Received: 23 September 2021 | Revised: 30 December 2021 | Accepted: 5 January 2022

DOI: 10.1111/jnu.12764

JOURNAL OF NURSING SCHOLARSHIP

The phenomenon of caring for older patients who are dying from traumatic injuries in the emergency department: An interpretive phenomenological study

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Abstract

Purpose: To gain greater understanding of what it means to care for older patients dying from traumatic injuries in the emergency department.

Design: A Heideggerian phenomenological design using the methods of Van Manen.

Methods: In-depth, face-to-face interviews were conducted with five emergency nurses who worked in an emergency department in Australia. Interview data were interpreted using a Heideggerian hermeneutic approach and guided by Van Manen's lifeworld analysis focusing on the experiential aspects of *lived time* (temporality) and *lived space* (spatiality) in the phenomenon.

Findings: The older patient reflects the passage of chronological time. This temporal aspect shaped the participant experience as there was a sudden awareness of the impact of the injuries sustained on the fragile physical condition of the patients. There was an unexpectedness and unpreparedness which was related to a precognitive assumption that the older patient would die from an age-related comorbid condition. Also of significance was the sacred liminal space in which the nurses worked to facilitate the dying patient transition from life to death.

Conclusions: The existential dimensions of temporality and spatiality revealed new insights into what it means to care for elderly patients dying from traumatic injuries. Temporal aspects were shaped by the longevity of the lives of patients and spatiality explored the liminal space where participants were morally guided to deliver end of life care with dignity and respect for a long-lived life taken by trauma.

Clinical relevance: The findings may contribute to further understanding of what shapes the experience for emergency nurses delivering EOL care in the ED, with specific relevance and focus on the older patient with traumatic injuries. Hermeneutic research may also encourage clinicians to explore phenomena to reveal new understandings that will inform further dialogue and future research.

KEYWORDS
death and dying, end of life, trauma, phenomenology

INTRODUCTION

Older patients increasingly present to emergency departments (EDs) in the final stages of their lives to be cared for by nurses who deliver end of life (EOL) care. The older population is living longer and engaging in more activity which exposes them to a higher risk of injury. Mortality data suggest a dramatic increase in trauma-related presentations to EDs in those aged 80 years and over (Hildebrand et al., 2016). In older patients, death due to an age-related illness is more anticipated than from traumatic injuries (Hogan, Fothergill-Bourbonnais, Brajtman, Phillips, & Wilson, 2016). Falls are acknowledged as the most prevalent event whereby older people experience a traumatic event (Llompart-Pou, Pérez-Bárcena, Chico-Fernández, Sánchez-Casado, & Raurich, 2017) with those on antithrombotic medication at an even higher risk of mortality (Meade et al., 2021). Higher mortality rates in the older population have been attributed to preexisting comorbidities, age-related physiological decline, slower recovery, and a higher risk of trauma-related complications (Sammy, Lecky, Sutton, Leaviss, & O'Cathain, 2016).

End of life care has been defined as care provided in the period leading up to death where it is acknowledged that death is inevitable (Razmaria, 2016). This definition differs from palliative care which accepts death as a natural outcome of a patient's disease process and focuses on noncurative symptom management (Devader, Albrecht, & Reiter, 2012). At the time a patient is recognized to be on a dying trajectory, the nurse becomes central to the dying experience and fundamental in the facilitation of "a good death." The concept of "a good death" is constantly referred to in EOL nursing research and is an overarching framework that guides nurses to deliver optimal EOL care (Bailey, Murphy, & Porock, 2011; Decker, Lee, & Morphet, 2015; Hogan et al., 2016). Anything that negatively impacts upon the nurse when facilitating a good death can lead to feelings of inadequacy in not meeting patient EOL needs (Hogan et al., 2016). Distress is particularly acute if nurses feel they are contributing to suffering in a dying patient (Decker et al., 2015; Hogan et al., 2016; Kongsuwan et al., 2016).

Qualitative studies are lacking in ED EOL care nursing experiences. There has been no prior qualitative research that has studied emergency nurses and the experience of caring for older patients on a death trajectory. The aim of this study was to gain insight into the structures of the phenomenon through the lens of emergency nurses when caring for older patients dying from traumatic injuries in an ED with a focus on the concepts of *lived time* (temporality) and *lived space* (spatiality).

METHODS

Theoretical framework

Hermeneutic phenomenology is the underpinning methodology of this study. The acknowledgment of the phenomenological "facts" of lived experience are meaningfully (hermeneutically) captured in language as an interpretive process. Hermeneutics is commonly referred to as the "science of interpretation" and as the study of the world of prereflection which captures the "as lived" of the experience and studies "what gives itself" (van Manen, 2017). It does so by bringing into focus, through language, those aspects of a phenomenon that are vivid while the meaningfulness of the experience is faded away or "reduced" (van Manen, 2017). Heidegger acknowledged that the fading of meaningfulness was necessary to "reveal" the essences that stand out in the phenomenon that generate a deeper or primal meaning of human existence and lived experience (Heidegger, 1962). Thus, the intention of hermeneutic research is to interpret essential dimensions of human experience in ways that compel attention and provoke further thinking (Finlay, 2013).

The intent of the study was to open the phenomenon to dialogue to gain greater understanding of the experience as shaped by the existential lifeworld concepts of *lived space* and *lived time* (van Manen, 1997). The concepts of spatiality and temporality are underexplored in EOL research and are strongly associated with interpretive phenomenological research and specifically hermeneutic phenomenology.

Participants/study site

The research site was a large tertiary, referral teaching and research hospital in Brisbane, Australia. The hospital was a major trauma center that provided a specialized trauma service receiving 61,000 adult presentations per year. Eligibility criteria for participation included: (a) working as a registered nurse in the ED for a minimum of the past 2 years, (b) caring regularly for trauma patients, and (c) willing to participate in the study. Participants were recruited using a purposive sampling strategy. In hermeneutic research, sample sizes are not predetermined and data acquisition does not achieve "saturation" because the goal is to uncover new insights and understandings in the phenomenon that are "new" but never final (Converse, 2012).

Data collection

Five participants who met the eligibility criteria participated in semi-structured face-to-face interviews conducted by the principal investigator, a female emergency nurse with over 20 years of clinical experience in critical care. Participants were invited to share any experiences of caring for elderly patients who were dying from traumatic injuries in the ED. The researcher did not ask prestructured questions, supported participants in "seeing" for themselves and sought to stay close to the lived experiences by asking participants to think of specific situations and to give examples to further illustrate meanings. The researcher maintained a reflexive journal, recorded decision-making steps and narrative notes after the interviews for transparency and for data analysis. All audio-recorded interviews were transcribed verbatim to an electronic document. The interviews were conducted in August 2017, ranged between 60 and 90 minutes.

Ethical considerations

Human Research and Ethics Committee approval was granted by the hospital where the participants were recruited and the university where the principal researcher was a postgraduate student. All participants were informed about the study, were provided with written information, and gave written consent to participate. Participants were able to withdraw from the study at any time without penalty. No identifying information was recorded. Additional safety considerations were designed to support participants if the interview experience raised feelings of discomfort or distress during, or after, the interview. A brochure was given to all participants at the beginning of the interviews which outlined several options for psychosocial support follow-up if needed.

Data analysis

Interview data were interpreted using a Heideggerian hermeneutic approach and guided by the six steps from the work of Max van Manen (van Manen, 1997). The steps were turning to a phenomenon of interest, investigating experience as we live it, reflecting on the essential themes which characterize the phenomenon, describing the phenomenon through the art of writing and rewriting, maintaining a strong and orientated relation to the phenomena, and balancing the research context by considering the parts (van Manen, 1997). A framework incorporating van Manen's fundamental existential lifeworld themes also informed reflection during the analytical process. The concepts of *lived space* (spatiality) and *lived time* (temporality) were used to interpret the dimensions of the experience and to develop new language (van Manen, 1997). The fundamental themes are conceived to belong to the existential realm which all human beings experience in the world. (van Manen, 2017). The existential themes are thus considered fundamental to the universal theme of life and are always present, although any one may dominate for each phenomena studied (van Manen, 1997).

The phenomenon (*lived experience*) shows itself while a participant is living through an experience at the time of interview. To interpret the text accurately, the researcher entered the *hermeneutic circle* which was accomplished by responding and listening to the call of the topic, and moving continuously between the whole (the topic) and data (participant experience) while extensively reading, rereading, reflecting, and writing (Moules, 2015).

Each audio interview was listened to for a minimum of three times while reading the transcriptions to ensure immersion in the data. Transcripts were then reread to gain a sense of the whole, with a narrative for each participant written in the researcher's reflexive journal to enable comparison between the parts and the whole. This process enabled the researcher to engage hermeneutically beyond participants' words and reflections to capture something of implicit horizons of meaning and *pre*-reflective experience (Finlay, 2013). Initially, this process generated 101 transcript themes which were reduced to 30 paradigm cases. The cases were further separated into essential and nonessential essences of the phenomenon. The essential essences of the phenomenon were then reflected upon from van Manen's lifeworld approach with a focus on the two existential themes of *lived space* and *lived time* to explore the lifeworld's of the experience of the emergency nurses.

Validity and reliability/rigor

Previous engagement with a topic area is an asset in hermeneutic research and enables the researcher to be better prepared for understanding (Thirsk & Clark, 2017). The lead researcher has over 20 years of experience as an emergency nurse delivering EOL care. Rigor in hermeneutic research is reflected in the move beyond typical understanding of an intervention to a more detailed and in-depth account of what is going on in the context of the phenomenon (Thirsk & Clark, 2017).

FINDINGS

The sample consisted of one male and four females aged between 25 and 52 years of age with ED experience ranging between 2 and 25 years. No participants withdrew from the study.

Temporality

Lived time (temporality) is subjective time and explores the temporal dimensions of past, present, and future which constitute the horizons of a person's temporal landscape (van Manen, 1997). Emergency nurses who care for older patients critically injured from a traumatic event are often exposed to the unexpected and unpredictable nature of sudden death in an older person. While it is acknowledged that death is more anticipated in older patients (Hogan et al., 2016), this does not necessarily translate into feeling more prepared for death. Regardless of age, it has been found that when confronted with sudden traumatic death, emergency nurses and staff can feel unprepared and inadequate with the experience (Malone, 2000; Saines, 1997). It is generally anticipated that the older person will die from an age-related condition and there will be "time" to say goodbye as noted by Participant A:

> Let's say someone is dying of cancer. It's almost like that was the natural progression of that diagnosis… but a trauma because it's so instantaneous and you don't see it coming and no one's prepared for it, it's harder.

The participants demonstrated a strong temporal association with elderly patients. The impending threat to life created a sense of urgency which made participants consciously aware of a timeline

in the patient's life. Participants experienced a temporal shift during the time preceding the confirmation of unsuccessful lifesaving efforts and active resuscitation when it was not known if the patient would survive. As it was determined that the patient had sustained unsurvivable injuries, the patient was then committed to a dying trajectory. The participants described the nature of the injuries experienced by older patients as catastrophic and the fragility of life was illuminated as these low-risk events commonly occurred around the home.

The realization that the older patient had experienced an unsurvivable event translated into an "absence of future time," as time was abruptly taken from the patient. This was particularly poignant for an older patient as there is relatively less potential "future time" to be lived than a young or middle-aged person. The vulnerability of older patients prompted participants to act as advocates in ensuring access to timely care and treatment. There was a perceived inequity in access to resuscitative care and participants advocated for older patients to have a choice of lifesaving treatments which may "buy" them more time. All patients have the fundamental right to lifesaving interventions and yet here there was the ethical dilemma of wanting to deliver benevolent care while adhering to the ethical principle of nonmaleficence (do no harm) for older trauma patients. One participant expressed the view that older patients have "earned" the right to access choices in their health care as measured by their lifetime contribution to society

> But I thought you know here's a bloke in his 70s, worked his whole life and this little surgeon's saying no, we're not going to do it he's probably going to die on the table. It was a poor decision on their part, fair enough he probably would have died on the table, but he wanted to have a crack at it.
>
> (Participant D)

Time was experienced in contrasting ways for living and dying patients. Living patients were able to access an unlimited amount of nursing time, while dying patients had access to a limited time of nursing care. Past ED research has acknowledged this inequity of access to nursing care where living patients are prioritized over dying patients (Bailey et al., 2011; Hogan et al., 2016). This was particularly noted where participants cared for older trauma patients and where younger trauma patients were more likely to receive ongoing resuscitative care and access to intensive care units. There were conflicting feelings when participants left older dying patients, with no family or friends, to attend to other patients. Time restrictions directly impacted the ability to deliver a patient a good death:

> What inhibited my care of him that day was my workload, so being pulled back into an area that was busy.
>
> (Participant B)

The value of the patient's life was qualified by measuring life in terms of the longevity of the lives of older patients in fulfilling their potential as human beings. The reality of an older trauma patient dying was perceived differently compared to a younger trauma patient. In the case of younger dying patients there was the loss of the potential life that had not been experienced, as articulated by Participant E:

> I guess with younger people who die, most of the time it's been very traumatic like they've been involved in a huge accident. You can see that it's a waste of life, but I guess when it's an older person you can kind of think well, they've had a life.

The very essence of having a life to live carries the certainty that death will come to all. There was an almost celebratory sense that acknowledged this specific time in the older patient's life as special. The event of dying was celebrated by participants as a special time point in the older patient's life and there was an appreciation of the privilege of witnessing the transition:

> It's a heightened experience, like you know this is a very special moment. This is a special moment in this person's life.
>
> (Participant B)

Other ED nurses have also perceived such an experience as a privilege to be with dying patients and families (Gerow et al., 2010).

Spatiality

The existential theme of spatiality or *lived space* was experienced as both physical and figurative dimensions of space. Once established on a dying trajectory there was a need to create a private and sacred space in the ED to which patients could be transferred to die. The *space* facilitated a transition from life to death. The participants described feelings of distress when exposed to the older patient suffering in the space. The moral distress was attributed to decisions made by medical staff or family where they felt the patient was exposed to interventions that exacerbated suffering. Participant C noted in relation to family choices:

> When they say, 'Oh yes I want everything done'... you know this lady... . the subcutaneous emphysema it was huge you know; it was like she was blowing up with air and it was traumatic. It would've been traumatic for the family; you know at 89 passing away at your granddaughter's wedding.

Despite often experiencing moral conflict, participants continually worked toward maintaining a dignified space for the dying older patient:

> Do you go further down the path and expose the patient to unnecessary insult to have the same outcome,

> or do you give them dignified pain relief and just let them pass.
>
> (Participant C)

Older patients occupy and inhabit a lived space in society. The loss of their lives brought an awareness of their disappearance from that space in which they had lived as vividly captured by the participants:

> You know she's obviously looked after herself, fit and mobile, she was 82 and was just out… You know, and then she's been taken out by a bus. (Participant A). They were at home, they were independent, they were coping and then they're not… it's just so sudden, it's like snuffing out a candle flame.
>
> (Participant C).

Older patients who were not able to access time-critical lifesaving interventions such as surgery or intensive care remained in the ED to die and were moved to an area of isolation for privacy. This also meant the patients had reduced access to nursing care as the surviving patient needs were prioritized. Nonetheless, alone and dying from a sudden traumatic injury instead of an aged-related illness imbued in participants, a desire to be present and bear witness to the transition to death:

> I wanted to be there for him. I wanted him to know that he wasn't alone, and I think he knew that on some level. I think he knew that.
>
> *(Participant B)*

DISCUSSION

Where an older person succumbs to a life-limiting event such as a trauma, the fragility and uncertainty of the physical body and of life is accentuated. Traumatic events in older patients often are situated in routine day-to-day life and are frequently classified as low-impact injuries with most occurring from falls (Hildebrand et al., 2016). This was confirmed by all participants in this study who described scenarios of caring for older patients who had experienced significant head injuries from falls which ultimately led to death. Falls were described as secondary to a cardiac or cerebral event, or as a mechanical fall with a secondary head injury. These patients were portrayed as victims while "doing life" as opposed to trauma-related injuries from risk taking activities being associated with a younger aged cohort (Kongsuwan et al., 2016).

The concepts of temporality (*lived time*) and spatiality (*lived space*) are two fundamental existential elements that provide a life-world framework for interpretive analysis when exploring human experience (van Manen, 1997). These two concepts contributed different but revealing aspects of the experience. Within hermeneutical enquiry, there is a strong connection between past, present, and future when understanding participant situated experiences (Moules, 2015).

Life and time are interrelated; when there is a threat to life, there is also a threat to time. The temporal experience of "being in the world" orientates a person through an awareness of linear time as experienced through a past, the present, and potential future. The chronicle of this experience is commonly captured as a "lifetime." Elderly patients reflect the passage of *lived time* as they are the physical representation of the process of aging against the passage of time.

Participants demonstrated an acute awareness of time in the experience. Their understanding of the existential threat to the patient's life was shaped temporally by reflecting on the long-lived life and the now abruptly shortened future for the patient. Past research has acknowledged that when the future loss of a patient's existence is anticipated it can provoke grief responses in nurses (Gerow et al., 2010). This study revealed a heightened sadness at a suddenly shortened life that prompted reflection on the grandparents of participants.

Older persons live with age-related conditions from which they mostly die. An awareness of "running out of time" and feeling unprepared has been acknowledged by emergency staff in sudden death situations (Saines, 1997). For the older person, time may appear to pass slowly. The perception of the slow movement of time contrasted with the sudden impact of a fatal traumatic event was experienced as a coming together of opposing energies which contributed to participant feelings of "unexpectedness." This experience was underpinned by a shattering of the assumed world where the older person would die from a chronic condition that evolves over time.

Dying is a transitional process that is guided by the temporal and not objective clock. All participants understood this process and acknowledged that EOL care was optimized when able to give the patients and family their time. Suggestions to improve EOL care all related to time, such as improving nurse–patient ratios when caring for a dying patient, taking dying patients off organizational time targets when it is determined that they are on a dying trajectory, and the use of death doulas so that nurses can focus on the needs of surviving patients.

Lived space is largely preverbal and not normally reflected upon, but we know that the space in which we find ourselves affects the way we feel (van Manen, 1997). Once established that a patient was on a dying pathway there was an awareness of a need to create an unseen sacred space in the department where patients could transition to die. The work of nurses in this sacred space has been described in past research as a "curtain of protection" which mitigates the grieving process and maintains supportive EOL care (Gerow et al., 2010). Similar to past ED nursing research, participants advocated for such a space to ensure a good death through seclusion, quietness, space, and time (Hogan et al., 2016). It was important to hold and protect the space for the transition from life to death.

Bearing witness to the transition facilitated a range of emotional reactions and feelings. As confirmed in past research, feelings of distress arose when witnessing the older patient suffering in the EOL care space (Decker et al., 2015; Gerow et al., 2010; Malone, 2000).

Conversely, bearing witness to the transition was also associated with a sense of celebration of the dying patient's life as an act of respect for another human being. It was a privilege to witness another human being's transition in the liminal space. The nature of this human connection between nurse and dying patient has been acknowledged in past ED EOL research and characterized as transcending the typical "professional" relationship (Gerow et al., 2010).

Central to facilitating a good death for patients in the ED is maintaining dignity. Dying with dignity was embraced as a basic human right in which the participants worked to deliver respectful, supportive EOL care in the space. Ensuring dignity for dying patients in the ED has been reflected upon in past hermeneutical research as the sociocultural acceptance of death and the finitude of the human condition (Monteverde et al., 2017). Providing dignity to an older patient who has experienced significant physical traumatic injuries was acknowledged as critical. Participants actively engaged with minimizing physical suffering for the patient as they were aware that addressing the visual traumatic injuries of the patient would impact on the memory making of the grieving relatives in the space.

The temporal dimensions of past, present, and future constitute the horizons of a person's temporal landscape (van Manen, 1997). The understanding of what it means to care for an older patient dying from traumatic injuries was associated with a strong connection to temporality. This was revealed in the phenomenon as all nursing care was referenced to the impact of age. Understanding of the temporal horizon in the participant experience of the phenomenon was summarized as the older patient having lived a long life, a sudden threat to their present life, and a shortened future life. The dimension of spatiality was centrally focused on the concept of "protecting the space" for a patient's transition to death. The role of the emergency nurse in this space was to facilitate "a good death" and the bearer of truth through an existential connection with the dying patient characterized by human connection.

Limitations

The findings of a hermeneutic study reveal essences that belong to the phenomenon. The essences are not part of participant experiences but rather interpreted as dimensions of the whole experience. As such, the essences do not belong to individual participants and therefore cannot be generalized to individual emergency nursing experiences. This is not a limitation but a contribution of new understanding in this area which can be further built upon by future research.

CONCLUSIONS

This study explored the phenomenon of caring for an older patient dying from traumatic injuries in the ED. Van Manen's lifeworld analysis utilized the existential lens' of temporality and spatiality to explore the lived experiences of ED nurses. These aspects of experience, underrepresented in EOL care research, facilitated new understandings about what it means to care for an older patient who is dying from traumatic injuries. The older patient reflects the passage of chronological time. The temporal aspect shaped the participant experience when caring for the dying trauma patient as a sudden awareness of the impact of the injuries sustained on the aging, fragile condition of the patients. The patient experience of living a long life, abruptly taken away, facilitated a tension in participants who revealed unexpectedness and unpreparedness related to a precognitive assumption that the older patient would die from an age-related comorbid condition. Time was experienced as limiting when the patient was committed to a dying trajectory. The study further revealed the sacred liminal space in which nurses work to facilitate the dying patient transition from life to death. The participants were morally guided to facilitate a good death, one which was focused on the provision of dignity and respect while maintaining a humanistic connection with the patient throughout the entire encounter.

ACKNOWLEDGMENTS

The authors acknowledge the contribution by Dr Alan Barnard in interview training techniques and data analysis. Open access publishing facilitated by Queensland University of Technology, as part of the Wiley - Queensland University of Technology agreement via the Council of Australian University Librarians. WOA Institution: Queensland University of Technology Blended DEAL: CAUL 2022.

CLINICAL RESOURCES

- Self-Care Supporting Staff Working in Palliative Care. https://www.palliaged.com.au/tabid/4316/Default.aspx
- End of life care and well-being for the nursing and midwifery workforce. https://www.rcn.org.uk/professional-development/professional-services/end-of-life-care-and-wellbeing-for-the-nursing-and-midwifery-workforce
- End-of-life ESSENTIALS-education for acute hospitals: My Toolkits. https://www.endoflifeessentials.com.au/tabid/5264/Default.aspx

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

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How to cite this article: Ryan, K., Windsor, C., & Jack, L. (2022) The phenomenon of caring for older patients who are dying from traumatic injuries in the emergency department: An interpretive phenomenological study. *Journal of Nursing Scholarship*, *54*(5), 562–568. https://doi.org/10.1111/jnu.12764