REVISTA DE ENFERMAGEM REFERÊNCIA
homepage: https://rr.esenfc.pt/rr/
ISSNe: 2182.2883

RESEARCH ARTICLE (ORIGINAL)

Family care in the emergency department: nurses' lived experiences

O cuidado à família no serviço de urgência: a experiência vivida do enfermeiro

La atención a la familia en los servicios de urgencias: la experiencia vivida por el enfermero

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Abstract

Background: Caring for the family in the emergency department is challenging for nursing due to the specificities and challenges of the context. Although the evidence reveals the family's experiences and needs, little is known about nurses' experiences.
Objective: To understand nurses' lived experiences of caring for the family in the emergency department.
Methodology: Qualitative study with Van Kaam's phenomenological approach. In-depth interviews were conducted with 11 nurses. The Moustakas' modified method guided data analysis.
Results: Nurses' lived experiences revealed eight dimensions: 1) "Feeling responsible"; 2) "Initially welcome the family"; 3) "Host the family in the emergency department"; 4) "To be fully present"; 5) "To cuddle in suffering"; 6) "Dance, with the family, in a borderline situation"; 7) "Comfort guided on the information"; and 8) "Let yourself be carefully touched by the family's experience".
Conclusion: Nurses' experiences reveal dimensions of the phenomenon in clinical practice, highlighting the importance of therapeutic communication with the families, their presence in resuscitation situations, and the need for family conferences.

Keywords: nursing care; emergency service, hospital; family nursing; qualitative research; philosophy, nursing

Resumo

Enquadramento: Cuidar a família no serviço de urgência é desafiante para a enfermagem pelas particularidades e desafios do contexto. A evidência revela as experiências e as necessidades da família, contudo pouco é conhecido sobre as experiências dos enfermeiros.
Objetivo: Compreender a experiência vivida dos enfermeiros no cuidado à família no serviço de urgência.
Metodologia: Estudo qualitativo com abordagem fenomenológica de Van Kaam. Realizaram-se entrevistas em profundidade a 11 enfermeiros. O método modificado de Moustakas norteou a análise de dados.
Resultados: A experiência vivida dos enfermeiros revelou oito dimensões: 1) "Sentir-se responsável"; 2) "Acolher, inicialmente, a família"; 3) "Hospedar a família no serviço de urgência"; 4) "Estar, plenamente, presente"; 5) "Aconchegar no sofrimento"; 6) "Dançar, com a família, numa situação-limite"; 7) "Confortar, pautadamente, com a informação"; e 8) "Deixar-se tocar, com cuidado, pela vivência da família".
Conclusão: As experiências dos enfermeiros desocultam dimensões do fenómeno na prática clínica, destacando-se a importância da comunicação terapêutica com a família, a sua presença em situações de reanimação e a necessidade de implementar conferências familiares.

Palavras-chave: cuidado de enfermagem; serviço hospitalar de emergência; enfermagem familiar; pesquisa qualitativa; filosofia em enfermagem

Resumen

Marco contextual: La atención a la familia en urgencias es un reto para la enfermería debido a las particularidades y los desafíos del contexto. Las pruebas muestran las experiencias y necesidades de la familia, sin embargo, se sabe poco sobre las experiencias de los enfermeros.
Objetivo: Comprender la experiencia vivida por los enfermeros en la atención a la familia en los servicios de urgencias.
Metodología: Estudio cualitativo con el enfoque fenomenológico de Van Kaam. Se realizaron entrevistas en profundidad a 11 enfermeros. El método Moustakas modificado guió el análisis de los datos.
Resultados: La experiencia vivida por los enfermeros mostró ocho dimensiones: 1) "Sentirse responsable"; 2) "Acoger inicialmente a la familia"; 3) "Alojar a la familia en el servicio de urgencias"; 4) "Estar plenamente presente"; 5) "Acercarse al sufrimiento"; 6) "Acompañar a la familia en una situación límite"; 7) "Consolar a partir de la información", y 8) "Dejarse afectar, con cuidado, por la experiencia de la familia".
Conclusión: Las experiencias de los enfermeros muestran dimensiones del fenómeno en la práctica clínica, y destacan la importancia de la comunicación terapéutica con la familia, su presencia en las situaciones de reanimación y la necesidad de implementar conferencias familiares.

Palabras clave: atención de enfermería; servicio de urgencia en hospital; enfermería de la familia; investigación cualitativa; filosofía en enfermería

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Received: 12.01.21
Accepted: 03.08.21

How to cite this article: Sá, F. L., & Velez, M. A. (2021). Family care in the emergency service: The nurse's lived experience. *Revista de Enfermagem Referência*, *5*(8), e21007. https://doi.org/10.12707/RV21007

Introduction

Nursing care to critically ill patients (CIPs) has evolved significantly in terms of quality of care thanks to the relevant technological investment that has been made in this area (Sweet & Foley, 2019). Evidence shows that the change in one of the members of the family system, through the impact of the illness, changes the other family members (Shajani & Snell, 2019). The critical illness of a loved one imposes significant challenges on the family, particularly due to the experience of the finiteness of human life, the uncertainty of the prognosis, and the technologically unknown environment, being associated with psychological consequences including anxiety, depression, and complicated grief (Kreuz & Netto, 2021). Thus, from a holistic approach focused on the patient, the family, and the health professional, which is the purpose of the nursing intervention, it is important to care for the family of CIPs in the emergency department (ED). Nurses' lived experiences are a key source of knowledge when the purpose is to bridge the gap between evidence and clinical practice, thus optimizing the transferability of nursing knowledge (Moxham & Patterson, 2017). Nurses' experience reports the intentionality in caring, in which the dimensions of the phenomenon represent the integral constituents of the essence of consciousness towards the Other. The state of the art on this topic reveals studies on the families' experiences and needs in the ED (Barreto et al., 2019; Berbís-Morelló et al., 2019; Hsiao et al., 2017; Yildirim & Özlü, 2018). Despite this, little is known about nurses' experiences (Sá et al., 2015). Therefore, this study aimed to understand nurses' lived experiences of family care in the ED

Background

In Portugal, the presence of the family in the ED was formalized through the right to accompany patients in the ED (Law no. 33/2009). The emergence of an institutional culture based on integrated and family-centered responses requires the reorganization of the ED. During the admission process, the person has the right to appoint a companion or, if this is not possible due to a change in the state of consciousness, a companion will also be assigned through proof of the degree of kinship (Law no. 33/2009). The ED is a highly differentiated and technologically challenging context in which the nursing decision-making process is complex, so nurses often need to prioritize the care of CIPs (Sweet & Foley, 2019), pushing family needs into the background. Still, nurses have the skills to assess and intervene to meet the family's needs (Shajani & Snell, 2019), being the health professionals in closer contact with families in the ED, which creates a window of opportunity for differentiated intervention.

The family of the CIP experiences intense suffering, which is different in nature from that of CIPs (Kreuz & Netto, 2021). These patients are often under the effect of sedation and without temporal awareness of the endless minutes of waiting experienced by their family between waiting rooms, sporadic visits, complementary diagnostic tests, surgeries, and resuscitation procedures. The family is in a situation of great vulnerability, requiring therapeutic nursing interventions (Yildirim & Özlü, 2018). Family participation in care optimizes the delivery of nursing care to patients (Shajani & Snell, 2019). A nationwide study found that nurses assign high levels of importance to families in nursing care in different care settings, including the ED (Fernandes et al., 2015). However, caring for the family of the CIP requires specialized nursing skills due to the particularities and challenges imposed by the emergency setting (Sweet & Foley, 2019). Thus, it is important to uncover nurses' lived experiences of caring for the family of CIPs in this context.

Lived experiences are closely linked to the primitive experience of the human being, that is, the fact felt while constructing reality from a humanistic and existential perspective (Van Kaam, 1959). A lived experience is the experience of human beings at the core of their relationship with the world around them and the basic foundation in their internal process of becoming aware of themselves and others. Lived experiences focus mainly on the individual perspective by describing how the phenomenon affects the body, the existence, and the world of each human being, in a balance between the individual and the universal (Husserl, 2017). The phenomenon is not neutral for the human being and entails a series of unconscious mental constructs, which only by force of intentional evocation submerge into the word, giving voice to the phenomenon under study. Therefore, the focus was the human experiences restricted to a given situation and shaped by a unique context - the ED - where nurses are actors and cobuilders of a phenomenon in the health/illness process - caring for the family of CIPs -, whose constituent dimensions should be better understood to improve care.

Research question

What are nurses' lived experiences of caring for the family of critically ill patients in the emergency department?

Methodology

In qualitative research, the researcher seeks to grasp the research object holistically, considering its wholeness, its particularities, and the context of the phenomenon (Creswell, 2013). Considering the subjectivity of the lived experience involves assuming a broader understanding of human experiences, supported by inductive reasoning. As a methodological approach, phenomenology allows nursing to understand reality beyond the visible and what it means to experience a given phenomenon (Moxham & Patterson, 2017). Phenomenology allows answering the research question by accessing nurses' lived experiences, starting from how care is experienced and structured and shapes clinical practice.

Van Kaam's (1959) descriptive phenomenological approach was adopted, which seeks to capture the essence of consciousness itself before the individual's theoretical conception of the experience. Thus, it develops individuals' perceptive capacity, focusing on the sensitivity of human relations in a concrete situation where it is important to understand their forms of participation and experiences. The sources of narratives in the health area can vary and, when narrated in the first person, they express feelings, self-knowledge, and therapeutic desires towards the pre-reflected situation (Creswell, 2013). The participants in this study were 11 nurses working in the same hospital unit who met the following inclusion criteria: working in an ED; having lived a significant experience of caring for a family with a CIP; having inner skills to describe the phenomenon; and accepting to voluntarily participate in the study. The exclusion criteria included nurses who did not provide direct nursing care and mainly had management functions in the ED. Participants were selected using the non-probability convenience sampling method (Streubert & Carpenter, 2013). All participants were informed of the study objectives and the possibility of withdrawal at any stage. The favorable opinion of the Ethics Committee (No. 2923) and the authorization of the hospital's Board of Directors were obtained, and all ethical considerations were followed throughout the research.

In the first semester of 2019, in-depth interviews were conducted with an average duration of 60 minutes at a location chosen by the participants. No time restrictions were imposed. Most of the interviewees selected a private room within the hospital unit, where the participants were asked to answer the following question: "Can you tell me about your experience of a meaningful situation of caring for the family of a critically ill patient?". This open-ended question aimed to access a specific moment in the individual's internal time in which the retention and anticipation of the preconscious processes of experience are present (Husserl, 2017). Therefore, the intention was to explore the phenomenon experienced in-depth, allowing participants to freely go through the lived experience until finding the essence of the structure. A researcher's Travel Journal was used as a faithful memorandum of the contextual aspects and the interaction between the interviewer and the interviewee, such as the interviewee's non-verbal language and the researcher's perceptions, allowing for data compilation and assessment. This aspect is important given that what is not verbalized can be as important for understanding the phenomenon as what is verbalized.

After data collection, the audio-recorded interviews were transcribed in full. The interviewees - P1 to P11 - and the sociodemographic variables (gender, age, education level, marital status, and family status) were coded. Two researchers analyzed the data using the following procedural steps of the Moustakas' (1994) Modified Van Kaam method: 1) Listing and Preliminary Grouping: Horizontalization; 2) Reduction and Elimination; 3) Clustering and Thematizing the Invariant Constituents; 4) Final Identification of the Invariant Constituents and Themes by Application: Validation; 5) Construction of an Individual Textural Description; 6) Construction of an Individual Structural Description; and 7) Construction of a Structural-Textural Description: Composite Description. Although based on pure and transcendental abstraction, the method seeks rational knowledge focused on the complexity of reality, through a systematic return to narratives as a way of structuring and validating the findings and grounding the meanings in the participants' discourse (Moustakas, 1994). Both researchers discussed all dimensions of the phenomenon until consensus was reached. The essential structure of the phenomenon was reached by reading and rereading the interviews and intersecting the constituents that emerged from the data.

Results

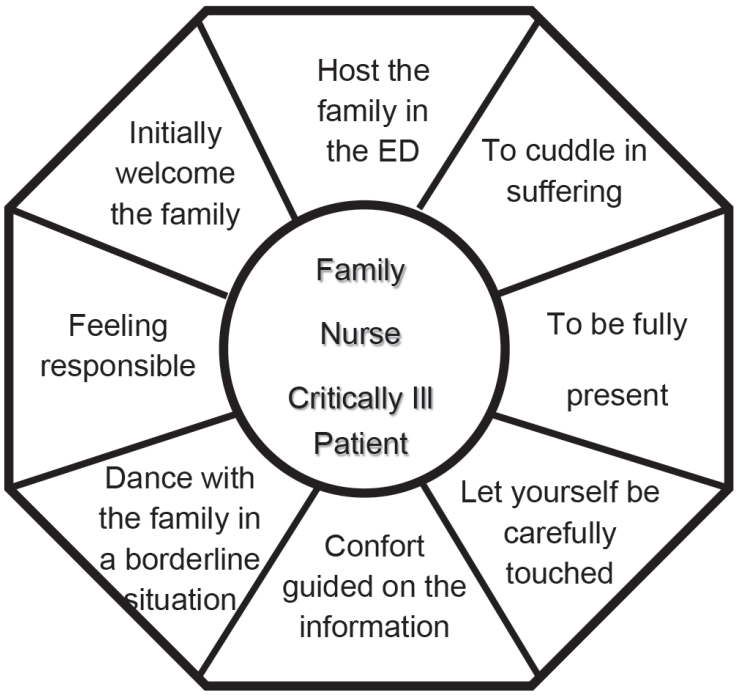
The experiential narrative is full of descriptions of nurses' emotional experience of limit and complex situations. Data show that the meaningful situations reported by nurses of caring for the family of CIPs mostly involve young adults at the end of life due to a sudden traumatic event such as road accidents, falls, and violence with penetrating trauma resulting, for example, from firearms. Among the interviewed participants, there was balanced participation of women (45%) and men (55%), with a mean age of 34 years and a mean length of professional experience of 11 years. Most of them had completed postgraduate education (specialization, master, and post-graduation; 82%). Concerning family status, most of them were married or cohabiting (64%) and had children (73%).

Understanding the essential structure of the phenomenon reveals a composite description of nurses' lived experiences consisting of eight dimensions: 1) "Feeling responsible"; 2) "Initially welcome the family"; 3) "Host the family in the emergency department"; 4) "To be fully present"; 5) "To cuddle in suffering"; 6) "Dance, with the family, in a borderline situation"; 7) "Comfort guided on the information"; and 8) "Let yourself be carefully touched by the family's experience".

According to Moustakas (1994), the composite description of the phenomenon should be presented graphically. Thus, the eight essential and structural dimensions of the composite description of the phenomenon are presented using a geometric figure, highlighting how they are interconnected and illustrating the essence of the phenomenon of caring for the family of the CIP in the ED from nurses' perspective (Figure 1).

Figure 1

Multidimensional octagonal model representing the composed description of the phenomenon of caring for the family of the CIP in the ED, including the family, the patient, and the nurse surrounded by a time spher



Thus, the composite description of the phenomenon encompasses these eight dimensions of experience that coexist in the same time and space, have the same meaning for nurses, and are integral parts of the same phenomenon.

Discussion

The family, the nurse, and the CIP are central elements of the phenomenon and, despite the fleeting moments that they experience together, in this therapeutic encounter, they are wrapped in a time sphere because time slows down and makes them live this experience in a unique way. Time is an immaterial phenomenon, given that temporal ordering is an experience synchronized with consciousness and emotional states, sometimes perpetually apprehended by lived experience and sometimes by intelligibility (Marcel, 2013), as a distinct and paradoxical reality of the encompassing, infinite, and universal environment. Subjective temporality translates the experience of time in light of the interiority of the subject (Van Kaam, 1959), encompassing thoughts, sensations, perceptions, and feelings that influence the very experience of time in a given situation, offering those involved a sense of mastery of the properties of time itself. The several dimensions of the phenomenon are exemplified below through illustrative excerpts from nurses' narratives.

The dimension *Feeling responsible* emerges when nurses narrate an impetus to meet the family in distress.

> It was not an easy situation at all . . . In the meantime, I thought of bringing the daughter next to the patient because the minutes, not the seconds, were passing. And the patient's condition was deteriorating right there in front of our eyes. I felt I had to do something! (P11)

The sense of professional and moral duty in the impossibility of not acting and the ambivalence towards the challenges arise in response to the other's call for ethical action (Levinas, 2011). A sense of duty to help the suffering other emerges in this dimension of the phenomenon.

> In the resuscitation room, at the initial approach, the family didn't go in and stayed outside. I told the daughters and granddaughter to sit down and that I would give them some information as soon as possible, but what does this mean? They're there with their hearts in their hands. Not knowing what's going on . . . I went to see them as soon as I could because I could only imagine what they were going through. (P10)

From an ethical and deontological perspective, the family must be included as an integral part of the humanization of nursing care (Shajani & Snell, 2019). It is not merely an expansion of the sphere of care, but rather a closer look at the family as an integral part of the individual and a focus of nursing care.

The dimension *Initially welcome the family* arises because the family experiences an unexpected life event, which makes them go to the ED, where they contact the nurses who care for their loved one in a limit situation.

> The lady came here completely alone, without

> knowing anything, without knowing about her son, how he was, if he was alive, if he was dead.... She came here in tears and couldn't even speak . . . . but I took her to the room and told her that her son was stable and that she would see him in a moment, I even gave her a glass of water. (P2)

The nursing welcoming allows for the beginning of the interpersonal relationship through active listening and dialogue (Costa et al., 2016). Families enter the ED looking for their loved one, often anxious, seeking information about their condition, and expressing the desire to see them.

> When the daughter got here (ED), she came up to me, grabbed my hands, and told me right away that she wanted to see her mother. She was very anxious and worried. And the patient was receiving respiratory and circulatory support for organ harvesting ... So it was very complicated to manage that whole situation, but I introduced myself, and then took her to the room and we talked about the last time she saw her mother . . . before the hit-and-run. (P1)

As a type of nursing care, the welcoming allows nurses to welcome the family in a humanized way, seeing the family as a subject and a participant in the care process, thus increasing the quality of care (Costa et al., 2016). Nurses are the health professionals on the frontline, those with whom the CIP and his/her family first contact; therefore, they are the ones responsible for the welcoming in this context.

> The dimension Host the family in the ED emerged because hospitality differs from welcoming in that it implies a set of concerted actions over time to make the presence of the other more comfortable, making him/her an integral part of the context's culture. "The parents could always be present and were given the possibility to be next to their child all the time. I put some chairs there, in the resuscitation room, so they were always there next to their son." (P4).

Nurses try to create a place for the family to feel comfortable, after being welcomed. It is hospitality that usually emerges uninvited at the most stressful moment, "*When a person is experiencing profound loss, their very being-soul-essence is troubled and needs to be tended and nourished.*" (Watson, 2002, p. 151), which puts the family of the CIP in a position that requires this nursing hospitality.

> At first, the only thing I could offer was a chair for him to sit there next to the patient. And I also lowered the bed as low as possible so that the son could be there at the same level and hold hands. Then I ended up moving the patient to bed X, which is in a corner of the room, with a little more space and privacy. The curtains can be pulled completely, and people are less exposed at that moment, with less interference from the unit's dynamics. And as time went by, because these critical situations sometimes drag on for a long time, I got the son one of our armchairs so that he could spend the night here with his father. (P5)

Human beings have the infinite responsibility to welcome the vulnerable Other (Levinas, 2011), so nurses, in their path of caring for the family, feel compelled to welcome the suffering family.

> His father went in for the visit, but his mother and brother were barred at the door by the security guard. I went to the door to get them, so that the three of them could go in. I had to arrange the space so that the three of them could be there by the patient's stretcher. I pulled the curtains and created a more welcoming environment. I remember that it was a big shock for the family to see the young man like that on the Stryker stretcher, with the Gardner-Wells tongs and everything else ... but this way they could all support each other ... I even lowered the bed rails so that they could be a little closer and kiss on the cheek. (P9)

The effective management of these unexpected visits in such a demanding context has a relevant impact on the transdisciplinary team (Sweet & Foley, 2019). To this end, it is important to create physical conditions (Barreto et al., 2019) and others for the family to exercise their right to accompany the patient.

The dimension *To be fully present* for families emerges in the nurses' narratives.

> So when I was there with the patient's relative, I felt like I was there 100%. And I was there just for him! In fact, one of the things I made sure to say was, "I'm with you now, and only with you! It's only for you! And I'm going to explain you everything and you're going to tell me what you need from me." (P3)

In Marcel's work (2013), the mode of being present emerges associated with physical proximity, and the author distinguishes it from the state of being present to the other, as the latter does not imply the former. The notion of presence implies a strong connection and awareness of presence towards the other, often through communion and availability. Therefore, the experiences of others are significant for the being and shape its existence, so the nurse seeks to fully support and demonstrate total availability to that family in that significant moment.

> Nobody was expecting this outcome... And I tried to give some support to the family. I asked the parents, "So don't you have family or friends who can come here and be with you now?" I clearly remember that I asked them about ten times if they needed anything else, if they didn't want to call someone else in the family . . . and they kept saying no. And I remember the parents' serenity and that I stood there quietly next to them. (P7)

Professionals perceive the presence of the family in the ED as positive due to its benefits for patients and the family itself, such as increased tranquility, safety, confidence, and comfort (Barreto et al., 2019). Here can be seen the gift of the self to the other to build and create time for the relationship, thus being present to the other (Marcel, 2013). The transcendental nature stands out because nurses feel that they are fully present to the families, even when they are not physically with them all the time. It is

also important to analyze the time sphere in which the relationship of this therapeutic nursing presence is built and shaped to the extent that it does not limit but rather expands the intensity of the relationship.

The dimension *To cuddle in suffering* is associated with the critical situation of the loved one, who is facing the unpredictability and the risk of the finiteness of life.

> I remember that mother and her suffering perfectly! I feel that I was able to establish a unique relationship with that mother, so much so that when her son was dying, she asked me for ... a lock of her son's hair. And I held out my scissors to give it to her because I was also having a hard time with the whole situation. And she asked me to cut it myself. And she told me: "I have a lock of hair from when he was born and now, thanks to you, I also have a lock of hair from when he died". I hugged her while she was crying . . . It was a very emotional moment! (P4)

Suffering affects both the patient and the family because the illness of a family member becomes a family affair (Shajani & Snell, 2019). In the emergency room, the family experiences feelings such as uncertainty, distress, fear, and grief (Barreto et al., 2019), which reflect their suffering in the face of the situation.

> At that moment, I could see in her (daughter's) eyes that the situation was irreversible and nothing else could be done... She looked at me and asked, "But why? Why did this happen?' and she cried, clinging to me. I remember that sorrow, that suffering... I tried to comfort her, and she told me some things she wanted to say, she got it off her chest. (P5)

A sudden death complicates the family grieving process because the family system had no time to prepare for the loss, cope with pending issues, and/or say goodbye to the person (Kreuz & Netto, 2021). As a result of the therapeutic relationship, which nurses describe as a meaningful interaction with the family member, nurses become references for that family and can provide comfort in suffering.

The dimension *Dance, with the family, in a borderline situation* entails a waiting period between complementary diagnostic tests and the observation by physicians of several medical specialties and the long-awaited diagnosis and, above all, prognosis.

> The situation was the children coming from abroad. So the difficult thing was to keep that lady there in the resuscitation room with us as long as possible, after everything else that I still had to do, as you can imagine, until the several children arrived to say goodbye to their mother. And the lady ended up passing away just when the last child had arrived . . . amazing! (P3)

During this waiting period, nurses manage the available resources to meet the family's needs (Hsiao et al., 2017). The nurse and the family 'dance', driven by hope, in the expectation of a positive outcome.

> And I took over the situation and said, "Come on, there's no problem," knowing that I would have to manage the conditions for that to happen. And then I was the one who was there for more than three hours with family and friends, in a caring process, I was with them cleaning, talking, reading books to him, turning him over, . . . they wanted to do everything and be with him all the time. (P6)

Nurses make decisions that promote the humanization of the process of caring and dying in the ED (Berbís-Morelló et al., 2019), involving the family's presence. The dance metaphor intends to illustrate the nurse-led dual relationship between nurse and family, as both seek to go through a time and space necessary for the action to unfold.

The dimension *Comfort guided on the information* emerged because the CIP's family has specific needs, namely the need for communication (Hsiao et al., 2017; Yildirim & Özlü, 2018). In the transmission of information, nurses collaborate with other professionals responsible for the diagnosis and prognosis of the situation. In this context, the nurse advocates for the family by mediating and presenting the family to the other health team members in an individualized way.

> I spent a lot of time talking to the family, basically helping them to better understand everything that was going on . . . I could see that in the end they were more comforted and told me that they didn't feel abandoned . . . I can't forget their faces . . . they were calmer . . . they stopped crying and started calming down. (P2)

Providing information to the family is relevant for the mental deconstruction of the reason for ED visit, the acceptance of the disease process, and the progressive construction of a prognosis of a critical situation (Barreto et al., 2019). In a process in which the family suffers with the critical illness of their loved one, the information conveyed emerges as a strategy that brings meaning to the situation.

> Those parents called me in great distress. The parents didn't understand what it meant to be unconscious, and then they don't know if he's in pain or sedated, right? Deep down, those concerns are ours too . . . and even being ventilated is a mixed bag of questions because, if you're going to die, why do you have a machine breathing for you? It's complicated to answer these questions, no doubt . . . they worry that their daughter might be suffering. And so, when I talk to them, I realize that it's a conversation to comfort them, those are the words of comfort that they understand. They need to know that everything humanly possible is being done. (P7)

Effective communication with the family reduces their suffering because it clarifies their understanding of the situation, provides emotional support, and reduces anxiety (Shajani & Snell, 2019). Through therapeutic communication, nurses can alleviate the patient's suffering, and, in this way, the family is also able to perceive the quality of care their loved one is receiving and the non-visible procedures that are part of this complex care.

The dimension *Let yourself be carefully touched by the family's experience* emerges when the nurse suffers with the other, sharing the pain experienced by the families,

because "*the nurse, through transpersonal caring and caring transactions, can enter into the intensely personal-subjective relationship with the grieving person - person to person - by embracing, holding, sharing the sorrow*." (Watson, 2002, p. 150). Thus, nurses experience the situation together with the family, feeling sadness, anger, and powerlessness in the face of the critical situation.

> I get really emotional, I put myself in that situation and think about these people, the daughters, and the granddaughter, who are leaving and probably won't see this lady anymore. And the sure thing is that I ended my shift and the lady passed away around 2 am. I remember talking to them and thinking that the granddaughter seemed to really like her grandmother and be really important to her. I remember thinking that I was telling her, "Each case is a case, it's all very unpredictable at this final stage", but maybe that was really a goodbye, she wasn't going to see her again . . . It's sad for us because we also have family and people who are important to us. (P10)

The absence of the family in the ED also affects some of the nurses. The learning experiences based on witnessing the pain and suffering of other families promote the transference and countertransference of these experiences to their own family domain.

> In mental illness, the family is usually the one managing the illness because the patient is unable to manage it . . . so it's hard when the family is not present. Basically, she has no one . . . The absence of the family makes me think about life and the importance of family. (P8)

Nurses also listen to the life lessons of the families they care for and feel that they learn from them, which is associated with the recognition of the relevance of the experience of the other for the subject (Marcel, 2013). The meaning of suffering and death poses nurses deep questions about the meaning of their own life and their experience within their families.

Analyzing the universal dimension of lived experiences allows for a new perspective about the composite descriptive construction because, based on a phenomenological reflection anchored in the various dimensions of the phenomenon, several meanings emerge for the sphere of nursing action. Van Kaam's (1959) theoretical framework advocates that human consciousness is, in the world, the result of direction and intentionality in the encounter with the Other, which this study uncovers in the complexity of the professional nurse-family relationship and the emphasis on effective communication, using several strategies. This study also reveals that most situations involve the presence of the family in the resuscitation room, where families are not usually present, demonstrating nurses' care in finding a place where they could talk, usually a room to hold a family conference.

The findings of this study arise from the context, which can be a limitation in that the results are valid only for the context where the research took place. However, this is due to the type of study, which seeks above all to uncover a phenomenon that should be further explored to provide better care.

Conclusion

The study revealed the composite description of the phenomenon, consisting of eight dimensions that give visibility to the meanings in the nurses' experience of caring for families of CIPs in the ED. The following aspects emerged from the phenomenological reflection: the importance of developing therapeutic communication skills with the family of the CIP, which drives the continuous improvement of nursing education and training; the presence of the family in resuscitation situations, which requires further research at the national level; and the need for family conferences, which mobilizes human and material resources in the management area of the context itself to support clinical practice. The knowledge produced through the phenomenological-descriptive approach has enhanced the understanding of nurses' lived experiences in caring for the family in the ED, with potential benefit for other families, nurses, and health professionals. Further studies on family care in the ED are also suggested, considering the current health policies.

Author contributions

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