descriptive codes. Pattern coding groups material completed during first cycle coding into simpler concepts that offered more depth and meaning (Saldaña, 2016). In a separate word document, each interview question was written out and each participant was assigned a number between one and eight. Under each question, the descriptive and pattern codes for each participant were listed. After all the codes for each interview question were listed, the entire document was reviewed looking for commonalities among the participants for each question. Commonalities among each participant and each question led to theme development and answering the research question: What are the lived experiences of transport nurses who have experienced patient death while providing patient care during transport or transfer of care (See Table 2).

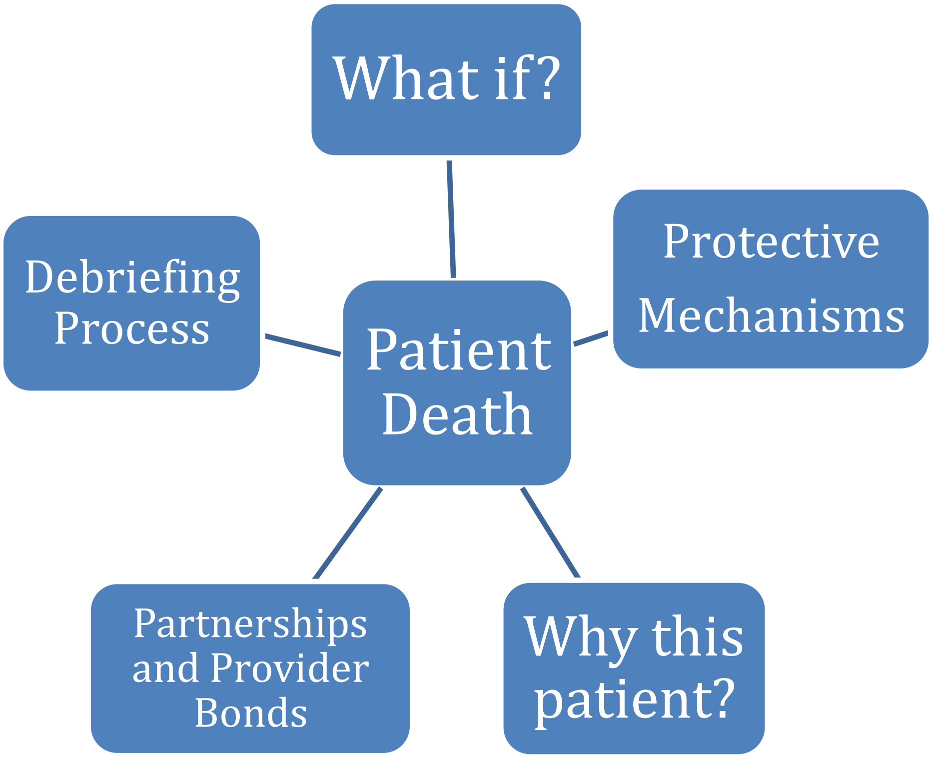

Figure 1. Five common themes.

Table 2

Main Themes/Subthemes

Main themes	Subthemes
Theme 1: What if?	
	Doubt
	Anger
	Questioning
	Self-blame
	Personal responsibility
	Sadness
	Gutted
	Blame
	Disbelief
	Regret
	Shock
	Emptiness
Theme 2: Why this patient?	
	Acute care
	Prehospital care
	Patient age
	Connection to patient
	Sudden versus expected
	Type of illness/injury
Theme 3: Partnerships and provider bonds	
	Bonding
	Joking
	Sharing
	Empathy
	Support
Theme 4: Debriefing process	
	No formal debriefing
	Reluctance
	Positive vs. negative
	Formative vs. summative
	Multifaceted
Theme 5: Protective mechanisms	
	Self-care
	Avoidance
	Self-protection
	Building barriers
	Emotional distance

	Appreciating life
	Lack of emotion

At the completion of the interview process and data analysis, thematic saturation was achieved, and five prominent themes emerged. Each participant recanted a story of a time they experienced a patient death as a transport nurse. Patients described in the experiences ranged from infants to adults. For example, when I asked what feelings or thoughts stood out after the patient death, Participant 1 stated, “obviously sad…the word gutted just comes to mind.” Upon reflection of their experience with patient death and recalling feelings or thoughts that stood out, Participant #2 stated, “there's not a day that goes by that I don't think about it. I see that accident in my head. We get called when I'm working first scene, and that's the first thing I think of.” Additionally, Participant 3 stated, “it was very difficult for me to come upon this patient who was talking to me one minute, and the next, out.” “It happened so fast…it didn’t even seem real to me" (Participant 4).

Each interview transcript was first reviewed, and descriptive codes were hand written and placed in the margin. A second review of each interview transcript and interpretive codes were created and placed in the margin beneath the descriptive codes. A second Word document was created, and each interview question was written out and each participant was assigned an identifier. For each question, the descriptive and interpretive codes for all participants were listed. Next, all of the codes for each interview question were listed and the entire document was reviewed looking for commonalities among the participants for each question. Similarities among participant responses were recorded and themes were created. Finally, sub themes were comprised of each participant’s experiences for each interview question.

Evidence of Trustworthiness

Strategies of trustworthiness were used during my study and included credibility, transferability, dependability, and confirmability.

Credibility

I maintained credibility was in study by providing thick descriptions of the data and performing triangulation. Triangulation included having an independent evaluation of the data by the dissertation chair, a doctoral-prepared researcher, to determine if the results were consistent and to ensure no personal bias influenced the interviews or data analysis. I also utilized reflexive journaling after every interview to ensure that personal thoughts, feelings or experiences were addressed, therefore adding to the validity of the study and evaluating its rigor (Ravitch & Carl, 2016).

Transferability

Transferability was enhanced in my study by completing eight interviews until thematic saturation was obtained. Recruitment of transport nurses from across the United States allowed for geographic and patient population diversity, which also helped enhance the transferability of this study and allowed for a representative look of the transport nursing population as a whole. By providing extensive detail and thick descriptions of the data, and examining the consistencies across the data, readers may not only share in participant’s experience, but gain a more inclusive look of the general experience (Creswell, 2014).

Dependability

Dependability for my study was established by completing thorough audit trails of each participant's interview through both descriptive and interpretive hand coding. Triangulation in the form of reflective journaling on both personal thoughts, feelings, and observations was also completed after each interview to establish dependability (Patton, 2014). In the event this study would recreated, establishing dependability may allow future researchers that ability to arrive at the results (Mores, 2015).

Confirmability

Finally, confirmability was completed in the form of an audit trail and reflexive journaling that I completed after every interview. These steps ensured that when I reflected upon each interview or conducting additional interviews, that in-depth moments could be confirmed rather than making biased assumptions (Amankwaa, 2016). I also made efforts not to interject personal feelings or experiences during the interview process.

Results

Themes were developed through iterative review and manual coding of the interview transcripts. These themes included: What if?, Why this Patient?, Partnerships and Provider Bonds, Debriefing Process, and Protective Mechanisms.

Theme 1: What if?

Research participants shared a range of emotions when sharing their experiences with patient death. For example, Participant 1 shared an experience of a pediatric death and stated “that’s the very first person I lost in transport…we bring them back alive. That's what we do. Just devastated that I just couldn't do it that day.” Participant 2 stated,

> “I think the first thought in my head was what did I miss? What did we miss? Could we have intervened sooner? I cried. I had a lot of emotions. I think the first one was shock, a little bit of anger mixed in there, anger at myself…he was so young, and hearing the family in the background crying and screaming, and it was very tough. It was really tough.”

Participant 3 shared a similar experience when reflecting upon the care provided and stated “what could we have done differently? What should we have done differently? Participant 4 described how early in their career, thoughts often revolved around doubt when something went wrong or lead to a patient death; “It was very traumatic…what could I have done different? If you’re taking it personal…it can wear on you.” Participant 5 described how the events went rather quickly and lead to self-doubt about the care being provided; “It was so fast. It was just, one minute he was answering my questions, completely with it and the next minute he was completely gone… And I remember as soon as he was gone, you have that immediate 'what did I do?' Participant 6 shared a story of losing a patient who was in his 30’s;

> “The reason this one stood out, I guess, the most was just the fact that he was in my term viable, and it would have been some much easier to save if things wouldn't have been missed previously. And so that kind of let a little bit of, I wouldn't call depression, but I'm wandering around the hospital on the night shift just kind of collecting my thoughts and stuff.”

"Did we try hard enough…did we go long enough? Was there anything else we could have done?" (Participant 7). Participant 8 shared an experience of patient death and stated, "It hit me like a punch in the stomach… What did I do wrong? What did I miss? What could I have done better?"

Although each individual story differed in the patient population and type of call, varying by each individual were appreciated with a commonality of doubt in the care they provided. This doubt lead to the multitude of emotional responses each participant shared.

Theme 2: Why this Patient?

To prepare for work in a complex setting, transport nurses are generally required to have in hospital experience prior to employment with a transport program. Participants were queried on their experiences of dealing with patients that died in an acute care setting versus their experience with death in the transport environment. A commonality among participants leading to the creation of this theme was the affect an unanticipated death, particularly in young trauma patients, in a pre-hospital setting had on them versus experiences in the acute care setting. "Transported a 12-year-old girl. It was an interfacility transport… not three hours later I got a call from the PICU that she had coded and died. It hit me like a punch in the stomach" (Participant 8). Participant 2 shared an experience of a young trauma patient that was cared for on a scene call and ultimately died upon arrival to the hospital:

> "It was a younger man. It was a semi versus semi, and was texting and driving, and rear ended at an estimated 45 miles per hour. He was awake and talking to us.

> He arrested again as we were descending at the level one where we were at. We continued to work him until we got into the ER. We stayed back at the ER, and they did pronounce about 25 minutes later. He's one of the calls that you have that you wake up in the middle of the night and remember. It's been close to eight years."

Another factor that affected transport nurses emotionally, were patients who appeared stable or perceived as not having a life-threatening illness or injury that deteriorated quickly, despite initially doing well and even communicating with the participant. In an acute care setting, however, participants often shared experiences of death being easier to handle. They were able to mentally prepare for a patient's death as it was often expected.

> "It was so sudden. Even though we knew his outcome was not going to be good, just how quickly he swirled the bowl, I mean for lack of better terms. In the hospital setting, I think we know, and we're prepared for it in some ways. We know patients are sick. They're in the ICU for a reason. Most of the patients didn't come in and then code and die. You know what I'm saying. We have a way to prepare ourselves for it" (Participant 2).

Participant 6 shared their views on the differences of patient death in an acute care setting by stating,

> "In an acute care setting you have the opportunity to prepare. It's not something that's usually a surprise to the caregiver. My own father's death didn't affect me as much as some deaths did earlier in my career… Because I watched it progress

> over several days where others you see them walking and they're either dead or dying."

Participant 7 stated, "Technically in an ICU, it's different because they don't just suddenly die. Whereas, pre-hospital, you don't know this person, you have no rapport with their family, you have nothing. This is just an absolute stranger that you're trying to help."

Theme 3: Partnerships and Provider Bonds

Regardless of the type of patient death that occurred, a common theme noticed among the participants was a strengthening of a partnership with those whom they worked with and how that partnership assisted in dealing with a patient death. A commonality shared among the participants was the creation of a unique bond that formed with their partner. This bond led to participants being able to rely on these partnerships for support and confirmation that despite their best efforts, they did everything they could for the patient. "You know actually being able to sit down together and cry it out and talk with each other, and I was very fortunate to have that kind of a partner that was so understanding of what I was needing, and then I was understanding of what he needed" (Participant 2). When describing a scene call which ended in a patient death, Participant 3 stated, "We definitely bonded a little bit more after that… I hate to say we joke about it, but we do, every time we get that scene call, we just kind of snicker like, "Oh God, no." "I've always had partners in these traumatic experiences where there's been a lot of empathy and a lot of support. I've never been made to feel like I was being silly or overreacting. I've been very lucky to have that support" (Participant 8).

Theme 4: Debriefing Process

Considering the experiences told involving the death of the patient, it was interesting to see the lack of formal a debriefing after each incident and the individual views regarding the debrief process, despite advocating for a process to formally occur. Although some participants shared experiences of an informal debrief with their partner pilot, base manager, or medical director, there remained a personal perception of shame surrounding the debrief process, or a sense that the entire debrief process was done as a way to exploit the situation. Participant 2 stated, “we didn't really have a solid way to debrief calls like this. We pushed for that for a while, and it really never came to fruition. There was no real formal debrief with our management or medical director after that.” Additionally, Participant 2 stated, “There's kind of a stigma to debriefing and processing emotions that you're weak.” When asked about the debrief process, Participant 5 stated,

> “We don't have a formal process. I think when they're done, I think sometimes I've been to some of these debriefings and they were done very well, and I thought they were effective. But then I've been to other ones that I don't know just this is for lack of better words but kind of felt like a dog and pony show. Like they were kind of like exploiting whatever happened. So, I think it just depends if it's done the right way and by somebody who, you know, is very skilled with the process like that.”

Participants also shared their views on when a debrief following a patient death should even occur. An interesting finding was that although all participants expressed the need and importance of a formal debrief, its occurrence and frequency varied to include both formative and summative debriefs. When discussing the debrief process and the appropriate time/place to have it, Participant 7 stated, “I do better a couple days after. But I know when you have a group of people, you've got to do it immediately, otherwise you lose people.” Participant 8 stated, “debriefs are not one and done. I think it's important to go back and re-debrief as many times as necessary, so the team feels okay.”

Theme 5: Protective Mechanisms

A common theme shared of all participants was the need to develop protective mechanisms that either helped them deal with a particular death or future deaths they may encounter. Participant 2 stated “I always keep him in the back of my head any time I get called to a scene… I don't tend to talk as much to patients I guess. I don't want to, and this sounds horrible, but it's almost like I put up a wall a little bit to protect myself.” Participant 4 stated “I'd found myself, like in a really bad place with depression and burnout, and things like that. Self-care is huge…I think a lot of things get repressed.” Participant 7 shared their experience and stated,

> “As morbid as it is, this is a body now, this is not a soul with feelings right now, and your job is to try to bring the soul back together with the body. If you can't, you can't. This is no longer a person, this is a body. That's how I kind of shut off that. It's made it more difficult to get close connections with people, because you don't know when they're going to die. It could happen at any moment.”

Not only are emotional protective mechanisms created, but protective mechanisms in everyday life. “Just try to enjoy what you can when you can, I guess…I’ll never go skydiving.” (Participant 3). Participant 2 shared an experience of a scene call involving texting and driving and its impact on her use of a cell phone in the car by stating "I'll never use a cell phone again."

An additional finding of interest among participants was the ability to embrace the prospect of a sudden patient death and an appreciation for the dying process. As participants gained more experience in transport nursing and were exposed to more patient deaths, the ability to accept death despite their best efforts and helping the patient die with dignity, rather than fight it, became more apparent. Upon the realization that a patient was about to die or in the process of dying, participants shared experiences of talking to the patient and providing some level of comfort in letting them know they were not alone. This was not only beneficial for the patient, but also for the family.

> "Often times we're transporting people that we know have a very low probability of living. I always make it a priority to contact the family and to tell them that I was their loved one's nurse, and that I held their hands and I kept them warm, and I gave them pain medicine and I told them that they were loved. (Participant 8).

Summary

The research question guiding my study was: What are the lived experiences of transport nurses who have experienced patient death while providing patient care during transport or transfer of care? Interviews conducted helped to answer this question in the form of five major themes. Transport providers experience a range of emotions after experiencing a patient death. Considering patient death and the setting in which they occur, death is viewed as much more sudden and unanticipated in the pre-hospital environment, versus being anticipated in the ICU, leading to self-doubt in the care being provided. Acute care nurses are more likely able to prepare themselves for the prospect of death of a patient as they spend more time with patients and have the necessary resources and staffing, versus short periods of time in a pre-hospital setting when much of the patient’s personal and medical history are unknown. Additionally, transport nurses are in the position to make autonomous decisions about the plan of care for the patient, which may be a factor in self-doubt following a patient death. This complex work and intense experiences help foster partnerships, bonds, and comradery among team members dealing with patient death. Unfortunately, formal debriefing concerning the events rarely occur. Although value is seen in the debrief process, variations in how it should be conducted and in what setting they take place remain a question to be answered. These experiences can lead to the development of protective mechanisms both in personal and professional lives affecting how transport nurse’s interact with patients and conduct themselves on a day to day basis.

In this chapter I discussed the data analysis process which included the setting in which the interviews took place, demographic information of the participants, the data collection process, and results. Evidence of trustworthiness during the data collection process was presented and the answers provided by the research participants helped answer the research question guiding my study. Chapter 5 will provide a discussion and conclusion of my study, and recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

My purpose in this qualitative study was to build on the existing literature of phenomenological studies regarding the lived experiences of health care professionals, including nurses, who experience patient death (Velarde-Garcia et al., 2016) by exploring the lived experiences of transport nurses who have experienced patient death. To address this gap in the current evidence of transport nurses' experiences, I conducted a qualitative phenomenological study using semistructured interviews. Findings from my study may be used by transport nurses, administrators, and other transport providers to gain an understanding of how those working in this unique environment may be affected by patient death. This may lead to social change within organizations where transport nurses may share their experiences to help create both social support and effective coping strategies for addressing patient death. I conducted semistructured interviews with eight transport nurses sharing their experiences of patient death. Key findings from my study included five major themes that described the lived experiences of transport nurses experiencing patient death. These themes included: What if?, Why this Patient?, Partnerships and Partner Bonds, Debriefing Process, and Protective Mechanisms.

Interpretation of the Findings

As a theoretical lens having driven my study, life-world by Husserl allowed individuals to describe and shed light on phenomena as described by their lived experiences. (Barrientos & Holmberg, 2018). This study enabled transport nurses to describe their lived experiences of patient death in a way that shed lights on the phenomena of death in this unique environment. Findings from my study aligned with previous research surrounding patient death as experienced by health care providers, including nurses. In a study examining the coping mechanisms of ICU nurses after a patient death, Bayou and Agbenorku (2018) suggested that death may often lead to feelings of sadness and lack of accomplishment. Participants in this study experienced similar feelings of sadness, shock and feeling gutted after the death of a patient. This also extended to self-doubt, regret, and questioning the care they provided which may have affected the patient's outcome.

A key difference of note among all participants was a lack of support and time when caring for a patient in a pre-hospital setting. Due to short transport times, small work spaces, minimal supplies, and a lack of traditional medical and ancillary support found in a hospital setting, experiencing a patient death is often more difficult. As highly trained professionals with increased levels of autonomy and responsibility for critical care and trauma management, the effect of being the primary decision maker as a transport nurse in life and death situations varied greatly from experiences within a hospital. Rather than a collective or shared experience of "blame" or "doubt" among medical professionals after a patient death, transport nurses often had an inherent fear of making the wrong decisions that may ultimately affect the patient's outcome. This also led to a sense of responsibility for a patient's death even though all measures to save their life were exhausted and out of their control.

A new finding not previously seen in the literature was the difference in experiences of patient death in an acute care setting versus a transport setting. Seen as expected or anticipated, death in an acute care setting was often easier to deal with. Having the appropriate resources, adequate working space, and personnel necessary to care for a patient, the outcome of death, despite those measures, was often easier to accept and deal with. This varied greatly in how nurses experienced patient death in the transport setting. Most deaths in the prehospital setting were unexpected and patients often had severe injuries or decompensated rapidly despite not appearing acutely ill or injured. Despite best efforts being made to save the patient's life, an increased sense of doubt and self-blame was experienced as transport nurses carry an increased level of responsibility and autonomy when caring for patients in the transport environment. As years of experience and the number of patient death they experienced increased, transport nurses were better able to accept the dying process and embrace the outcomes patients faced. This included providing compassionate and end of life care, communicating to the dying patient and relaying the care giving to family members after the patient died.

Participants of my study also described partnerships and bonds among their colleagues and the importance having them were. Bonding, teamwork, and trust was fostered among transport providers who experienced a patient death together. This concept was reflective in the literature as described by Hogan et al. (2016) and MacDermott and Keenan (2014) who described the importance of sharing experiences with peers as paramount to processing death and returning back to the bedside. Although death affects individuals differently, coping may be facilitated through peer support (Lindsay & Heliker, 2018; Khalaf et al., 2017). A key finding of note, however, was that transport nursing is a unique setting that varies greatly from working at the bedside in an acute care facility, therefore affecting how peer interactions may occur. Transport nurses often work with one other person and may include a paramedic, respiratory therapist, or another transport nurse for extended periods of time. Shifts may range from 12 hours to 72 hours in length and consist of lengthy or multiple transports occurring back to back. Small working spaces, minimal resources, the intensity of patient transports, and increased levels of autonomy facilitate shared experiences among partnerships, which often lead to turning to one another for comfort and support when faced with difficult situations like patient death.

An additional finding coinciding with the literature was the lack of a formal debrief process. My study concluded that although a debrief process was viewed as important, it's occurrence rarely happened. Those individuals who completed a debrief, even among themselves, indicated that professional bonds were strengthened and returning to work became easier. MacDermott and Keenan (2014) concluded that with administrative support, nurses may better manage grief which allows for them to enhance their future care to patients and families. Similarly, Bacon (2017) stressed the importance of administration and management involvement when staff experience patient death, which may help lead to education to provide guidance and support. Regardless of the type of debrief, its duration, or frequency of occurrence, all participants recognized the importance and need for a formal debrief process following the death of a patient. Whether a debrief is completed among the crew caring for the patient, administrative personnel, or a medical director, its success hinges on fostering a stigma-free environment of support.

My study also revealed how transport nurses created protective mechanisms to protect their feelings and create emotional barriers. This included purposely avoiding the creation of relationships with patients especially when anticipating a poor outcome such as death. As transport providers with an increased level of decision making, responsibility, and autonomy when caring for critically ill and injured patients, outcomes from this study aligned more closely with physicians. This included similarly shared views of increased expectations, responsibilities, and personal competency as a primary care provider. This was supported by the literature as described by Whitehead (2014) who described his phenomenological study of the lived experiences of physicians dealing with iatrogenic patient death. Whitehead discovered underlying themes that expectations and responsibilities of providing care and questions of competency. Often when death did occur, physicians questioned their own competency as a practitioner (Whitehead, 2014).

Limitations of the Study

There were limitations to my study. My study included transport nurses with a wide-range of experience who worked in diverse settings and geographic regions; however, their experiences may not represent the experiences of all transport nurses. With qualitative inquiry there is a risk of researcher bias being introduced. As a full-time transport nurse who has experienced multiple patient deaths, my personal feelings and experiences potentially created bias during the interview process and data analysis. To avoid this, an independent analysis of the interview transcripts was conducted by my dissertation chair to ensure no personal bias influenced the interviews or data analysis. Current volunteer work on the board of directors for ASTNA created a likelihood that research participants would be familiar with my own employment as a transport nurse and role in the transport community. Knowledge of these roles could have potentially influenced their interaction and responses during the interview process.

Recommendations

I undertook this study to bring awareness to the transport community concerning the affect that patient death has on transport nurses. Although similarities in the literature existed surrounding death in acute care and prehospital settings, this unique population and unique working environment must be recognized and addressed. Although participants shared similar experiences surrounding patient death, a common area discussed was the recognition of the lack of a formal process for a debrief after a patient death. Recognizing that debriefing based on the type of transport is integral in enabling transports team to discuss difficult patient transports, even if the call did not end in death. When the effect of a difficult call including patient death is profound, immediate support for transport teams is recommended. This may include a formal, robust debrief either immediately following the incident, or shortly thereafter. This debrief process may include the transport team, base manager or administrative representative, and medical director. Giving transport personnel the ability to physically and emotionally step away from patient care and allowing them the opportunity to simply collect their thoughts, discuss the call, the care they provided, and any difficulties faced may prove beneficial.

Recommendations for a formal debrief process are encouraged to be adopted by transport programs to allow transport providers a safe environment to discuss patient death. Peter et al. (2013) suggested that the nurse’s role in a patient death is often exhausting and compels nurses to be reflective on how they both deal with and process death. This environment may be created immediately following a patient death, or in the near future depending on the individual needs of the transport provider. Creating a formal debrief process may afford transport nurses the opportunity to discuss patient death and the care they provided surrounding that particular transport. By having a formal discussion, transport nurses may share their feelings surrounding the care they provided which may help decrease frequent emotions including self-doubt and questioning of the care they provided. This may assist in helping to affirm and support the decisions that were made during the transport. In turn, this may lead to stronger bonds among transport teams and mitigating the creation of protective mechanisms such as building emotional barriers that could may affect future patient care.

A lack of literature describing the lived experiences of transport nurses experiencing patient death led to the creation of my study. Based upon the data collected from transport nurses experiencing patient death, recommendations for further research are indicated and include: a large-scale study to validate the findings, which may include conducting interviews with transport nurses outside of the United States, and conducting interviews with other transport personnel including paramedics, respiratory therapists, or physicians.

Implications

Results from my study are supported by the literature that health care providers, including nurses, are affected by patient death. Transport nurses share many of the same experiences of patient death faced by other health care providers; however, there are significant differences that must be noted. These differences include an increased sense of responsibility and autonomy which may lead to self-doubt and questioning of competency in the event a patient dies during transport or transfer of care. Addressing these feelings in a formal debrief may facilitate communication among team members, administrative personal, and medical directors to offer insight and assurances that although the patient died, care was provided to the best of their ability. Regardless of the experience of patient death, partnerships and bonds among team members can be strengthened as they work to support one another. Often after experiencing the death of a patient, protective mechanisms are created to help limit emotional attachment and decrease the likelihood of bonding with a patient who may suddenly die. These protective mechanisms may be mitigated if transport nurses are able to formally debrief patient transport ending in patient death and allowed the opportunity to discuss their feelings, either immediately afterwards, or in the near future.

My study has implications for social change as it provides much-needed research in an area that has not been previously studied. With this information, individuals and transport programs may work to create awareness and education regarding patient death and the affect it may have on individuals. By having knowledge of patient death and the unique affect it has on transport nurses, transport providers may better understand how they function in their role as a caregiver in the event a patient dies. This may affect how they interact with their colleagues which may lead to forming lasting personal and professional bonds. Ultimately, this knowledge may be used to educate future generations of transport professionals to provide insight and understanding into how death may affect them. Armed with this knowledge, administrative support can recognize the importance supportive measures like formal debriefings may in helping to deal with difficult transports that include patient death. By providing insight into the lived experiences of transports nurses experiencing patient death, transport nurses, their management, and the transport industry as a whole may have a better understanding of how death affects this unique population. Husserl (1970/1954) describes the practical application of life-world as allowing individuals to see that human beings are aware of their surrounding world, how they live in that world, and how having experiences can directly affect their surroundings. My study offers valuable information that may help the transport industry to recognize the affect death has on individuals and the steps that may be taken to assist in the coping process and longevity of a transport nurse's career.

Conclusion

My study examined the experiences of transport nurses experiencing patient death and shed light on its effect on both personal and professional lives. By gaining a better understanding of death in the transport environment, positive social change may be promoted by educating and encouraging transport programs to create coping strategies and formal processes to assist in dealing with the affect that patient death may have on transport nurses.

Death is an inevitability that all individuals must face in their life-time. As medical professionals, transport nurses are in a unique and humbling position to be present with another human being in their final moments of life. Whether death is anticipated or unexpected, it can take an emotional toll and influence future care of other patients. Education and self-care are vital for transport nurses to continue their work of saving lives in this unique and challenging environment. Despite exteriors of calm and collectedness, we owe it to ourselves to recognize that we are fallible human beings that can be affected by those for whom we care and in order to continue that legacy, we must first care for ourselves.

References

Air and Surface Transport Nurses Association. (2018). *About us*. Retrieved from https://www.astna.org/general/custom.asp?page=AboutUs

Anney, V. N. (2014). Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies*, *5*(2), 272-281. Retrieved from http://jeteraps.scholarlinkresearch.com

Amankwaa, L. (2016). Creating protocols for trustworthiness in qualitative research. *Journal of Cultural Diversity, 23*(3), 121-127. Retrieved from http://tuckerpub.com/jcd.htm

Arnold, B. L., Lloyd, L. S., & von Gunten, C. F. (2016). Physicians' reflections on death and dying on completion of a palliative medicine fellowship. *Journal of Pain and Symptom Management, 51*(3), 633-639. doi:10.1016/j.jpainsymman.2015.09.006

Bacon, C. T. (2017). Nurses' experiences with patients who die from failure to rescue after surgery. *Journal of Nursing Scholarship, 49(*3), 303-311. doi:10.1111/jnu.12294

Banjar, A. K. (2017). Till death do us part: The evolution of end-of-life and death attitudes. *Canadian Journal of Critical Care Nursing, 28*(3), 34-40. Retrieved from https://www.caccn.ca/canadian-journal-of-critical-care-nursing/

Barrientos, C., & Holmberg, M. (2018). The care of patients assessed as not in need of emergency ambulance care: Registered nurses' lived experience. *International Emergency Nursing, 38*, 10-14. doi:10.1016/j.ienj.2018.01.007

Bayuo, J., & Agbenorku, P. (2018). Coping strategies among nurses in the burn intensive care unit: A qualitative study. *Burns Open*, *2* ,47-52. doi:10.1016/j.burnso.2017.10.004

Beckstrand, R. L., Rohwer, J., Luthy, K. E., Macintosh, J. L. B., & Rasmussen, R., J. (2017). Rural emergency nurses' end-of-life care obstacle experiences: Stories from the last frontier. *Journal of Emergency Nursing*, *43*(1), 40-48. doi:10.1016/j.jen.2015.08.017

Blackman, V. S., Walrath, B. D., Reeves, L. K., Mora, A. G., Maddry, J. K., & Stockinger, Z. T. (2018). En route care provided by US navy nurses in Iraq and Afghanistan. *Critical Care Nurse*, *38*(2), e1-e6. doi:10.4037/ccn2018630

Björk, M., Sundler, A. J., Hammarlund, K., & Hallstrom, I. (2016). Like being covered in a wet and dark blanket - Parents' lived experiences of losing a child to cancer. *European Journal of Oncology Nursing*, *25*, 40-45. doi:10.1016/j.ejon.2016.08.007

Brand, M. C., Cesario, S. K., Symes, L., Montgomery, D. (2016). Journey to becoming a neonatal nurse practitioner: Making the decision to enter graduate school. *Advances in Neonatal Care*, *16*(2), E3-E11. doi:10.1097/ANC.0000000000000256

Brady, M. (2015). Death anxiety among emergency care workers. *Emergency Nurse*, *23*(4), 32-37. doi:10.7748/en.23.4.32.e1448

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum*, *41*(5), 545.

doi:10.1188/14.ONF.545-547

Conte, T. M. (2014). The lived experience of work-related loss and grief among pediatric oncology nurses. *Journal of Hospice & Palliative Nursing*, *16*(1), 40-46. doi:10.1097/NJH.0000000000000019

Chu, H. Y. (2015). *The meaning of death: A phenomenological study of Chinese adults who have lost a loved one* (Order No. 3722321). Available from ProQuest Dissertations & Theses Global. (1719540150).

Clute, M. A. (2017). Living disconnected: Building a grounded theory view of bereavement for adults with intellectual disabilities. *Omega*, *76*(1), 15-34. doi:10.1177/0030222815575017

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods Approaches.* (4th ed.). Thousand Oaks, CA: SAGE

de Swardt, C., & Fouché, N. (2017). "What happens behind the curtains?" An exploration of ICU nurses' experiences of post mortem care of patients who have died in intensive care. *Intensive and Critical Care Nursing*, *43*, 108-115. doi:10.1016/j.iccn.2017.05.005

Dorney, P. S. (2014). *The "lived experience" of baccalaureate nursing students following the sudden death of a classmate* (Order No. 3618044). Available from ProQuest Dissertations & Theses Global. (1528594408).

Fernández-Aedo, I., Pérez-Urdiales, I., Unanue-Arza, S., García-Azpiazu, Z., & Ballesteros-Peña, S. (2017). Original article: A qualitative study about experiences and emotions of emergency medical technicians and out-of-hospital emergency nurses after performing cardiopulmonary resuscitation resulting in death. *Enfermería Intensiva (English Ed.*), *28(*2),57-63. doi:10.1016/j.enfie.2016.10.001

Ferrerosa, J. (2013). *Caregivers of older adults: Burden, perception of strain, and health* (Order No. 3575053). Available from ProQuest Dissertations & Theses Global. (1459228112).

Gavrilovici, C., Starcea, M., Hiriscau, I., Miron, I., & Oprea, L. (2017). The social meaning of death and its implications for organ procurement. *Revista De Cercetare Si Interventie Sociala*, *58*, 221-232. Retrieved from https://www.rcis.ro

Granek, L., Bartels, U., Scheinemann, K., & Barrera, M. (2015). Challenging patient deaths in pediatric oncology. Supportive Care in Cancer: *Official Journal of The Multinational Association of Supportive Care in Cancer, 23*(8), 2349-2356. doi:10.1007/s00520-015-2602-3

Hanna, F. J., Wilkinson, B. D., & Givens, J. (2017). Recovering the original phenomenological research method: An exploration of Husserl, Yoga, Buddhism, and new frontiers. *Journal of Humanistic Counseling*, *56,* 144-162. doi:10.1002/johc.12049

Hogan, K., Fothergill-Bourbonnais, F., Brajtman, S., Phillips, S., & Wilson, K. G. (2016). When someone dies in the emergency department: Perspectives of emergency nurses. *Journal of Emergency Nursing*, *42*(3), 207-212. doi:10.1016/j.jen.2015.09.003

Husserl, E., 1970/1936. In: Carr, D. (Ed.), *The Crisis of European sciences and transcendental Phenomenology*. Northwestern University Press, Evanston, IL (Trans.).

Husserl, E. (2014). *Ideas: General introduction to pure phenomenology*. Retrieved from https://ebookcentral.proquest.com

Jacinto, C., Santos, F. P., Guedes Soares, C., & Silva, S. A. (2016). Assessing the coding reliability of work accidents statistical data: How coders make a difference. *Journal of Safety Research, 59,* 9–21. doi:10.1016/j.jsr.2016.09.005

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of Basic and Clinical Pharmacy, 5*(4), 87-88. doi:10.4103/0976-0105.141942

Kellog, M. B., Barker, M., & McCune, N. (2014). The lived experiences of pediatric burn nurses following patient death. *Pediatric Nursing, 40*(6), 297-300. Retrieved from http://www.pediatricnursing.net

Kondo, M., & Nagata, H. (2015). Nurses' involvement in patients'dying and death: Scale development and validation. *Omega, 70*(3), 278-300. doi: 10.1177/0030222815568959

Khalaf, I. A., Al-Dweik, G., Abu-Snieneh, H., Al-Daken, L., Musallam, R. M., BaniYounis, M., & ... Masadeh, A. (2017). Nurses'experiences of grief following patient death: A qualitative approach. Journal of Holistic Nursing: *Official Journal of The American Holistic Nurses' Association*. doi:10.1177/0898010117720341

Lavoie, S., Talbot, L. R., Mathieu, L., Dallaire, C., Dubois, M., & Courcy, F. (2016). An exploration of factors associated with post-traumatic stress in ER nurses. *Journal of Nursing Management*, *24*(2), 174-183. doi:10.1111/jonm.12294

Lenz, E. R., Suppe, F., Gift, A. G., Pugh, L. C., & Milligan, R. A. (1995). Collaborative development of middle-range nursing theories: Toward a theory of unpleasant symptoms. *Advances in Nursing Science*, *17*(3), 1-13. Retrieved from https://journals.lww.com/advancesinnursingscience/pages/default.aspx

Lenz, E. R., Suppe, F., Gift, A. G., Pugh, L. C., & Milligan, R. A. (1997). The middle-range theory of unpleasant symptoms: An update. *Advances in Nursing Science, 19*(3), 14-27. Retrieved from https://journals.lww.com/advancesinnursingscience/pages/default.aspx

Lewis, A., Cahn-Fuller, K., & Caplan, A. (2017). Shouldn't dead be dead?: The search for a uniform definition of death. *Journal of Law, Medicine & Ethics, 45*(1), 112-128. doi:10.1177/1073110517703105

Lindberg, E. E., Karlsson, P. P., & Knutsson, S. S. (2018). Reflective seminaries grounded in caring science and lifeworld theory – A phenomenological study from the perspective of nursing students. *Nurse Education Today, 61,* 60-65. doi:10.1016/j.nedt.2017.11.016

Lindsay, J., & Heliker, D. (2018). The unexpected death of a child and the experience of emergency service personnel. *Journal of Emergency Nursing: JEN: Official Publication of The Emergency Department Nurses Association, 44*(1), 64-70. doi:10.1016/j.jen.2017.06.002

MacDermott, C., & Keenan, P. M. (2014). Grief experiences of nurses in Ireland who have cared for children with an intellectual disability who have died. *International Journal of Palliative Nursing, 20*(12), 584-590. doi:10.12968/ijpn.2014.20.12.584

Miles, M., Chapman, Y., & Francis, K. (2015). Peeling the onion: Understanding others' lived experience. *Contemporary Nurse*, *50*(2-3), 286-295. doi: 10.1080/10376178.2015.1067571

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*(9), 1212 – 1222. doi: 10.1177/1049732315588501

Moschella, M. (2016). Deconstructing the brain disconnection-brain death analogy and clarifying the rationale for the neurological criterion of death. *The Journal of Medicine and Philosophy, 41*(3), 279-299. doi:10.1093/jmp/jhw006

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Pao-Feng, T. (2003). A middle-range theory of caregiver stress. *Nursing Science Quarterly*, *16*(2), 137-145. doi:10.1177/0894318403251789

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: SAGE.

Peters, L., Cant, R., Payne, S., O’Connor, M., McDermott, F., Hood, K., & ... Shimoinaba, K. (2013). How death anxiety impacts nurses’ caring for patients at the end of life: a review of literature. *The Open Nursing Journal*, *7*,14-21. doi:10.2174/1874434601307010014

Ramvi, E., & Gripsrud, B. H. (2017). Silence about encounters with dying among healthcare professionals in a society that ‘de-tabooises’ death. *International Practice Development Journal, 7*, 1-12. doi:10.19043/ipdj.7SP.009

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Thousand Oaks, CA: SAGE

Razeq, N. A., & Al-Gamal, E. (2018). Maternal bereavement: Mothers’ lived experience of losing a newborn infant in Jordan. *Journal of Hospice & Palliative Nursing, 20*(2), 137-145. doi:10.1097/NJH.0000000000000417

Reimer, A. P., Alfes, C. M., Rowe, A. S., & Rodriguez-Fox, B. (2018). Emergency patient handoffs: Identifying essential elements and developing an evidence-based training tool. *The Journal of Continuing Education in Nursing, 49*(1), 34-41. doi: 10.3928/00220124-20180102-0

Rudestam, K. E., & Newton, R. R. (2015). *Surviving your dissertation* (4th ed.). Thousand Oaks, CA: SAGE.

Sagarra, S. E. (2015). Researchers developing tools to help EMS providers ‘COPE’ with pediatric deaths. *EMS World, 44*(5), 35-36. Retrieved from https://www.emsworld.com

Saldaña, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Thousand Oaks, CA: SAGE.

Snow, T. M. (2014). Successful transportation managing common respiratory conditions of precious cargo: becoming an expert neonatal transport nurse. *Advances in Neonatal Care, 14,* S1-2. doi:10.1097/ANC.0000000000000103

United Nations, Department of Economic and Social Affairs, Population Division (2017). *World Mortality 2017 – Data Booklet*. Retrieved from http://www.un.org/en/development/desa/population/publications/pdf/mortality/World-Mortality-2017-Data-Booklet.pdf

Velarde-García, J. F., Luengo-González, R., González-Hervias, R., Cardenete-Reyes, C., Alvarado- Zambrano, G., & Palacios-Ceña, D. (2016). Facing death in the intensive care unit. A phenomenological study of nurses' experiences. *Contemporary Nurse, 52*(1), 1-12. doi:10.1080/10376178.2016.1194725

Whitehead, P. R. (2014). The lived experience of physicians dealing with patient death. *BMJ Supportive & Palliative Care, 4*(3), 271-276. doi:10.1136/bmjspcare-2012-000326

Wilson, J. (2014). Ward staff experiences of patient death in an acute medical setting. *Nursing Standard, 28*(37), 37-45. Retrieved from https://journals.rcni.com/nursing-standard

Williams, A. (2013). The strategies used to deal with emotion work in student paramedic practice. *Nurse Education in Practice, 13*(3), 207-212. doi:10.1016/j.nepr.2012.09.010

Wolf, L. A., Delao, A. M., Perhats, C., Clark, P. R., Moon, M. D., Baker, K. M., & ... 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. *Journal of Emergency Nursing, 41*(5), e23-e33. doi:10.1016/j.jen.2015.05.018

Velarde-García, J. F., Luengo-González, R., González-Hervias, R., Cardenete-Reyes, C., Alvarado- Zambrano, G., & Palacios-Ceña, D. (2016). Facing death in the intensive care unit. A phenomenological study of nurses' experiences. *Contemporary Nurse, 52*(1), 1-12. doi:10.1080/10376178.2016.1194725

Zambrano, S. C., Chur-Hansen, A., & Crawford, G. B. (2014). The experiences, coping mechanisms, and impact of death and dying on palliative medicine specialists. *Palliative & Supportive Care, 12*(4), 309-316. doi:10.1017/S1478951513000138

Zheng, R., Lee, S. F., & Bloomer, M. J., (2017). How nurses cope with patient death: A systematic review and qualitative meta-synthesis. *Journal of Clinical Nursing, 27*, 39-49. doi:10.1111/jocn.13975

Zhou, H., Zhang, L., Ye, F., Wang, H., Huntington, D., Huang, Y., & ... Wang, Y. (2016). The Effect of maternal death on the health of the husband and children in a rural area of China: A prospective cohort study. *Plos One, 11*(6), 1-14. doi:10.1371/journal.pone.0157122

Appendix A: Interview Protocol

Introduction

Thank you for taking the time to meet with me today to assist in my doctoral dissertation research.

Prior to Beginning

As you know this is being recorded. If at any time you wish to not answer a question or stop the interview process you may do so. Being in this interview would not pose any risks beyond those of typical daily life. There is no personal benefit to you; however, this research may have a positive impact on transport nursing in the future. Interview recordings and full transcripts will be shared with each interviewee, upon request. Transcripts with identifiers redacted will be shared with my university faculty along with my analysis. The interview recording and transcript will be destroyed as soon as I have completed my dissertation.

Introductory Statement

The purpose of this study is to explore the lived experiences of transport nurses experiencing patient death. As a transport nurse, you provide unique insight and experiences and that will be of great benefit in helping to explore how patient death is experienced by those in your profession.

Interview Questions

- Tell me about a time when you went on a transport and the patient ended up dying.
- What thoughts stood out to you after dealing with a patient death?

- Tell me about how you felt after that patient died.
- How did that experience of your patient dying affect you?
- What changes in your life, if any, do you associate with experiencing a patient death?
- Tell me how the experiences you have had with a patient death affect your day to day activities?
- How does your experience with patient death affect the work you do as a transport nurse?
- Tell me how your experience of dealing with a patient death as a transport nurse differs from past experiences of being a nurse in an acute care setting.
- How do the emotions of coworkers after a patient death affect you?
- Tell me how, if applicable, a death you've experienced in other settings was the same or different as a death experienced as a transport nurse.

Closing Statement

Thank you for taking the time to meet with me and share your personal experiences. Before we close, do you have any questions regarding the interview?

Appendix B: Recruitment Email/Flyer

Dear Transport Nurse,

My name is Josh Wall and I am a PhD student at Walden University. The proposed study described in this letter is being conducted as a part of my doctoral research. The study is being completed independently and is not affiliated with any transport provider programs. I am interested in learning about your experiences as a transport nurse, specifically surrounding experiences with patient death.

The purpose of this study is to examine the lived experiences of transport nurses experiencing patient death. The benefit of your participation in this study is to shed light on the experience of death as seen through the eyes of a transport nurse. As a transport nurse, you provide unique insight and experiences and that will be of great assistance in helping to explore how patient death is experienced by those in your profession.
Your experiences may potentially help facilitate positive change in the field of transport nursing by allowing other transport nurses, administrators, and employers to learn of your experiences and how they may potentially impact you personally and professionally. If you have been employed as a transport nurse for at least three years and have experienced the death of a patient while working in the role of transport nurse, your participation is requested. If you have worked less than three years as a transport nurse or have not experienced a patient death while in the role of transport nurse, you are excluded from participating. No preference is given to modes of transport nursing and may include helicopter, airplane, and/or ambulance.

If you agree to participate in this study, I will send you a consent form for review which you may sign upon arrival to the interview. I will also have you complete a brief demographic survey. While the preferred method of interviewing would be in person, an online interview via FaceTime, Zoom, or other electronic method may also be utilized. If this method of interview is conducted, I will request the consent form prior to conducting the interview. This interview should take no longer than 60 minutes of your time. Each participant will be asked a series of open-ended questions regarding their experience surrounding the death of a patient while working as a transport nurse. Your participation in this study is voluntary and can be ended at any time during the interview process.

If you are interested in participating in this study, please email me at Joshua.Wall@waldenu.edu and I will respond to set up a day and time to meet. Additional questions or concerns may also be addressed by contacting my dissertation committee chair, Dr. Anna Valdez, at anna.valdez@mail.waldenu.edu. Thank you for your consideration in participating in this study!

Kind regards,

Josh Wall
Walden University

Transport Nurses Needed for Research Study

Seeking 8-10 transport nurses to voluntarily participate in one-on-one interviews lasting 60 minutes

Study Purpose

The purpose of this study is to gain an understanding of how transport nurses experience patient death.

Inclusion Criteria

-Minimum 3 years experience as a transport nurse

-Experienced at least one patient death as a transport nurse

-Civilian transport including rotor wing, fixed wing, and/or ground ambulance

A $10 gift card will be provided for your volunteer efforts after the completion of the interview!

Qualified Participants Contact

Josh Wall

Joshua.Wall@waldenu.edu

801-703-3107

contact Josh Wall at:
Joshua.Wall@waldenu.edu
(801) 703-3107

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Appendix C: Consent Form/Demographics Sheet

CONSENT FORM

You are invited to take part in a research study about how patient death is experienced by transport nurses. The researcher is inviting transport nurses with three or more years of transport experience AND experienced a patient death as a transport nurse to be in the study. This form is part of a process called “informed consent” to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Joshua Wall who is a doctoral student at Walden University. The proposed study described in this letter is being conducted as a part of my doctoral research. The study is being completed independently and is not affiliated with any transport provider programs.

Background Information:
The purpose of this study is to gain an understanding of how transport nurses experience patient death.

Inclusion Criteria:

- Minimum of three years’ experience as a transport nurse
- Experienced at least one patient death as a transport nurse
- Civilian transport including any/all of the following transport methods: rotor wing, fixed wing, ground ambulance

Demographic Information

- No age minimum/maximum
- No limit on years’ experience (must meet three year minimum requirement)
- No gender preference
- Transport experience may include adults, pediatrics, and/or neonates

Procedures:
If you agree to be in this study, you will be asked to:

- Take part in a 60 minute interview where you will be asked questions about your experiences with patient death as a transport nurse.
- Conduct the interview in person (preferred) or by an electronic method (Skype, Zoom)
- Review your answers to ensure accuracy of the interview, if you wish

Here are some sample questions:

- Tell me about a time when you went on a transport and the patient ended up dying.
- How do your experiences with patient death affect the work you do as a transport nurse?

Voluntary Nature of the Study:

This study is voluntary. You are free to accept or turn down the invitation. No one at your place of employment will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop the interview at any time and for any reason.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of minor discomforts that can be encountered in daily life, such as stress, sadness, anxiety, or becoming upset when recalling the death of a patient. Being in this study would not pose risk to your safety or wellbeing.

It is important to remember that you do not have to answer any questions you are not comfortable with. In the event that discussing the death of a patient triggers distress, the interview may be stopped at any time.

Free mental health resources including hotlines and lists of local mental health professionals in your area may be found at mentalhelp.net. You are also encouraged to refer to your employer's employee assistance program (EAP) for further resources.

Although there are no personal benefits to you by participating in this study, your experiences may potentially help facilitate positive change in the field of transport nursing by allowing other transport nurses, administrators, and employers to learn of your experiences and how they may potentially impact you personally and professionally.

Payment:

Your time and participation in this study is greatly appreciated. As a small token of my gratitude, all participants will receive a $10 Starbucks gift card for their time.

Privacy:

Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as participant names, the location of the study, or transport programs will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by encrypted flash drive, password protected files in Dropbox, and password protected MacBook Air and iMac computers. All participants will be assigned a number that will be the only identifying feature in this study. Names of the participants and their respective programs will be stored separately from the interview data and destroyed upon completion of this study. Only myself and my dissertation committee consisting of three faculty members at Walden University will view this material. Data from the interviews will be kept for a period of at least five years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via phone/text/email:

Joshua.Wall@waldenu.edu

If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 612-312-1210. Walden University's approval number for this study is **12-24-18-0124090** and it expires on **December 23, 2019.** For face-to-face research, the researcher will give you a copy of this form to keep.

Obtaining Your Consent

If you feel you understand the study well enough to make a decision about it, please type your name and date of consent below. Finally, indicate your consent by replying to this email with the words, "I consent."

Printed Name of Participant ______________________________

Date of consent ______________________________

A Phenomenological Study of Lived Experiences of Transport Nurses Experiencing Patient Death

(Confidential Participant Demographic Form)

Please indicate your gender
☐ Female
☐ Male

Current age range
☐ 18-25 ☐ 25-35 ☐ 35-45 ☐ 45-55 ☐ 55-65 ☐ > 65

Please indicate the number of years of experience you have had in civilian transport nursing:

☐ <3 ☐ 3-5 ☐ 5-10 ☐ 10-15 ☐ 15-20 ☐ Over 20

Have you experienced the death of a patient while employed as a transport nurse?
☐ Yes
☐ No

Please indicate the method of transport where you work: (you may pick multiple)

☐ Rotor Wing
☐ Fixed Wing
☐ Ground Ambulance
☐ Other, please specify________________________________

Please indicate your main patient population served: (you may pick multiple)

☐ Neonates
☐ Pediatrics
☐ Adults
☐ Other, please describe______________________