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THE NURSE'S STORY: A QUALITATIVE STUDY OF HOW NURSES' EXPERIENCE
CARING FOR PATIENTS WHO DIE UNEXPECTEDLY

By

Shantel N. Sullivan

BA State University of New York at Potsdam 2006
MSW University of New England 2008

A DISSERTATION

Presented to the Affiliated Faculty of

The College of Graduate and Professional Studies at the University of New England

Submitted in Partial Fulfillment of Requirements

For the degree of Doctor of Education

Portland & Biddeford, Maine

May 3, 2017

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Shantel Sullivan
May 3, 2017
Educational Leadership

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CARING FOR PATIENTS WHO DIE UNEXPECTEDLY

ABSTRACT

The primary purpose of this qualitative study was to describe the experience of compassion fatigue among nurse professionals in order to examine natural grieving reactions and how they potentially change nurses' lives. The focus of this study included nurse professionals working in rural community hospitals in Upstate New York. The nurse professionals in the study were exclusively those who identify and practice as registered nurses (RN). The nurses were asked to share their experiences of repetitive exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult). Purposive sampling was utilized as a means to select participants. The researcher collected data by conducting face-to-face interviews with each participant.

Nurses recalled experiences of high stress caregiving were examined as they relate to critical issues of compassion fatigue, also known as vicarious traumatization, or secondary traumatic stress disorder. After interviewing six registered nurses and analyzing the data, six themes emerged: (a) *Sometimes We Do Lose People*, (b) *You Need to Find Something that Works for You*, (c) *Too Close to Home*, (d) *I Care*, (e) *It's Not a Job*, (f) *Self-Preservation*, and (g) *The Role of Hospital Administration*. In addition to the six major themes, there were 14 subthemes.

Through this qualitative research, it has become clear to the researcher that nurses make significant sacrifices to ensure the health and well-being of others. They give of themselves to

mend the physical, mental, and emotional wounds of others. Nurses need to have support early and often to debrief, share their experiences, connect with their colleagues, and be celebrated for the lifesaving work they do.

University of New England

Doctor of Education
Educational Leadership

This dissertation was presented
by

Shantel N. Sullivan

It was presented on:

March 2, 2017

And approved by:

Joanne Cooper, Ph.D
Lead Advisor
University of New England

Michelle Collay, Ph.D
Secondary Advisor
University of New England

Shelley Cohen Konrad, Ph.D
Affiliate Committee Member
University of New England

ACKNOWLEDGEMENTS

This doctoral journey has proven to be one of the most transformative experiences of my life, second to becoming a mother. First, I want to thank my daughters, Charlotte and Vivienne, for they were my motivation for getting to the finish line. I hope one day they will recognize that anything you put your mind to is possible. Also, I would like to thank my mother; none of this would have been possible if not for her ongoing support and encouragement. She was there to pick up the responsibilities of “mothering” my girls while I spent hours at my desk reading, writing, and editing. In addition, I would like to thank my husband, Patrick; my sisters, Tiffany, Annalee, and Megan; and my grandmother, Elizabeth, for understanding my drive and determination to make this dream a reality. I want to thank my extended family and friends for their continuous words of encouragement.

I would like to extend my gratitude to the nurses who participated in the study. I will be forever grateful for the opportunity to share their stories and to have had the opportunity to bear witness to their courageous acts of caregiving. My colleagues in this journey, Dianna and Gizelle, offered steady guidance, validation, and laughter through the highs and lows of this endeavor. I will cherish the connections made with all those I encountered in this program.

Lastly, I would like to thank the University of New England and the School of Social Work for fostering my commitment to lifelong learning. My time as a graduate student attending the Westbrook campus was life-affirming. I knew when looking to advance my education to the doctoral level I would once again turn to UNE for my academic aspirations. I am also grateful to the Doctoral Program in Educational Leadership and the faculty serving on my dissertation committee. It was an honor to learn from Dr. Michelle Collay, Dr. Joanne Cooper, Dr. Thea

Williams Black, and to have the distinguished pleasure of reconnecting with Dr. Shelley Cohen
Konrad as an affiliate member of my committee. As educators, our work is never finished!

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CHAPTER 1

INTRODUCTION

Nurse professionals are charged with caring for high risk patients with multiple comorbidities; this kind of caregiving has the potential to be physically, mentally, and emotionally exhausting, as well as rewarding. The complexity and frequency of exposure to individuals with serious life-limiting conditions requires the most energy and attention from the nurse professional. On the other hand, these complex cases also require attention and care for nurses to prevent burnout, compassion fatigue, or in the most extreme cases, vicarious traumatization, also known as secondary trauma disorder (Ford, 2014).

Burnout has collectively been a psychological term that refers to long-term exhaustion and diminished interest in work, which leads to feelings of helplessness, hopelessness, chronic fatigue, and one's sense of being trapped in a job (Perkins & Sprang, 2012; Sabo, 2011). Burnout has been assumed to result from chronic occupational stress. Nurse professionals may begin to demonstrate irritability and resentment toward a patient, colleague, and even the organization; these changes contribute to the overall quality of care and provider/patient satisfaction (Perkins & Sprang, 2012). Unaddressed, with continued exposure to work related stress and no self-care plan, nurses are at a greater risk for experiencing compassion fatigue.

Compassion fatigue, a newer concept than burnout, has been separated from burnout with respect to the specific behavioral changes exhibited by nurses as a result of providing constant care to the sick, suffering, and traumatized (Smart et al. 2014). Working in high trauma environments has been referred to as "chaotic and hectic" (Wentzel et al., 2014, p. 95). According to the research of Adams et al. (2006) and Figley (2002), as cited by Sabo (2011),

“the dominant theoretical model postulating the emergence of compassion fatigue draws on a stress-process framework” (p. 3). Therefore, nurses, like other caregiving professionals, are exposed to work environments that have significant adverse psychological outcomes.

Gail Kinman, a professor and lead researcher on compassion fatigue at Bedfordshire, postulates that caring and empathy are fundamental pillars of nursing practice and further, are most noted by patients and their families (Ford, 2014). As a result of such emotional expressions of caring and empathy, nurses experience a high degree of emotional output and stress as a regular part of their job. Stamm (2010) conceptualized the balance between the positive and negative aspects of caring. He supports that professional quality of life is measured through the cumulative experiences of compassion satisfaction and compassion fatigue (ProQOL).

Problem Statement

Research confirms that nurses experience a range of emotions as part of their daily work experiences and when nurses fail to recognize and disclose their emotional expressions, they are more likely to exhibit signs of burnout (Erickson & Grove, 2007). As a result, developing a culture of meaningful recognition can directly influence a nurse’s overall experience of compassion satisfaction and compassion fatigue (Sacco et al., 2015). Hence, organizational systems claiming to value excellence, compassion, and opportunities for continuous improvement, reported rates of high absenteeism, changes in co-worker relationships, lack of flexibility, negativity towards management, and reluctance toward change; and a lack of vision for the future seems to contradict the fundamental principles that guide healthcare systems

Problem Statement

Nurses and healthcare institutions may struggle to provide quality care if those who provide care to others are depleted. Graber (2009) indicated that, to make lasting and sustainable change to improve the overall satisfaction and quality of care, healthcare institutions will have to embark on “radical cultural changes” (p. 519). In fact, there are a number of healthcare organizations that have effectively made such changes to the cultural perception and daily clinical practices by focusing on the interpersonal skill development of the caregiver. Research supports that culture change of this magnitude requires authentic caring, whereby caregivers are encouraged to be increasingly aware of their intentionality, caring consciousness, and heart-centered human presence (Graber, 2009). The problem at hand is that the culture of nursing makes it difficult for nurses to access, recognize, and share emotions of grief and loss. Moreover, even when given the venue to do so openly, some still choose not to participate. A lack of organizational support perpetuates the internalization and harboring of nurses’ natural emotional reactions.

Purpose of the Study

The primary purpose of this qualitative, phenomenological study was to describe the experiences of compassion fatigue among nurse professionals in order to examine natural grieving reactions and how they change nurses’ lives. Parish (2016) professed that “nursing is a job in which the relationship between professional and client transcends normal social boundaries” (p. 5). Further, Parish reported that these close relationships are established through the interactions in life and in death, leaving nurses with their own sense of grief. Nurses then can find themselves grieving following the patient’s death.

The focus of this study is nurse professionals and their perceptions of compassion fatigue in rural Upstate New York. The study included registered nurses (RN). Specifically, this cohort of nurses was asked to share their experiences of repetitive exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult). Recalled experiences of high stress caregiving were examined as they related to critical issues of compassion fatigue, also known as vicarious traumatization, or secondary traumatic stress disorder.

Research Questions

The qualitative, phenomenological study considered the use of the Kubler-Ross model, which implies that nurses as healthcare providers experience grief reactions that lead to compassion fatigue. The central question of the study is: How do nurse professionals in a rural Upstate New York recall their experiences of repetitive exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult) and how do these emotions impact their lives?

Sub Questions:

There are five sub questions associated with the studies inquiry:

1. What is the experience like to care for a patient or patients experiencing traumatic incidents, death, or an unforeseen loss (infant, child, multiple accidents)?
2. How do nurses display compassion for self and others (peers, patient, and families)?
3. What is the grief process like to nurses when a patient dies?

4. In what ways are a nurse's life changed as a result of caring for a patient in terms of their care being categorized as a critical incident (unexpected outcomes, mass casualties, and/or death of infant/child/young adult)?
5. What are the opportunities to implement programming to address nurse occupational stress outcomes?

Conceptual Framework

In a social worker role, the researcher has participated in the debriefing of direct care providers. This experience moved the researcher to be drawn to the human response to first- and second-hand exposure to trauma. In a clinical role, the researcher becomes a witness to one's experiences of loss, abuse, and caregiving. This leads to pondering the notion of how people, particularly direct care providers, continue day after day to care for others. Further, are nurse professionals aware of their repetitive exposure to critical incidents or do they just chalk it up to doing their job? Nurses have been overheard making comments, such as "this is just what we do," alluding to a notion of acceptance to this phenomenon. Kulkarni, Bell, Hartman, and Herman-Smith (2013) indicated three key factors that increase nurse vulnerability and exposure reactions: high workloads, low autonomy, and lack of supervision (p. 118). This constant repression of emotional response leads to a decline in job satisfaction, loss of compassion, and reduced well-being.

Numerous studies have addressed the phenomenon of burnout and compassion fatigue among nurses. Three significant themes emerged: (1) generation disconnect and perceptions of nursing values, (2) caregivers' decrease in work and personal life satisfaction leading to intentions to quit, and (3) overall cost to quality among organizational and hospital institutions,

all as a result of not addressing the implications of compassion fatigue among their workforce (Sabo, 2011; Sacco et al., 2015; Sprang et al., 2011; Wentzel & Brysiewicz, 2014).

Assumptions

Using the guidelines offered by Roberts (2010), the assumptions of this study consider the strengths and weaknesses in the methodology as indicated by the research design to include the following: nurses in the study will recall their experiences of compassion fatigue, secondary traumatic stress, and vicarious traumatization and verbalize their thoughts, emotions, and reactions to such experienced events and further, nurses responding to the study answered all of the interview questions openly and honestly. Their recollections will be changed by time passing and be presented in the context of other, subsequent experiences.

Limitations of the Study

This study was limited to the registered nurses employed in rural Upstate New York. Therefore, findings from this study cannot be generalized to all nurse professionals in other healthcare systems. This study was limited to nurse professionals categorized as registered nurses (RN). This study does not represent all medical providers, excluding physicians, respiratory therapists, and radiologists; therefore, this study does not represent all medical personnel who provide patient care. The completion of this interview was voluntary; some nurses who met the criteria opted-out of participating in an interview, thus limiting the sample size.

Significance and Scope of the Study

Nurses are required to demonstrate high competence, skill, and physical assessment of a patient simultaneous to conveying concern and empathy for a patient's emotional needs.

Presented as an editorial response in the *International Journal of Nursing* (2013), a convincing

argument questioned the nursing profession's ability to deliver compassionate quality care.

Derbyshire and McKenna (2013) are quoted in the editorial, who indicate that a "crisis of caring in nursing" reports educational and organizational failures in conveying acts of authentic care for patients among healthcare institutions (p. 177). In the very early studies, the disappearance of a nurse's ability to nurture was a means to protect oneself from the emotional wear and tear of caring for others. There is argument that suggests, in order to effectively treat patients, healthcare organizations must start with caring for the people within the organizations. The patient, employee, and the organization as a whole are being disadvantaged when the implications of occupational stress fail to be acknowledged.

Sacco et al. (2015) validate that when comparing nurses working in less stressful conditions with nurses working in high stress environments, nurses in high stress settings experience mental and physical exhaustion leading to more missed days of work and higher rates of attrition (p. 33). NSI Nursing Solutions Inc., in the 2015 National Healthcare Retention & RN Staffing Report, published an upward trend in nurse turnover rates. The national hospital turnover rate is 17.2%, a 0.7% increase from 2013 (NSI Nursing Solutions, Inc. 2015, p. 4). An even more challenging task can be the recruiting and filling of vacant positions. Specifically this year, the Difficulty Index for all nurse specialties has documented that hospitals report that they "can't find experienced RN's" (p. 7). NSI Nursing Solutions conclude that hospitals are experiencing a significant paradigm shift, and in order to retain a quality workforce, hospitals will have to place greater value on their people.

Definition of Terms

Authentic caring: the ability for the nurse to honor the human dimensions of nursing's work and

the inner life world and subjective experiences of the people they serve (Watson, 1997, p. 50).

Burnout: A psychological term that refers to long-term exhaustion and diminished interest in work leading to feelings of helplessness, hopelessness, chronic fatigue, and one's sense of feeling trapped in a job (Sabo, 2011; Perkins & Sprang, 2012).

Compassion: sympathetic consciousness of others' distress together with a desire to alleviate it (Merriam-Webster, 2016).

Compassion fatigue: "is a state experienced by those helping people or animals in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it can create a secondary traumatic stress for the helper" (Figley, 2002, p. 7).

Vicarious traumatization: "is a process of cognitive change resulting from chronic empathic engagement with trauma survivors" (Stamm, 1999, p. 12).

Conclusion

With a growing workforce, there is a need to ensure healthcare fields are able to sustain, retain, and attract high performers to such professions. Day in and day out, healthcare providers offer compassion and empathy to those whom they are treating; this can lead to caregiver stress. Healthcare systems can offer solutions for combatting the compounding effects of burnout and compassion fatigue. The literature indicates that organizations can improve healthcare and service providers' and nurses' perceived effectiveness and job satisfaction by supporting programming that enhances healing relationships, leading to the retention of high performers (Kulkarni et al., 2013, p. 126).

CHAPTER 2

REVIEW OF THE LITERATURE

Sabo (2011) validates nurses, physicians, social workers, and psychologists as healthcare providers most likely to be exposed to occupational stress (p. 1). According to the research of Adams (2006) and Figley (2002), as cited by Sabo, “the dominant theoretical model postulating the emergence of compassion fatigue draws on a stress-process framework” (p. 3). The complexity and frequency of exposure to individuals with serious life-limiting conditions require the most energy and attention from the nurse professional. On the other hand, these complex cases also require the most attention and care for the provider to prevent burnout, compassion fatigue, or in the most extreme cases, vicarious traumatization (Ford, 2014).

The *Nursing Times* published an article entitled, *Compassion “Exhausts” Nurses*, presenting research conducted by the University of Bedfordshire in the United Kingdom, indicating that, in fact, “nurses can suffer as a result of having to display compassion all the time” (Ford, 2014, p. 2). Nurse professionals tend to bear witness to one’s experiences of loss, abuse, and suffering. This literature review was formulated as a means to better understand how people, particularly nurse professionals, continue day after day to care for others.

In the healthcare industry, trauma and loss tend to be perceived as *this is just what we do*, alluding to a notion of acceptance of this phenomenon. These ideas support and perpetuate a mental model within healthcare providers that such a profession requires one to simply *suck-it-up* and keep working. This comprehensive literature review of international evidence on burnout and compassion fatigue is presented to identify supporting evidence that such constant repression of emotional response leads to one’s decline in job satisfaction, compassion, and well-being. In

addition, evidence will uncover healthcare costs on employee satisfaction and strategies for quality improvement through the use of self-care as an organizational framework. Particular attention will be focused on the experience of repetitive exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult) among direct care providers to include healthcare providers and nurse professionals in a vast collection of hospitals and organizations.

Considering the movement of this body of research, it is imperative to set aside personal experience in an effort to mindfully read and synthesize existing literature without personal bias or preconceived notions about the phenomenon, vicarious trauma, and compassion fatigue (Creswell, 2013). Enacting in a systematic literature review, the process of reviewing preexisting literature, supports and encourages the researchers' ability to bracket information, completing an extensive review of literature representing both views and perspectives for and against the phenomenon being studied.

Enacting the Literature Review

A systematic approach was used to guide the review and synthesis of the literature in three main phases: (a) planning the review (b) conducting the review, and (c) reporting the review (Kitchenham, 2007). The search strategy was initiated with articles published between the period of 2007 and 2014 and involved the following keywords: *job satisfaction, burnout, compassion fatigue, caregiving, healthcare, and quality care*. Key bibliographic and review databases were searched, including ProQuest, ERIC, Sage Publications, and databases were not limited to one discipline area. Articles were gathered from the fields of social work, nursing, medical education, educational leadership, psychology, and human resources.

Quality Assessment

The framework by Callahan (2014) postulates using a system for evaluating literature, which requires the researcher to critically select, read, synthesize, and evaluate literature pertaining to the topic being studied. The “Five C’s,” *concise, clear, critical, convincing, and contributive*, provided a comprehensive, systematic approach to the evaluation process of the literature reviewed on compassion fatigue (Callahan, 2014, p. 272-274). By incorporating this approach, each article was evaluated using the five characteristics with the author’s personal interpretations.

Study Selection

A total of 53 articles and two books were included in the initial review database search. Following the title screenings and the quality assessment indicators using Callahan’s (2014) five characteristics, 26 articles were omitted as they met the rubric for exclusion. Of the 53 articles, 27 were further reviewed and synthesized. The articles selected met the criteria because they examine the cost and quality implications pertaining to nurse professionals’ burnout and compassion fatigue.

Burnout and Compassion Fatigue

Burnout has collectively been a psychological term that refers to long-term exhaustion and diminished interest in work leading to feelings of helplessness, hopelessness, chronic fatigue, and one’s sense of being trapped in a job (Sabo, 2011; Perkins & Sprang, 2012). Burnout has been assumed to result from chronic occupational stress. Nurse professionals may begin to demonstrate irritability and resentment toward a patient, colleague, or even the organization, which has been known to contribute to changes in quality care and provider/patient satisfaction

(Perkins & Sprang, 2012). Unaddressed, with continued exposure to work related stress and no self-care plan, nurse professionals are at a greater risk for experiencing compassion fatigue.

Compassion fatigue has been considered a newer concept than burnout and has been separated from burnout with respect to the specific behavioral changes exhibited by nurses providing constant care to the sick, suffering, and traumatized (Smart et al., 2014). Working in high trauma environments has been referred to as “chaotic and hectic” (Wentzel et al., 2014, p. 95). According to the research of Adams et al. (2006) and Figley (2002), as cited by Sabo (2011), “the dominant theoretical model postulating the emergence of compassion fatigue draws on a stress-process framework” (p. 3).

Nurse professionals and healthcare institutions may have difficulty admitting the reality of healthcare provider expressions of burnout and compassion fatigue, yet according to the research conducted by Erickson and Grove (2007), a substantial 86.9 percent of emergency response personnel reported symptoms after highly distressing events with traumatized people. Further, a whopping 90 percent of new physicians, between 30 to 39 years old, reported that their family life has suffered as a result of their work (p. 3). Mathieu & McLean (2015) estimate that “depending on the studies, between 40 percent and 85 percent of helping professionals were found to have compassion fatigue and/or high rates of traumatic symptoms” (p. 31). Analysis confirms that “emotions are a pervasive feature of nurses’ daily occupational experiences” and “nurses who covered up their true feelings were more burned out than nurses who did not cover up such emotional experiences” (Erickson & Grove, 2007). Jonas-Simpson, Pilkington, MacDonald, and McMahon (2013) draw from Pilkington (2006), promoting that “the experience of grieving a loss is a significant human experience” and that grieving can be experienced by

those acting as healthcare providers (p. 1). In fact, those who participated in Jonas-Simpson et al.'s study indicated that their lives were impacted personally and professionally as a result of being exposed to grief in the workplace. Nurses offered that they were “sometimes overwhelmed” by their own grief reactions (p. 5).

To further understand the phenomenon of burnout and compassion fatigue among care providers, three significant themes arose perpetuating ongoing behavioral expressions of compassion fatigue: generation disconnect and perceptions of nursing values, nurse professionals' decrease in work and personal life satisfaction leading to intentions to quit, and overall cost on quality among organizational and hospital institutions as a result of not addressing the implications of compassion fatigue among their workforce (Sabo, 2011; Perkins & Sprang, 2012; Erickson & Grove, 2007; Mathieu & McLean, 2015).

Career Longevity and Moral Distress

To further explore relationships between the reports of experiences and exposure to burnout and compassion fatigue, attention was placed on potential gender, age, education, and level of experience. The layered emotional and symptomatic responses of burnout, compassion fatigue, and moral distress have been noted as the “cumulative effects of working in high-stress, high volume workplaces” (Mathieu & McLean, 2015, p. 32). Mathieu and McLean (2015) define moral distress as the state “when you believe you know the right thing to do, but for whatever reason – pressure from superiors, fear of retribution or circumstances beyond your control – you act against that belief; this is a deep ‘emotional toll’” (p. 32).

Cicognani, Pietrantonio, Palestini, and Prati (2010), using the model of McMillian and Chavis (1986), conducted a study that included 764 emergency workers to investigate coping

strategies and psychological variables contributing to reported quality of life at work. Similar to the work of other noted authors in the field, the literature review began with a review of the work of Figley (2002), highlighting the implications leading to caregiver expression and exhibiting behaviors of burnout and compassion fatigue. Through the use of online questionnaires, Cicognani et al. (2009) presented data that suggests females, full-time workers, and volunteers are most vulnerable to experiencing compassion fatigue and burnout.

The National Association of Alcohol and Drug Abuse Counselors announced a new crisis, “a serious shortage of substance abuse counselors,” speculating that the shortage was a result of the compromised quality of life reported by substance abuse counselors (Perkins & Sprang, 2012). Perkins and Sprang (2012) identified key demographic characteristics as contributing factors that lead to increased reports of burnout; age, with younger counselors being more susceptible, higher levels of education, and those who were married are presented with increased vulnerability, and male counselors reportedly demonstrated a lower rate of emotional exhaustion than their female counterparts.

Based on generational teaching and experience, Leduc (2009) illuminates research presenting a three-group comparison design, assessing nursing values based on cohorts, first by age and second, by level of experience as a means to understand nurse performance and behavior. According to Anderson (2000), as cited by Leduc (2009), “faculty and staff need to model professional behaviors and values for students while setting clear expectations and enforcing appropriate consequences for failure to meet those expectation” (p. 280). Role modeling by faculty and staff could include self-care strategies to prevent burnout and compassion fatigue.

Leduc (2009) asserts that there is a difference in nurse application of values as presented within the American Nurses Association (ANA) Code of Ethics. In September 2014, the ANA announced the following position statement:

Registered nurses and employers in all care settings must collaborate to reduce the risks of nurse fatigue and sleeplessness associated with shift work and long work hours. Evidence-based strategies must be implemented to proactively address nurse fatigue and sleeplessness; to promote the health, safety, and wellness of registered nurses; and to ensure optimal patient outcomes. (p. 283)

The research found that, overall, respondents placed more value and emphasis on the codes that were connected to professional issues than the codes addressing societal issues. Each generation offers strengths to the field of healthcare. However, in order to sustain the nurse workforce and to meet increasing demands in the healthcare field, nursing curricula must focus particular attention on teaching values. Further attention to values has the possibility to narrow generation gaps to foster improved quality working relationships and service delivery.

In a response to improve generational relationships and in order to build dialogue between nursing staff and healthcare providers, The American Nurses Association (2013) identified *Five Principles for Collaborative Relationships* between clinical nurses and nurse managers: (1) Engage in active listening to fully understand and contemplate what is being relayed, (2) Know the intent of a message and what is the purpose and expectations of that message, (3) Foster an open, safe environment, (4) Whether giving or receiving information, be sure it is accurate, and (5) Have people speak to the person they need to speak to so the right person gets the right information. Narainsamy and Van der Westhuizen (2013) add value to the

essence of communication. As their intention, communication was to understand and investigate work-related well-being in a medical laboratory setting. Using a four-factor model, well-being was measured by the following dimensions: burnout (fatigue vs. vigor), engagement (enthusiasm vs. depression), occupational stress (indicating anxiety vs. comfort), and job satisfaction (pleasure vs. displeasure). Overall, the study concluded that the majority of medical laboratory staff articulated being satisfied, confident, and competent in their job. Communication was a positive indicator for individual well-being.

Increasing communication skills, decision making skills, team work, leadership competence, coordination, and crowd management were all noted as opportunities to promote and improve coping strategies among emergency workers, who were perceived as vulnerable to burnout and compassion fatigue (Cicognani et al., 2009). Taking a deeper assessment of the application of the *Five Principles for Collaborative Relationships* could potentially challenge historic mental models among care providers.

In effect, generations could challenge one another to share in dialogue expressions and personal reactions to hide the change demands. A reciprocal relationship could be formed to develop emerging strategies for self-care, advocacy, and increased autonomy. A framework promoting assistantship and experience prior to entering the field can offer an opportunity for faculty, advisors, supervisors, and prospective students to observe and acknowledge if they have the emotional intelligence and compassion to enter a highly emotional, demanding, and stressful profession (Gountas, et al., 2014). A proactive approach could yield a reduction in student dropout rates and improve both employee and patient satisfaction. Not only can compassion fatigue lead to job dissatisfaction and intentions to quit, but it can significantly impact what

nurses tend to do best: express feelings of care and empathy toward a patient and coworker (Wentzel, 2014).

Career Satisfaction and Retention

In 2010, the U.S. Department of Health and Human Services Health Resources as well as the U.S. Health Services and Resources Administrations (HRSA) released that as of 2008, there was a recorded 3,063,162 Registered Nurses in the United States and 84.8 percent of them were employed in nursing positions. This was the highest rate of nursing employment since 1977.

Atefi et al. (2014) offer strong empirical evidence supporting a correlation between job satisfaction, patient safety, and quality care. Three main themes were identified as impacting nurses' reported job satisfaction and dissatisfaction: (1) spiritual feeling, (2) work environment factors, and (3) motivation (p. 352).

Studer (2012) offers another perspective addressing the common pitfalls individuals encounter keeping them from fully integrating into a new work environment and for remaining stagnate within an organization or profession. For those who have been within the same organization for a long period of time, Studer (2012) challenges the employee to consider seeking new skills to increase competency and marketability. This is a notable consideration and application as the population of nursing professionals, specifically Registered Nurses (RN's) demonstrated a rapid growth. Considering nurses often work in a variety of healthcare settings with multiple roles and responsibilities, assessing nurse perceptions of job growth and trajectory is important.

According to the HRSA, 62.2 percent of RN's reported working in hospitals in 2008 with ambulatory care, as the second highest care location. The HRSA indicated that that there is a

steady shift in care setting as nurses age. Specifically, “nearly 85 percent of RN’s under 30 years old work in hospitals, but this percentage declines steadily with age” (p. 48). The HRSA survey revealed that, “More than 73 percent of nurses reported that they change positions or employment due to workplace issues, such as stressful work environments, lack of good management, or inadequate staffing” (p. 53). The cost associated with nurse turnover is staggering. Pendry (2007) calculated that costs associated with recruiting, training, and terminating a nurse can range anywhere between \$46,000 and \$145,000 dollars depending on demand and specialization. Pendry (2007) draws from the earlier research of Corley, Elswick, Gorman, and Clor (2001) reporting, “15% of the nurses in one study reported resigning a position due to experiencing moral distress” (p. 1). Further, even more disturbing, “nearly one-third of participants in the study reported leaving their first nursing position within 1 year; 57% left by 2 years” (Pendry, 2007, p. 3)

Fostering positive supportive relationships encourages and challenges fears about expressing emotion. The act of creating a place for positive supportive relationships would help to counteract what Mathieu and McLean (2015) describe as “the first causality of burnout and compassion fatigue in the workplace; collegiality” (p. 33). Positive, supportive, working environments offer opportunities to reduce negative emotional toxicity and attributes to positive outcomes of satisfaction and performance (Gountas et al., 2013). Graber (2009) notes that it is the responsibility of the manager to recognize, assist, and counsel clinicians; it is when dialogue fails to occur, or occurs sporadically, that nurse professionals are more likely to demonstrate compassion fatigue. Boev (2012) supports a framework indicating the importance associated with the relationship between nurses and nurse manager, positing that patient perception and

satisfaction are drawn from customer service and nurse friendliness, and courtesy is present when there are positive relationships between manager and organization (Graber, 2009; Boev, 2012, Gray & Muramatsu, 2010). Gray and Muramatsu (2010), compared to the research of Sprang et al. (2011), suggest social support was linked to low intentions to quit as a result of building positive work relationship. When nurse professionals report positive associations with their supervisor and/or other colleagues, they are less likely to leave their place of employment. The deterioration of work relationships or effective staff management leads to a shift from care and humanism to that of annoyance, disconnect, and a lack of compassion or empathy for those being treated (Graber, 2010; Wentzel, 2014).

Organizational Costs

Healthcare organizations can maintain and promote core values of the organization, which are professionalism, respect, integrity, compassion, and empathy, through encouraging care and support for care givers. With a growing workforce, there is a need to ensure healthcare fields are able to attract, sustain, and retain high performers to such professions. Day in and day out, nurse professionals offer compassion and empathy to those whom they are treating. This commitment to patients can lead to caregiver stress.

Kulkarni et al. (2013) offer extensive research and reviews to support key organizational risks leading to burnout among domestic violence services workers to include crisis hotline counselors, medical and legal advocates, group and individual counseling, and emergency shelter workers. Kulkarni et al. (2013) indicates that “high workloads, low autonomy, and lack of supervision jeopardizes work engagement and promotes increased vulnerability and exposure reactions” (p. 118). Presented as an editorial response in the *International Journal of Nursing*

(2013), a convincing argument questioned the nursing profession's ability to deliver compassionate quality care. Derbyshire and McKenna (2013) are quoted in the editorial, indicating a "crisis of caring in nursing," which reports educational and organizational failures in conveying acts of authentic care for patients among healthcare institutions (p. 177).

In order to effectively treat the community, healthcare organizations must start with caring for the people within the organizations. The patient, employee, and the organization as a whole are being disadvantaged by not focusing on preventative self-care. Nurse professionals are more likely to burn out, leave, and call in sick (Graber, 2009). Graber and Mitcham (2009) indicate that organizational culture is "the key element" to fostering "individual caring among hospital clinicians" (p. 531). The work of Griffin (2004) reveals the following negative effects of lateral violence: lowered self-worth, decreased job satisfaction, and stress. Griffin postulates that "providing an educational forum on lateral violence for newly licensed nurses in orientation is essential for raising consciousness" (p. 258).

If compassion and excellence are at the core of the healthcare delivery system, organizations must address the challenges of enacting them. Nurse professionals cannot perform high quality care if they are not being cared for themselves and by themselves. When healthcare organizations begin to educate about the signs and symptoms of burnout, nurse professionals will be better at recognizing the symptoms. Preemptive measures could significantly impact their personal and professional lives to reduce negative outcomes.

Institutional Policy

There are opportunities for policy improvement and strategies to institute a culture of caring through the use of self-care practices to promote compassion satisfaction. Three poignant

problems were identified through the review of the literature relating to perceptions of supporting nurse professionals: (1) a lack of standard procedure and hospital-wide communication (possible duplication of services and confusion of resources and roles), (2) a culture mental model of “I don’t need help, my job is to help others,” and (3) a disconnect between nurses’ understanding of a problem versus management’s understanding of a problem. Instituting and promoting policy to care for nurse professionals in the event of a critical incident and following an exposure to an unforeseen event reminds us that we are human and fosters dialogue to sustain health physical, mental, and emotional well-being. Organizations can improve healthcare and service providers’ perceived effectiveness and job satisfaction by supporting programming that enhances healing relationships leading to the retention of high performers (Kulkarni et al., 2013, p. 126). Addressing issues of job-fit, workload, continued education, support services, and positive relationships with co-workers can improve employee engagement and satisfaction scores, potentially reducing intentions to quit (Leary et al., 2013). Leaders who encourage staff participation in the development of policies increase the sense of autonomy, improving satisfaction and levels of justice within the organization (Andrews & Kacmar, 2014).

Strategies for Self-Care

Nurse professionals are human! Cicognani et al. (2009) argues that there is little attention to the concept of *compassion satisfaction*. Although there is attention to burnout and compassion fatigue associated with emergency related outcomes, care providers also experience positive, beneficial purpose and meaning in their work. Ying (2007) supports the notion that in “high stress workplaces, self-compassion has the ability to positively affect an individual’s ability to

cope with professional stressors” (p. 311). Individuals who are able to demonstrate self-compassion tend to exhibit three qualities to support positive self-orientation: mindful awareness, belief in common humanity, and self-kindness (Ying, 2009). Ying (2009) supports the earlier definition drawn by Neff (2003), indicating self-compassion as “one’s ability to be open to the emotional experience of exposure to one’s suffering and personal reaction of suffering without the behavioral response to disconnect from such suffering” (Ying, 2009, p. 310). Nurses tend to put others’ needs before their own, increasing their risk and vulnerability toward burnout and compassion fatigue (Wentzel et al., 2014). The promotion of self-compassion can be taught and through dialogue and practice, care providers will begin to recognize the implications of caring for others and be more cognizant to their mental, emotional, and physical reactions. A cultural shift like this can occur through organizational response to implementing wellness programs, strategic case assignment, informal opportunities to debrief, and asking employees what it is they need to do their job well (Sprang et al., 2011, p. 209). Organizations can further prevent the conflicting expectations between nurse professionals and the interdisciplinary team by “fostering good relationships between staff, collaboration for end-of-life care with an interdisciplinary team, and allowing for ethics consultations can decrease feelings of moral distress” (Hanna, 2004, p. 73).

Summary of Compassion Fatigue, Employee Satisfaction, and Self Care

This review has highlighted the bio-psychosocial impacts on the human body as a result of work-related stress. Work stress has been evaluated using the three factors: psychological job demands, decision latitude (job control), and social supports at work. The literature suggests that people experiencing job strain and who are simultaneously socially isolated carry higher risks

than their counterpart's thus personal stressor in combination with professional stressors place healthcare providers at greater risk for reduce expression of quality of life (Chandola, Heraclides, & Kumari, 2010). This is propelled when expectations are "too high or unrealistic" (Perkins & Sprang, 2012).

Chandola's et al. (2010) rhetoric on psychophysiological biomarkers of workplace stressors suggests that work-based stress measures are consistently associated with alteration in the autonomic nervous system, validating the importance of self-care. Repetitive exposure to critical incidents qualifies as work stress and takes into consideration the multitude of exposure as a healthcare worker, yet there is no way to be certain the potential level of stress one may experience from shift to shift. Awareness of the physiological changes caused by work stress should serve as just cause to ensure that those working under such stressed conditions have access to health and wellness training to prevent undesired outcomes and to safeguard against work-related biopsychosocial hazards.

Graber (2009) indicated that, in order to make lasting and sustainable change to improve the overall satisfaction and quality of care, healthcare institutions will have to embark on "radical cultural changes," and in fact, there are a number of organizations and hospitals that have effectively made such changes to the cultural perception and daily clinical practices by focusing on the interpersonal skill development of staff (p. 519-527). Culture change of this magnitude requires authentic caring, where nurse professionals are encouraged to be increasingly aware of their intentionality, caring consciousness, and heart-centered human presence (Graber, 2009).

Concluding Thoughts

This review confirms that failure to address caregiver stress and burnout has significant financial ramifications on the institution. In an organizational system positioned with a commitment to excellence, compassion, and innovation, problems like high absenteeism, changes in co-worker relationships, lack of flexibility, negativity towards management, reluctance toward change, and lack of vision for the future all point to caregiver burnout and compassion fatigue. Accordingly, increasing programs for peer support and debriefing offers opportunities to build colleague alliance and organizational support. The same factors that negatively contribute to employee satisfaction also correlate to a decrease in patient satisfaction scores. With knowledge of reimbursement measures, poor patient satisfaction scores lead to revenue loss; nurse professionals and healthcare institutions cannot expect to provide quality care if those who provide care to others are depleted. Larger population-based studies of self-care and debriefing among healthcare providers are required to develop further theoretical and empirical evidence for develop interventions to improve care provider mental and emotional wellness counteracting symptoms of burnout and compassion fatigue.

CHAPTER 3

METHODOLOGY

The primary purpose of this qualitative study was to describe the experience of compassion fatigue among nurse professionals in order to examine natural grieving reactions and how they potentially change nurses' lives. The focus of this study is nurse professionals and their perceptions of compassion fatigue working in rural community hospitals in Upstate New York. The nurse professionals in the study were exclusively those who identify and practice as registered nurses (RN). The nurses were asked to share their experiences of repetitive exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult). Their recalled experiences of high stress caregiving were examined as they relate to critical issues of compassion fatigue, also known as vicarious traumatization, or secondary traumatic stress disorder.

Research Questions

This qualitative, phenomenological study considers the use of the Kubler-Ross model, implying that nurses as healthcare providers experience grief reactions that lead to compassion fatigue. The central question of the study was: How do nurse professionals in rural Upstate New York recall their experiences of repetitive exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult) and how do these emotional reactions impact their life?

Sub Questions:

There were five sub questions associated with the studies inquiry:

1. What is the experience like to care for a patient or patients experiencing traumatic incidents, death, or an unforeseen loss (infant, child, multiple accidents)?
2. How do nurses display compassion for self and others (peers, patient, and families)?
3. What is the grief process like to nurses when a patient dies?
4. In what ways are a nurse's life changed as a result of caring for a patient in terms of their care being categorized as a critical incident (unexpected outcomes, mass casualties, and/or death of infant/child/young adult)?
5. What are the opportunities to implement programming to address nurse occupational stress outcomes?

Setting

Participants in this study practice nursing in a rural, remote, and sparsely populated area at the base of the Adirondacks. The participants within this study were New York State registered nurses, who had been practicing for at least one year. The nurses in this study have worked or are currently working in an array of practice areas that include critical care, mixed, adult and pediatric, general medical, surgical care units, labor and delivery units, emergency departments, and perioperative services. Nurses were invited to participate in the interview if they were 18 years of age or older and were employed full-time, part-time, or per diem.

Participants

Purposive sampling was utilized as a means to select participants based on their chosen professional practice as a direct care provider within the rural community (Rubin, 2005). Using the approach presented by Creswell as indicated through the work of Moustakas (1994), the participants were asked two broad questions:

1. What have you experienced in terms of the phenomenon?
2. How has this experience impacted your life?

The use of these two broad questions supported the process of connecting themes and deriving the commonalities shared between the participants.

Identification of the target population

Considering the following presented by Englander (2012) who asked “when it comes to selecting the subjects for phenomenological research, the question that the researcher has to ask themselves is: *Do you have the experience that I am looking for?*” (p. 19). Thus, the following inclusion criteria were considered of potential participants:

1. Are you a current employee at a rural community hospital in Upstate New York?
2. Do you function as a registered nurse (RN)?
3. Have you participated in direct patient care that has involved one or more of the following?:
 - a. unexpected outcome (death);
 - b. mass casualties; and/or
 - c. death of an infant/child/young adult

In total, there were six participants in this study. Collectively, they offered 134 years of nursing experience.

Stakeholders

The following stakeholders were identified as having potential interest and connection to the study’s design, findings, and recommendations:

1. Nurses – Nurses certified and licensed at all levels - nurses are exposed, some more than others to patients who die.
2. Hospitals/Healthcare Organizations – Awareness and understanding of the physical, emotional, mental, and social impact experienced by nurses who care for dying patients could be used to change and improve policy/producers and organizational responses.
3. Schools of Nursing – Awareness and understanding of nurses’ experiences of caring for a patient as a result of a critical incident could foster new curriculum development and offer education on how nurses can communicate, share, assess, and address emotional reactions.
4. American Association of Nurses – Awareness and understanding of nurses’ experiences and occupational stress characteristics could aid in shaping current or future policy, seminars, and continuing education.

Socio-Demographic and Practice Characteristics

Demographics were recorded to include age, gender, marital status, and highest education attained. Practice characteristics will include years of practice, professional affiliation, and current practice location by unit.

Data Collection

Six participants, one male and five females, were asked to provide the evidence needed to understand the nurses’ experience of caring for a patient during what has been defined as a critical incident. The researcher began participant selection by working with a consulting agency, which communicates as a third party, to identify potential participants (see Appendix A). The consulting agency emailed registered nurses who were among those registered for continuing

education and professional development with the agency. Those who received, read, and expressed interest in participating in the study emailed me directly. They were sent a response email that introduced the researcher, stated the purpose of the study, described the research, and clarified the procedures, confidentiality, risks, and benefits. Any risk to the participants was minimal as they disclosed personal information only if they chose to do so and, as consenting adults, were informed they could withdraw from the study at any time and have their data destroyed (Appendix A). The response email also requested that participants propose an interview date, time, and location at the participants' discretion, and solicited names of other possible candidates. Participants chose the interview site. It was recommended the location be quiet, such as a public library, conference room, or coffee shop. The components of the informed consent form were as follows: who is conducting the study, why the participants were chosen, purpose of the study, time commitment, benefits to be expected, potential risks and how they are managed, voluntary nature of the study, confidentiality, debriefing, contacts and questions, and a copy of the informed consent form was provided to them for their records.

Drawing from Table 4.1 in Creswell (2013), as adapted from Moustakas (1994) for the purpose of a phenomenological study, in-depth interviews were the primary focus. Interviews support the phenomenological research approach to “assemble the textual and structural descriptions” of a phenomenon (Creswell, 2013, loc. 1753). The researcher focused particular attention to the participants' narrations with focus to “understanding how people interpret their experiences, how they construct their words, and what meaning they contribute to their experience” (Merriam, 2009, p. 5). The researcher collected data by conducting face-to-face interviews with each participant at the agreed upon time and location. At the start of the

interview, again, the researcher reviewed the purpose of the study, procedures, risks and benefits, and confidentiality as outlined in the initial letter. The research additionally, verbally went over the informed consent form with each participant making sure they understood what they were agreeing to. Following this explanation, each participant was asked to sign the consent form, acknowledging they fully understood the study. The interviews were audio recorded and transcribed. Once transcribed, participants were given the opportunity to read his or her transcripts from his or her interview and to make edits as they saw necessary.

Data Analysis

Merriam (2009) notes that there is in fact a preferred way to analyze qualitative data, that being a “simultaneous” process to data collection (p. 171). The researcher began the analysis process while continuing to collect data. Audio recordings were transcribed and through the use of coding, “the process of making notations next to the bits of data that strike you as potentially relevant” were noted; this use of “open coding” offered an opportunity to potentially find something within the transcript that was not anticipated and to expand on additional themes or future studies (Merriam, 2013, p. 178).

Participant Rights

The nature of this study requires working with human subjects. Prior to participating in the study, each participant read and marked a box to indicate informed consent and willingness to participate in the voluntary study. Placing an X in the box rather than participant signature was obtained to further protect participant confidentiality. The informed consent form, located in Appendix B, is in accordance with the University of New England’s Human Subject Review Board for the protection of Human Subjects (Appendix B). The participants completed open-

ended interviews voluntarily and anonymously. Due to the sensitive nature of the content and the act of asking participants to recall events that have been traumatic, participants were provided a resource list of licensed mental health professionals that have agreed to offer further debriefing if required.

Potential Limitations and/or Biases

Creswell (2013) directs the researchers' attention and concern to the "importance of reflecting about the relationship that exists between the interviewer and the interviewee" (p. 173). The primary investigator in the study is a licensed master social worker in the state of New York. The principal investigator has conducted critical incident debriefing for healthcare providers following the death of a patient or patients. The researcher in this study incorporated the process of *epoche*, whereby becoming aware of personal prejudices, viewpoints, and biases in an effort to remove them from the experience and focus on the phenomenon under investigation (Merriam, 2009). The first step was to list all the potential bias that could occur during the time of the research design process. In addition, the researcher stepped away from direct clinical practice for nine months prior to conducting the participant interviews. Further, conscious and purposeful self-reflection was used prior to each interview; the researcher would use this time to "out loud" be reminded that this was not a client and the role was to be a researcher.

Pilot Study

Pilot testing is valuable to identify and mitigate the potential biases and content validity (Creswell, 2013). Further, this process can serve as a practice round for the interview and to become familiar with asking the questions. To pilot the interview questions, two individuals

were identified, who had worked within the hospital setting and who had experience with the traumatic or unforeseen loss of a patient. This person verbally narrated their experiences. The researcher was mindful to their personal reactions to the participants' sharing of their experience caring for a patient that died. The participants also received the same survey letter and consent form as intended for future participants.

In summary, this chapter provided a detailed description of this research study's methodology. A qualitative methodology was designed to examine the lived experiences of registered nurses who experienced repetitive exposure to critical incidents. The participant sample was made up of six purposefully selected individuals. The following is a discussion of the findings and detailed accounts of the interviews to support and further define the findings.

CHAPTER 4

RESULTS AND OUTCOMES

The primary purpose of this qualitative study was to describe the actual experiences of nurse professionals who experienced natural grieving reactions in order to understand how nurses' lives were changed as a result to their exposure to critical incidents in the workplace. The central question that guided this study was "How do nurse professionals in rural Upstate New York recall their experiences of repetitive exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult) and how do their emotions impact their lives? The participants in this study were interviewed to provide the evidence needed to understand the actual experiences of registered nurses who have experienced critical incidents.

Brief Review of Methodology

The interview questions were designed to guide the conversations and help elicit the actual experiences of registered nurses who have been exposed to critical incidents while delivering patient care. Purposive sampling was utilized as a means to select participants. Once participants were identified and vetted to ensure they met the inclusion criteria as discussed in chapter three, the researcher collected data by conducting face-to-face interviews with each participant at the agreed upon time and location. The same two broad questions were asked the same way to each participant: (a) What have you experienced in terms of the phenomenon? and (b) How has this experience impacted your life?

After interviewing six registered nurses and analyzing the data, six themes emerged: (a) *Sometimes We Do Lose People*, (b) *You Need to Find Something that Works for You*, (c) *Too Close to Home*, (d) *I Care*, (e) *It's Not a Job*, (f) *Self-Preservation*, and (g) *The Role of Hospital*

Administration. In addition to the six major themes, there were 14 subthemes. The major themes will be discussed in this chapter with their implications discussed in Chapter 5. There will be a summary at the end of the chapter re-stating the six major themes.

Data Analysis

This qualitative study utilized 90-minute interviews with each participant. Member checks were conducted and data was coded, organized, and interpreted using two theoretical frames: The Stages of Grief (Kubler-Ross, 1991) and the criteria for Compassion Fatigue and Vicarious Traumatization (Figley, 2002). The following section presents coding, organization, and interpretation of the data that was collected.

Coding

The researcher used Creswell (2014) to guide the process of data analysis and interpretation of the findings. According to Creswell, the researcher followed the six step outline as directed in the analysis of qualitative research. The first step was to organize and prepare the data for analysis, the second step was to read or look at all the data, and the third step was to start coding all the data; the researcher chose to code by hand. The fourth step was to use the coding process to generate the description of categories and themes as they emerged. The fifth step was to consider how the description and themes would be written in the narrative, and the sixth and last step was to make interpretation of the data, which will be discussed in chapter five.

To accomplish step one, the following tasks were completed. After transcribing all six recorded interviews, open coding was used to organize the data. Simultaneously, the researcher conducted two member checks; once member-checked transcripts were returned, that document was converted into a Word document. From there, an Excel spreadsheet was created to begin listing

the emerging themes. During the first review of the transcripts, there were 25 themes that were “winnowed” into the six main themes and 14 subthemes (Creswell, 2012). Quotations were organized so that the data was presented in a logical manner.

After finalizing the organization of the open coding, repetitive themes, and quotations, the researcher began to interpret the data. The Kubler-Ross Stages of Grief (1991) and Compassion Fatigue and Vicarious Traumatization Theory (Figley, 2001) were used as the lens to interpret the emerging themes.

The data were organized by initial reactions following the death of their patients. The data was considered through Kubler-Ross (1991) to explore grief reactions. The data was simultaneously viewed through the lens of Figley (2001) to understand the longitudinal effects of such exposure to the unforeseen death of a patient. These two theoretical frameworks were used to ensure the researcher was developing a theory-driven interpretation of the data.

Results

The following is a brief description of each of the participants and the patient case scenario they presented. Participants were given permission to create their own pseudonyms.

Devoted Nurses and the Patient They’ll Never Forget

All six participants are New York State registered nurses who currently work in Upstate New York and have met the inclusion criteria of this study.

Grace

Grace (30), is a registered nurse (RN), who has been working in the field for eight years. She has a bachelor’s degree and has remained engaged as a member of the American Nurses Association for ongoing professional development. She has worked in a variety of clinical

settings, which include intensive care, medical-surgical, and emergency services. Grace is married and has two young children, who are not school age. Grace recalled a critical incident event that occurred while she was working on a critical care unit. She described a brief description of the patient case that left her feeling sad, angry, and curious about the patient's spouse's own grief and healing process.

Approximately two years ago, Grace had a patient transferred to her unit from the emergency department, who, after having been alert, conscious, and communicable, ended-up intubated and on life support for roughly 48 hours. During that time, Grace cared for the patient a total of 24 hours. As the RN assigned to the patient, Grace provided ongoing care that included administering medication, positioning, communicating with the patient and their family, as well as in the end, comfort care. In addition, Grace sat with the patient and her spouse until the moment the patient took her last breath. What stood out the most to Grace was that the patient had been undiagnosed for such a long duration of time that her condition rapidly progressed and her prognosis of a full recovery was slim.

Leonardo

Leonardo (27), has the least amount of experience as a registered nurse compared to the other participants for this study since he has been practicing for only the past four years. For the duration of his nursing career, Leonardo has worked on a medical surgical unit. He indicated that the majority of his patient population is chronically ill, geriatric patients. Leonardo is single and does not have any children. He has an associate's degree in nursing and aspires to advance his education at some point in time.

Leonardo indicated that there was one very specific critical incident that stood out in his mind, which met the inclusion criteria for the study. He indicated that there was a patient in his mid-twenties who was on his unit for quite some time, about a month and a half. Leonardo recalled that although the patient had a history of a chronic disease, his death occurred “suddenly, unexpectedly, [and] just took a turn for the worse.” Leonardo added that in fact, he was walking by the patient’s room when he noticed the patient did not look to be conscious; it was Leonardo who found the patient unresponsive and called a rapid response code. Leonardo was not present when the patient died, however, he was the last one to see him responsive that day.

Joan

Joan (80), a registered nurse for approximately 47 years shared her own account of the sudden death of a patient. Joan, still practicing as a nurse at the age of 80, recalled the sudden death of a two-year-old she was caring for on a pediatric unit. As a practice nurse for nearly four decades, Joan has worked in several capacities and on many units. At the time of this interview, Joan was a nursing supervisor. Joan is divorced, has three adult children, and has young-aged grandchildren. She talks about her nursing career with great pride and passion.

Joan was tearful as she recalled the events leading up to the death of a two-year-old patient. She vividly described the footed pajamas the toddler was wearing when she took her last breath one evening while Joan was rocking her to sleep. Joan was the nurse who had developed the closest relationship to the toddler. Although the toddler suffered from cystic fibrosis, she was not critically ill at the time of her death. Joan shared that it seemed like “her little heart just gave

out.” The toddler Joan cared for remains a constant image in her head for the past thirty or so years. Joan declared, “I suppose she always will.”

Lily

Lily (52), is currently a peri-operative nurse. She has been a registered nurse for the past 28 years and indicated that she has “experienced many critical incidents both as a nursing student and as a practicing nurse.” Lily has also worked as a nurse in respiratory services and on a medical-surgical pediatrics unit. Lily is married and has two children; one of her children has pre-deceased her. She disclosed, “My personal experience dealing with an unexpected death has impacted me greatly in many different ways.” She noted that she has struggled with a little bit of depression, anxiety, and flashbacks. However, Lily does not allow her personal critical incident to interfere with her work. Instead, Lily has taken her personal loss as a way to help other parents as both a bereaved parent and a nurse. Lily noted, “I know I help other parents deal with their unexpected outcomes with their child’s death or near miss [death] experiences.”

Lily had several examples of critical incidents that she was exposed to over her career. She shared the story of a patient who she cared for periodically over the course of several months. This patient was 14-years-old, who lost her battle with cystic fibrosis. According to Lily, this was not a critical incident. However, Lily indicated that becoming acquainted with the patient and her family over a long duration of time led her to the “utter shock” that she passed away. Lily recalled another critical incident that occurred while she was working in respiratory services. She remembered being called to the emergency department following a child being run over by a lawn mower. “I will never forget what I witnessed; those poor parents.” Lily noted that these two parents are often in her mind; sometimes for several days at a time.

Nana

An experienced nurse, Nana (62), is married, a mother of three adult children, and has been a nurse for forty-two years. She noted that she could not vision herself doing anything else. Nana has practiced as a nurse in a variety of capacities that include emergency services, medical-surgical, intensive care, and as a charge nurse of the unit (a nurse who is responsible for all the other nurses on that unit). Nana indicated that she was a private duty nurse and has cared for her own elderly family members.

Nana quickly recalled a critical incident that involved a patient that “makes [her] want to go back and try to still find answers as to what had happened, why it happened, what are the things that were involved that led up to that situation.” These were some of the lingering questions that surrounded the unfortunate death of a young woman following the birth of her third child. Nana recollected the shift she worked as a charge nurse when what seemed to be a routine cesarean section (C-section) resulted in a newborn without a mother and a father that became a widower. During this critical incident, Nana was responsible for managing the situation, the staff, and the support person for the patient’s devastated spouse. Nana further shared that this case was “very sad and upsetting, to think that I couldn’t help her in any way, to save her, along with the rest of the staff.”

Gwen

Gwen (47), was a registered nurse for eighteen years, is married, and has two adult children. She indicated that after she cared for her own child with special needs, she wanted to continue to give back and care for other people who suffer from medical and developmental complications. She has worked in both a skilled nursing setting, in the emergency department,

and as an emergency medical technician (EMT). Gwen indicated that there was one critical incident that impacted her to the point where she had to take a year of medical leave to heal mentally, emotionally, and physically from what she experienced.

Gwen spoke about a patient who tragically died hours after being admitted to a residential skilled nursing facility. Gwen indicated that the patient died as a result of having aspirated on his own vomit. Gwen noted that she has always felt as though the patient's death was self-induced. This critical incident not only impacted her due the sudden death of her patient but also affected her own personal story's connection with the patient family's story. Gwen echoed what the other participants in this study recalled about their own critical incidents: "this is something that I will never forget."

Shock and Denial

"Sometimes we do lose people"

Each of the participants vividly recalled the very moment another person's life was put in their care as part of the healthcare team. Furthermore, the participants recalled similar thoughts of "this can't be happening." Each account of their exposure to a critical incident began with a sense of shock and despair even though, as nurses, they anticipated such circumstances. All of the critical incidents occurred with patients under the age of 35 and for some, although they had chronic illnesses, the timing of their death was sooner than expected. Grace mentioned sometimes patients die in the hospital: "Once in a while, sometimes we do lose people. Typically, people that we code in Intensive Care Unit (ICU) or [die] in ICU are older people that have chronic illnesses. But, every once in a while, we do have somebody pass that you were not expecting."

This can't be happening. When participants described the death of a patient that was unforeseen, they noted the difference in experience when it is someone who has lived a full life, indicated by age, versus a patient that was an infant, child, young adult, or a young parent. Two participants offered the following: “Yeah, I don’t want to say it is easier, but you can cope better” and “When the patient is young and has so much life left to live, it is just not fair.”

Nana recalled during a code situation (when the patient becomes non-responsive and CPR may have to be administered) with a young patient, who had a routine C-section. It appeared that the patient developed a blood clot that complicated her recovery. When the patient ultimately passed away, the nurse noted to herself, and possibly out loud, “this should not be happening.” She referred to many things: the loss of a young life, a new mother dying, a helpless newborn being left without a mother, and the spouse who endured the pain and suffered by burying his wife on what the participant exclaimed “should be one of the happiest days of their life.”

Grace indicated her shock during the initial moments she first laid her eyes on a patient who was transferred from the emergency department to the ICU. She noted, “Oh man, this is not the patient that I thought I was getting. This is a much bigger problem than I thought I was going to be dealing with...” In a very short time, the nurse discussed the various options with the patient that included intubation. The patient wanted intubation and mentioned that he had faith. The patient never recovered.

Leonardo echoed that he experienced a similar initial reaction to the death of his patient: “How could this happen to someone the same age as me? I can’t believe this.”

Similar to Leonardo and Grace, Lily further validated the experience of denial: “I just never dreamt that she would pass on so soon because she was up and walking. You just don’t expect it. It is an eye-opener as to how quickly things can turn.”

In each critical incident, the nurse experienced a moment of denial; a period of time where they did not believe or did not want the death of a patient to be true. Furthermore, the amount of time that a nurse cared for his or her patient did not seem to matter. It also appeared that the patient’s age, the family or loved ones left behind, and the relationship between patient and participant added to their overall reaction to the situation.

They stay with you, always. Within the participant’s narrative of critical incidents, there was an ongoing presence of lasting memories of their patient encounters, a vivid recollection of the details of the situation. Nurses held on to visions of their patients’ faces, their clothing, a last conversation, and they frequently have articulated lingering questions. Another commonality was the participants’ concern about how the deceased patients’ families managed the loss of their loved ones. Permanent memories were illustrated in the following comment by a participant: “I still think about her because I know her funky hairdo that she used to have and the band that she liked. . .her upbeat personality and her positive outlook on life. That’s why I say, ‘live for today because you don’t know what tomorrow’s going to bring.’”

When asked about what a participant felt during the discussion of her patient that passed away two years ago, the participant mentioned that she still had strong feelings. Grace validated the lasting impact of not only the patient encounter but also the family in mourning as she stated, “Yeah, I think I always will think about this person. Thinking about her husband makes me sad. I worry about him and I wonder how he’s doing now. It was just so hard for him to come to that

decision [to extubate] and he kind of really beat himself up over it. That was really hard. I hope that he has found peace and that he's doing okay.”

Joan weighed in on her last memories of her patient: “I was rocking [the patient] to sleep, I was softly singing to her that evening. Her mother had just left not too long before that time. All of a sudden, I just felt her take her last breath. I just felt the life leaving her little body. I knew she wasn't suffering anymore, but her poor mother. I will never forget that feeling, holding her.”

Similar to Grace and Joan, Leonardo courageously added that following his patient's death, he avoided the room in which the patient died. He said, “I remember a couple months after that patient died. I had another young patient who was also ill, and I remember feeling that I couldn't connect with her. I remember reflecting why. I usually never had a problem connecting with patients no matter what age they are. So that again led me to reflection. . .I think it was a personal internal conflict.”

Similar to the previous participants, Joan Leonardo, Grace added a concluding comment that summarized their sentiments best: “They are your patients. As a nurse, you have to take care of your patients and you will never, ever forget them. You'll never forget their stories; you do not forget their names. They stay with you always. And their families stay with you. There are certain family members that stay with you always.”

The nurses were rattled with feelings of shock, despair, disbelief, and denial following the death of a patient. The participants were with their patient until the very last moments of their life. In these times, they shared intimate moments: life and death conversations, bathing and repositioning to ensure comfort, holding one another's hand, and praying for safe passage. The

nurses collected the sights, sounds, and images surrounding them during the critical moments.

These images of their patients created a lasting impression on the nurses.

Another patient to take care of. Nurses are responsible for more than one patient during their shift. Nurses take care of three to four patients at a time; they meet their medical, personal, and family's needs. The participants noted their need to be flexible and agile to address the needs of all patients. This proved to be a challenge in the time of crisis, both with respect to meeting the patients' needs and their own. There are several competing demands to be met.

Leonardo exemplified this juggling of emotions much like his nurse peers. He recalled some self-talk after he returned to his medical-surgical unit after he transferred his intubated patient to the ICU: "I remember having to step off the floor, just to be like, 'okay, you still have your own patient load you need to take care of. Keep things in check, it's okay. . .'"

The constant emotional struggle between caring for terminally ill patients who are stable and caring for patients who are in critical conditions or crashing can be "draining." Grace shared, "You walk into the next room and you have a totally different demeanor. You're constantly flip flopping your emotions back and forth. Having to be kind of low key and quiet, sensitive, and supportive of the family, and then I walk into the next room and smile and act all happy when I'm not. Or I have to listen to somebody in the next room asking why I wasn't there immediately and their dinner is cold. I'm like, 'Well, I was coding (which can include providing CPR) [to] somebody in the next room.' But, you can't say that to people. It just gets really hard to kind of juggle those emotions constantly.

Like the previous participant, Lily also commented on the demands to return to caring for other ill patients following the death of one: “. . .And I’ve got another patient to take care of, and, it’s like, ‘I’m still in that moment.’ It’s not like I can just erase it. It happened.”

Bargaining. What else could have been done? Participants in this study all had thoughts and questions about what they personally could have done different to save their patients’ lives. Some blamed themselves while others blamed the lack of medical intervention available. Some questioned what their care team could have done differently and even what the organization itself could have done to alter the tragic outcome. All these reflections appear to be bargaining for alternative outcomes.

Leonardo reported being mad at himself. He shared, “I think I was mad at myself for a little bit. I did blame myself. I took care of him so much, some of these things I probably should have advocated more, paid more attention to.”

Similar to Leonardo, Nana stated, “I just felt like we weren’t competent enough to take care of her particular needs that night. It was very sad and upsetting to think that I couldn’t help her in any way, to save her, along with the rest of the staff.”

Like Leonardo and Nana, both Lily and Joan made similar comments about their young patients that died early into their battle with cystic fibrosis. Lily grappled with the advancement in medicine and the potential life saving techniques that could have possibly changed the outcome of her patient: “If only at that time, there was the medication and treatment available that is part of the treatment for cystic fibrosis now. The young girl may have lived longer, and had a fuller life.” Grace, on the other hand, discussed one of the challenges she encountered was

the lack of resources available to some rural hospitals. She mentioned that the patients being treated often have multiple co-morbidities that further complicated their medical conditions. The nurse taking care of this patient while she was held in the ER [emergency room], was a nurse without critical care experience. Because this hospital was so busy at that point, there were no ER or ICU nurses available . . . [instead, she] was a medical surgical nurse. Therefore, the medical surgical nurse didn't pick up on the size of the shock." Grace discussed further about her own processing of what she could have done differently: "Sometimes, if it wasn't a good outcome, I often think about what did I do right or what could I have changed to get a better outcome."

You Need to Find Something that Works for You: Personal Reactions

The participants in this study worked between eight and 12-hour shifts. However, most of the participants worked a 12-hour shift. Participants shared their individual strategies for coping with the end of a long, difficult, and emotionally taxing shift. Participants relied on a combination of personal reflection, colleagues, family, and spirituality.

Time to grieve. In addition to their coping strategies, the participants shared other significant reactions, such as an inability to eat, sleep, and concentrate. Overall, there was consensus that the symptoms following the unexpected death of a patient vary and change in their length of time. Leonardo gave an example that "it was kind of a grieving process." He went on to say, "I had to grieve on my own, I think. I don't know if I could necessarily quantify an amount of time but it still stays with me; two plus years later."

Similar to Leonardo, Nana offers a similar experience: “It again depends on the situation. This [patient’s death] hung around for a little while, but there are some [deaths] that might stay just a few days. I don’t know what the other nurses do to cope with their patient’s death.”

Like Leonardo and Nana, Lily confirmed that her life had been temporarily impacted by the unforeseen death of one of her patients. She exclaimed with some hesitation, “My personal experience dealing with an unexpected death has impacted me greatly in many different ways. Maybe a little bit of depression, a little bit of anxiety, and a little bit of flashbacks.”

Similar to Lily, Gwen noted that following the unexpected death of her patient, she took a full year off of work to “grieve,” “mourn,” and as she shared, “figure out what I was going to do next.”

Furthermore, Nana also expressed her own experience of grieving following the death of a young, or unexpected patient: “I feel myself grieving. I hold everyone special in my heart, so there is a grieving process that I go through. That usually gets in there quite a bit for me, unfortunately. It’s just sad to see the young ones pass away when they do.” Nana concluded, “nurses grieve, quite a bit.”

After a patient dies, the nurses need time to collect themselves. The participants ranged in their responses from quietly reflecting on the time spent with the patient, their families, and the sequences of events leading up to their death to crying, sobbing even. The time of reflection varied among participants, nonetheless, a lasting impression was shared.

Time to cry. There is ongoing debate as to whether or not it is appropriate to cry with a patient and/or their family members. Some see it as an extension of being empathic while others may see it as crossing the professional boundary. For Gwen, Lily, and Nana, crying is part of how

they “cope,” “connect,” and convey that the patient really mattered. Lily mentioned that she has cried with families after their loved one dies: “I think it created a better bond between the patient, the family and the caregiver, that we’re not made of steel, we’re also human. It just tears me apart to see them going through such an emotional time with their mom or their family member that is going to pass on or just gotten bad news that there’s nothing more we can do, but to make them comfortable.”

Like Lily, Nana added that although she is a seasoned nurse, she is still sensitive. She shared she has sat at the bedside of the deceased and cried with the family member or friends; she too believes it is a reciprocal process to cry: “I think it helps them.”

Similar to Lily and Nana, Gwen recalled that after the death of her patient, she went to the end of the hall and her head dropped into her hands while she sobbed. She noted, “I just remember crying and saying to myself, ‘that poor mother.’” She went on, “it all just didn’t feel real.”

Unlike other participants, Grace recalled that she cried when she experienced a patient die for the first time during her career as a nurse. She verbalized the following assessment of her own observation of others who use crying as a coping mechanism: “There are some nurses who I know that cry every time a patient dies, and they cry with the family. I think that’s great. I think as the family, they’re probably looking at their nurse as being very compassionate.”

Participants indicated that the support and camaraderie of their peers helped in the initial experience of a patient death. Those who cry tend to cry together while others will sit quietly for a few moments, step off the unit, or ask for a hug from one of their nurse colleagues.

Time for reflection. In addition to crying, there are other modalities nurses use to cope following the death of a patient. All six participants talked about some form of self-reflection. A common place for this time of reflection occurred on the participants' commutes home. There was, however, variation in the preferences for driving in silent reflection or listening to soft music. The length of their commutes ranged from twenty to fifty minutes. Some even considered their commute as sacred time. Leonardo shared that he has often been questioned by peers why he does not consider moving closer to the hospital. He responded, "I live 40 minutes from work. It's been that way the whole four years that I've worked in the same facility, so I always get, 'Don't you want to move closer?' Well, I would like to live ten minutes down the road, but it's nice having that 40 minutes of just downtime where I can decompress, reflect and detach."

Like Leonardo, Nana, too, enjoys her 30-minute drive. She discovered that her commute assisted her by transitioning from her nursing responsibilities towards her home responsibilities of being a wife, mother, and grandmother: "One of my doctors asked me, 'Why do you live 30 minutes away?' . . . I said that's when I get to think about everything. I have that downtime before I get back home, to think about what had happened that day at work, and how I could have done this, or handled something, or maybe do something better the next time, before I get home and have to deal with another family 'life' situation."

Similar to Leonardo and Nana, Gwen uses her commute to decompress. Gwen has the longest commute, and she uses her 50 minutes, sometimes longer, to "get unwound" and "decompress" before she gets home.

Sharing the day. Not only did the nurses use time to self-reflect but they also shared the day with others to "let it go." Participants were adamant that they ensured they do not divulge too

much information as to compromise patient confidentiality. The participants shared their patient exposures with colleagues, family members, spouses, and friends. Two participants indicated that they felt as though nurses or others in the medical field understood and appreciated the experience more so than their non-medical related friends and family members.

Leonardo indicated that after the death of his patient he was compelled to not spend too much time in introverted reflection, that he purposefully brought up some of the internal struggles he was having with his peers. Leonardo emphatically identified his initial conversations about his lived experience of having a patient his own age that died suddenly with his peers: “Instead of being introverted reflection, more extroverted conversations, like life, death, goals in life; things we want to accomplish, things like that. It was hard at the time to make sense, like, ‘How could this happen to someone the same age as me,’ sort of things. Talking with people [within] the same age group did help.” Leonardo, like another participant, reached out to others for emotional support.

However, Grace sought her mother for guidance. She indicated that this has been the most meaningful because she her mother worked in healthcare and truly understands the language, experience, and science of medical intervention, unlike her spouse. Grace stated, “My [mother] is also a health care provider; my own personal debriefing is with her. She does the same thing. A lot of times, she’ll come to me and be like, ‘Oh, I had this case today.’ We kind of go back and forth and share information.”

Unlike Leonardo and the other participants, Nana added her own technique. Nana considered her technique useful. “I am told by my family I tell them too many things, not specifics, but tell them too many things. They are like, ‘Mom there’s more things in life than just

what happens at work.’ Sometimes, I talk about it; it’s just to help them to be aware of what to watch out for when it could actually happen to them. This is most often with motor vehicle or [all-terrain vehicles] ATV accidents.”

Participants use a variety of means to espouse their experiences. Overall, participants found some relief and validation in their conversations with others.

I was just so burned out. All but one of the participants indicated that they had intentionally changed roles within their nursing career. Lily added, “in the nursing profession, you’re given many different opportunities.” This supported her desire to move off of a pediatric ICU unit to somewhere that she indicated, “wasn’t so sad all the time.” She then uttered, “those footie pajamas, I’ll never forget those footies.”

Grace shared that that after she had several months of caring for dying patients, several really hard cases, she was “just so burned out.” These two participants recognized their need for a change of venue.

Unlike the other participants and Grace, Gwen indicated that three days after the critical incident occurred, she realized, “I needed time to separate myself from it.” She took a yearlong medical leave of absence.

Too Close to Home

The participants for this study indicated that there were three elements that added additional complexity and emotional challenges to caring for patients under critical circumstances. When a patient is within close proximity to the nurse’s age, it caused more room for the consideration of one’s own mortality. Further, when the patient the nurse is caring for is someone the nurse knows or has worked with, this made the role additionally cumbersome. And

lastly, the participants commented that when the patient is within close relation to their own loved ones, by means of age or circumstance, this created added hyper vigilance. This was reflected in the following ways.

Connection to self. Consistently, Leonardo talked about caring for a patient that was male and the same age as him. This caused both increased bonding and difficulty when trying to fathom his patient's abrupt death. Similar to Leonardo, Nana discussed in her narrative that she noticed that her patients were similar to her age, were her friends, and were her colleagues. Furthermore, her patients were also dying. She reflected, "It's sad when you start seeing people your age, your friends dying." Both Grace and Leonardo mentioned that it is often easier to have a patient die who is 85 or who has lived a full life. They indicated it is easier to rationalize than say a mid-20-year-old or a child.

I know you. All six participants mentioned that there were both positive and negative implications associated with living and working in rural communities. Participants shared that working in a rural community means they know their patients. Furthermore, if the participant did not know the patient before, due to the nature of chronic diseases, the participant would quickly get to know the patient through their frequent hospitalizations. Again, the participants worked 12-hour shifts and spent a great deal of time talking with, medicating, examining, and caring for their patients as well interacting with their fellow peers. Leonardo weighed in on his perception of working in a rural community: "We see the same patients over and over and over again and then we go into the community and we see them there as well. I think we do develop stronger relationships with these patients."

Like Leonardo, Grace shared some of her own personal experiences of becoming acquainted with her patients: “I have patients that I know exactly. I know that Mrs. Jones likes her ginger ale without ice and Mr. Smith likes this or that to eat. I know that they got to bed at 8 o’clock, like, you get to know these patients so well that you know their routine. You know their family, you know what their family members like, you know what time their mom gets their hair done. You know all these little details because you get to know these people and their families because they’re constantly coming back.”

Similar to Leonardo and Grace, Nana offered this intimate experience she encountered: “For myself, [some of my patients] were co-workers, and they weren’t unexpected deaths necessarily. There were some of them who might have cancer. . . I had one man who had leukemia, and his family decided to go with natural medicine instead of going with medicinal medicine, and that didn’t work for him. You just know these people in the community, because they almost become a part of your life, because you take care of them, and you take care of all their needs.”

Proximity to loved ones. There have been instances where either at the time of the unexpected patient’s death or after the fact, sometimes later, something is provoked within the nurse as a result of the proximity of the patients’ ages or circumstance in relation to the participants’ loved ones. This was the case for Gwen. Her son had Autism and at the time, she considered placing her son in a residential, skilled nursing facility that her patient with a development disability died in shortly after being admitted. She indicated that this intensified her reaction to the situation: “I felt guilty; I struggled with what to do for my son.” She went on to say, “I was scared.” Further, she bonded with the patient’s parents because she “felt somehow responsible.”

Similar to Gwen, Nana indicated that years later, when her daughter was having a baby, she needed to have an emergency C-section. Nana was flooded with the emotions she felt that day her patient died from a routine C-section. She shared, “When my daughter was having her babies, and she had C-sections, I worried about her. I worried that could happen to my child, which was very disturbing. . .”

Like Gwen and Nana, Joan experienced something similar. Joan shared that as a result of some of her experiences as a nurse, she was fearful and cautious about what her children were doing; specifically, with motor vehicles and ATVs, she expressed, “think about the horrific things I have witnessed—the real danger in it.”

Similar to Gwen, Nana, and Joan, Lily experienced something similar. Lily almost tearfully expressed that after some horrific event happens and someone dies unexpectedly, she responds by going home and hugging her child or loved one. She concluded, “You have to just thank God it wasn’t [your] family.”

These personal testimonies by the participants demonstrated a juxtaposition between being a nurse professional with all the ethics, boundaries, and knowledge of medicine with that of the emotional, human, relationship pre-existing or newly established with the patient and their family. The participants grappled with the essence of being a nurse—being compassionate and caring to setting boundaries as a means to protect themselves for the repeated exposure, potential over-exposure to loss.

I Care. It’s Not Just a Job

Not one participant in this study indicated that they no longer wanted to be a nurse. They all were loud and proud about their professional affiliation and career accomplishments. Albeit

they had encountered some obstacles and struggled with unpredictability and fragility of life, they could not view themselves in any other profession. There were two subthemes that stood out concerning their continued investment and passion for the nursing profession: the compassion they have for their patients and the comradery amongst their colleagues that led to overall career satisfaction and engagement.

Compassion. The participants in this study care deeply, feel deeply, and are proud of their profession. Leonardo captured the following about the essence of nurses' roles to their patients: "Nursing is all about connecting with people, establishing good relationships with the patient, but it seems it is never taught what to do when you have this close of a relationship with a patient and then something unexpected happens."

Throughout this chapter, participant have professed their endearment they have toward their patients. The participants referenced their patients as "family" or extensions thereof as a result of the therapeutic relationship established during their hospitalization or hospitalizations. Lily spoke of her role as a nurse: "I care. It's not just a job. It's not just my career. It's what I like to do. It's my passion." For these participants, being a nurse seemed to be a significant part of their identity. It's not something that they leave at the door when their shift is over; it defines them within themselves and within the community.

Similar to Lily, Leonardo discussed his admiration for the relationships he established with his patients: "For me, I like developing those relationships and seeing the same people inside the hospital repeatedly and then outside the hospital as well. For me, I find it beneficial."

Like Lily and Leonard, Nana offered that when she knows a patient is dying, she enjoys singing to them. Furthermore, Lily has been known to hold someone's hand, even after her shift is over because "they're not alone, someone is with them; I am with them."

Collegiality. It seemed that often, these participants supported one another to weather the storm. The participants in this study spoke highly of the camaraderie and respect among their peers. Some participants referenced having intense bonds with their colleagues, felt as though they understood one another like no other person could understand, and appreciated the experiences of a nurse. Nana indicated that the best part of being a nurse for the last forty-two years are the colleagues she encountered and the lasting friendships she created. Like Nana, Leonardo attributed his relationships with his nursing colleagues as his coping mechanism when he dealt with difficult patient outcomes and the trials and tribulations he encountered while being a nurse.

Self-Preservation

The participants discussed various ways of setting boundaries both personally and professionally, as well as ways they "detached" and cared for themselves. Some of the ways participants reported coping and detaching from the emotional complexities of the nature of their work was through the peer relationships they formed, reading, taking hot baths, drinking wine, eating, shopping, expressing gratitude, and staying connected to a form of spirituality.

Gwen indicated that she has always envisioned herself as a "giver" and at times, that tended to wear on her. She indicated, "I don't know if being a nurse has changed me." She indicated that nurses, due to the nature of the work, "need some sort of outlet to let go of stress." Gwen felt as though over time, she has learned to internalize her work less although, she could not quite account for how she has done this. Similar to Gwen, Lily expressed that she, too, felt

that over time she has been able to internalize difficult patient outcomes less and used her sense of spirituality and her outlook on life to help aid the difficulties that she may encounter. Like Gwen and Lily, Leonardo indicated that he is aware that some nurses meditate, others unwind with their friends, or listen to music, maybe drink beer, but for him, he reported that, “I do a lot of reading.” He added, “When I leave work, though, I just try to focus on what I have going on in my personal life, with family, with friends, things like that, and just try to leave the stuff the best I can. . .It’s hard some days, but as best I can, just detach it on my drive home.”

It was presented by the participants that there are things that get in the way of engaging in consistent self-care practices. Participants identified competing responsibilities, such as being the caretaker for children or elderly parents, finances, time, and energy. Most participants presented that they had knowledge and awareness that they needed ways to reduce stress, however, they often lacked consistency or strategies for sustainability. Regardless of the coping strategies, these participants have put into place their own coping strategies; they all indicated that they would benefit from additional opportunities for debriefing and skills development for handling these difficult losses. This leads to the final theme, the role of the hospital administration.

The Role of the Hospital Administration

There was consensus among participants that they were not adequately trained to deal with the exposure to the unexpected and often tragic deaths of their patients. The participants discussed having limited exposure or access to formal debriefing sessions following a critical incident. There were several suggested strategies that they felt organizations could take to further support nurses either following a critical incident or as a preemptive measure with the anticipation of potential exposure to a critical incident event.

Lily, Joan, Nana, and Grace indicated that on occasions, they were aware of or engaged in debriefing, but it was not something that happened consistently. Grace made it clear, “We need to talk about it.” Collectively, participants articulated a need to offer time for everyone to weigh in on the experience followed by the death of a patient. They did not indicate that it had to be exclusive to a critical incident or unexpected outcome. Rather, anytime there is a death there could be room for pause and reflection.

Similar to Lily and Grace, Leonardo contributed that he was not taught formally in nursing school how to cope with critical incidents; this training could be integrated into clinical practice. He commented, “I think just giving the opportunity to talk about things that have worked for certain nurses and things that have not worked for certain nurses would be helpful.” Like Lily, Grace, and Leonardo, Gwen’s own opinions validated others. She indicated, “Nurses need to have some PTSD counseling or a regular venue for them to talk about these things that happen.”

Summary of the Findings

Through the use of qualitative research, the lived experiences of six RN participants were highlighted. These findings demonstrate the unique critical incident experiences of nurses in rural Upstate New York. Participants alluded to six major themes: Sometimes We Do Lose People, You Need to Find Something that Works for You, Too Close to Home, I Care. It’s Not a Job, Self-Preservation, and Role of The Hospital Administration. In Sometimes We Do Lose People, (not all people who arrive to the hospital or are admitted get to go home). With that, nurses experienced a wave of mental, emotional, physical, and social reactions. There were four subthemes within this major theme: This Can’t Be Happening, They Stay with You Always,

Another Patient to Take Care Of, and What Else Could Have Been Done. In You Need to Find Something That Works for You, participants accounted for their initial coping strategies following the unexpected, unforeseen death of a patient they were caring for. The nurses' responses contained five subthemes within this major theme: Time to Grieve, Time to Cry, Time for Reflection, Sharing Your Day, and I'm Just So Burned Out. In Too Close to Home, the participants considered three additional subthemes that reflected the relationship to the patient at various intervals: age, relationship, and proximity to their own loved one by age, nature of the situation, or something that created a correlation between the patient and the participant's loved one. The three sub themes were Connection to Self, I Know You, and Proximity to Loved Ones. In I care. It's Not a Job, the participants professed their commitment to the profession of nursing, their patients, the patient's family, and their colleagues. The two subthemes were Compassion and Collegiality. In Self-Preservation, the participants accounted for their unique and personal means of engaging in self-care, setting boundaries, and considering the stress of the job. In the Role of the Hospital Administration, the participants offered their experiences of debriefing following critical incidents and potential strategies the administration could establish to better support nurses.

The researcher will analyze the findings and offer recommendations and opportunities for further research considerations in the following chapter.

CHAPTER 5

DISCUSSION/SUMMARY/CONCLUSION

This phenomenological study was designed to investigate how registered nurses in rural Upstate New York recalled their experiences of repetitive exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult) and simultaneously described how their emotional responses impacted and changed their life, if in fact they did. This research study was conducted to fill a literature gap and to represent the personal accounts of nurses and their experiences of first-hand exposure to critical incidents and the impact such exposure had on their lives. In this chapter, the researcher begins with a review of the research question guiding the study and a summary of the participants' responses. Next, this chapter offers an interpretation and alignment of findings with the literature. The major findings are presented with a discussion of how they validate or add to the current body of research supporting the grief cycle and symptoms of compassion fatigue amongst nurses. The findings are organized under the following headings: (a) nurses care deeply for their patients, (b) a nurse's life is changed as a result of their exposure to critical incidents, (c) grieving is part of the job, (d) various strategies are used to cope with the exposure to dying, and (e) administrative acknowledgement is fundamental to nurse well-being and job satisfaction. Then, this study's implications and recommendations for action and future research are presented. Finally, the chapter will wrap-up with a conclusion of the overall research synopsis.

Review of Research Question and Summary of Responses

This phenomenological study was designed to investigate how registered nurses in rural Upstate New York recalled their experiences of repetitive exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult) and simultaneously described how their emotional responses impacted and changed their life, if in fact they did. The study was qualitative in design, drawing from Creswell (2013). In-depth interviews were the primary focus for data collection. Interviews supported the phenomenological research approach to “assemble the textual and structural descriptions” of a phenomenon (Creswell, 2013, loc. 1753).

Further, purposive sampling was used to select participants based on their employment as a registered nurse working in Upstate New York (Rubin, 2005). Through a qualitative methodology, interpretation and meaning were made from the personal accounts of registered nurses. Analysis was accomplished through the conceptual framework of Kubler-Ross, Stages of Grief, and the symptomology of compassion fatigue (1993). The final step synthesized the textual and structural statements captured in the participant interviews.

There were five sub questions associated with the study’s inquiry:

1. What is the experience like to care for a patient or patients experiencing traumatic incidents, death, or an unforeseen loss (infant, child, multiple accidents)?
2. How do nurses display compassion for self and others (peers, patient, and families)?
3. What is the grief process like to nurses when a patient dies?

4. In what ways are a nurse's life changed as a result of caring for a patient in terms of their care being categorized as a critical incident (unexpected outcomes, mass casualties, and/or death of infant/child/young adult)?
5. What are the opportunities to implement programming to address nurse occupational stress outcomes?

Analyzing the data for the five sub-set of research questions produced five interrelated themes from chapter four. Nurses care deeply for the patients they are charged to take care of. Nurses spoke about their commitment to the patient and their emotional reactions to the death of a patient. Nurses harbored memories of the patient and their families long after their shift was over. In fact, collectively, the participants reported that they did not imagine they would ever forget the patient or the sequences of events leading up to their deaths. Another theme emerged: a nurse's life is changed as a result of their exposure to critical incidents. Nurses in this study ranged in the time they felt physical, emotional, and mental ramifications from the death of a patient. Regardless, they identified some form of shifting in their thinking, relationships, and outlook on life. Nurses seemed to acknowledge and accept that grieving was something that occurred as a result of the work they do, and that they could very easily identify the stages of grief they experienced. Additionally, nurses used various forms of coping strategies to address their experiences and work related stressors. Lastly, keen attention was paid to the role hospital administration could play in supporting and acknowledging the occupational stressors associated with the nursing profession. Several recommendations were made for improving the overall

satisfaction and workplace wellness of nurses. Next, the interpretation of these themes and their alignment with the literature review will be discussed.

Interpretation and Alignment of Findings with Literature

Two theories informed the analysis of the experiences of registered nurses in the aftermath of being exposed to a critical incident. The Elizabeth Kubler-Ross Stages of Grief and Charles Figley's (2002) theory of compassion fatigue provided insight into the development of the five overarching themes. The analysis yielded five areas: (a) Nurses Care Deeply for Their Patients, (b) A Nurse's Life is Changed as a Result of their Exposure to Critical Incidents, (c) Grieving is Part of the Occupational Hazard, (d) Various Strategies are Used to Cope with the Exposure to Dying, and (e) Administrative Acknowledgement is Fundamental to Nurses' Well-Being.

Nurses Care Deeply About Their Patients

Consistent with Ford (2014), nurses are required to demonstrate a great deal of care and compassion for the patients they care for. Such high levels of empathy expression can take an emotional toll on the nurses' own emotional well-being and expression of self-compassion. As professed by Ford (2014), "Nurses can suffer as a result of having to display compassion all the time" (p. 2). In many cases, participants evoked an emotional attachment to their patient, often as the result of having repetitive exposure to the patient due to the rural nature of the community in which they live and work or due to the frequency or duration of the patient's hospitalizations. Nana talked about how patients she has cared for have also been members of the community in which she lives. She further noted that as she has aged, she is now taking care of her peers, fellow nurses as they have become critically ill. Leonardo referenced the unique nature of seeing

patients in the grocery store or at community events. Leonardo indicated that “This is what happens in rural communities,” as if he is stating some obvious notion that nurses have relationships and bonds with those they treat, sometimes before the person becomes their patient.

At times, nurses experience a degree of moral distress—a struggle between what they know is right and what is possible through medical intervention, science, resources, and the disease process. Mathieu and McLean (2015) discussed this notion as a matter of “cumulative effects from working in high-stress” (p. 30). Although nurses received extensive training and had practical knowledge that medical intervention only goes so far and that we all die, at some point in time, repetitive or extreme exposure to the death of a patient is difficult to accept. All but one of the nurses in this study had switched units following exposure to critical incidents involving a patient’s death. Nana, Lily, and Joan all left pediatric units and transitioned to alternative practice areas (medical surgical, ambulatory surgery, and nursing administration). In the case of this study, nurses who expressed empathy and somehow connected to the patient care deeply, causing a lingering emotional attachment to the patient long after their death. Lily, years later, still vividly recalled the footie pajamas that her patient was wearing, and Joan indicated that she would never forget the little girl’s face and the lullabies she would sing to her.

A Nurse’s Life is Changed as a Result of Their Exposure to Critical Incidents

In all six participant interviews, the nurses expressed that in some shape or form their lives had been forever impacted. Nana talked about how she is extra cautious and concerned whenever one of her own children becomes ill or is anticipating surgery. It is fair to say she worries; she knows first-hand how fragile life is. The lasting memories, images, conversations, or recollections of the critical incidences remained steadfast in their minds. Consistent with other

research, nurses who experience high stress situations and repetitive exposure to death exhibit symptoms of compassion fatigue. Nurses reported having to take temporary leaves of absence from their work or changing their area of practice from one specialty to another as a result of the emotional wear-and-tear. The nurses' reports support the 2008 research conducted by the U.S. Health Services and Resource Administration (HRSA) that more than 50% of nurses have changed positions or employment as a result of workplace issues, stressful work environments, lack of good management, or inadequate staffing (p. 53).

In addition to changing positions as a result of high stress environment, the nurses also indicated that their life had been changed in other ways, such as their sleep and eating patterns, their reactions to others, and their overall sense of happiness. Leonardo shared that after his shift, he attempted to treat himself to fast food, and after getting his meal, he realized he had no desire to eat. He further noted that the night of the patient's death, as he laid down to go to bed, he couldn't sleep; this went on for a few days. Consistent with compassion fatigue symptoms, nurses in this study exhibited the symptoms of caregiver stress. Caregiver stress, as defined by McCann and Pearlman (1990), can be seen in the form of cognitive changes. Changes in mood, sleep patterns, energy, and over satisfaction with life are all examples. Further, other manifestations were outlined by Teater and Ludgate (2014) in the areas of the caregivers psychological, physical, and behavioral perceptions and actions. Lily, Nana, and Gwen all indicated periods in their nursing careers where they felt anxious and depressed as a direct result of the events they were exposed to.

Grieving is Part of the Occupational Hazard

Nurses reported symptoms of grief following the death of a patient. Nurses in this study expressed that following the patient's death, they had bouts of anger, sadness, depression, denial, and over time, a level of acceptance with the course of events. Kublar-Ross (1969) reports that people experience stages of emotions following the death of a loved one. These symptoms occur in stages or at times, simultaneous, overlapping, skipping from one to another and back again, or missed all together. The stages include a battery of denial, bargaining, anger, depression, and acceptance. Gwen indicated that after she took a year off of work before she felt ready to go back to being a nurse. Leonardo, in his own time, also indicated experiencing bouts of confusion, frustration, sadness, and denial of his patient's death. He noted that after experiencing this range of emotions, he did feel "better."

Jonas-Simpson et al. (2013) confirmed that nurses have reported grief reactions to the loss of a patient. In fact, their research concluded that nurses reported they were "sometimes overwhelmed" with their reactions (p. 5). Consistently, nurses in this study expressed the exhausting nature of essentially recovering from the death of a patient, too. Gwen talked about her need to take as long as a year off from working as a nurse to recover from the death of her patient. Leonardo also shared that it took him time to "grieve" over the death of the particular patient event that he was exposed to. Additionally, Lily and Grace talked about the anger they harbored surrounding some the circumstances of their exposure to an unforeseen patient death. Regardless, nurses seemed to accept this as an occupational hazard and maintained their commitment to the profession. Nana validated this notion as she said, "It never gets easier; you just learn how to deal with it differently."

Various Strategies Are Used to Cope with Dying

One thing is for sure, it is easy to identify that having healthy coping strategies is important to self-care and well-being. to practice them with fidelity (Perkins & Sprang, 2012). The nurses in this study had an array of coping strategies; some were good and some were not so healthy. Nonetheless, they were able to identify them. Crying with patients, crying alone, stepping off the unit, asking for a hug from colleagues, quiet conversation, attending patient funerals, the commute home from work, sharing the workday with family and friends, sleeping, warm baths, playing with pets, and reading were some of the coping strategies identified. It was evident that the collegial relationships established were important to the overall nurse narrative.

Sprang et al. (2011) shared in their research the importance of social support and its ability to alleviate intentions to leave the profession. None of the nurses in this study indicated that they would want to quit their job or find an alternative profession. It was quite the contrary; most often, the nurse could not see themselves doing anything other than being a nurse. Nana, Gwen, Joan, and Leonardo all indicated if given the opportunity, they would not have chosen another profession. Something that was not directly correlated was who the close connection was with. The nurses in this study varied in their responses and sense of who they could turn to for support. Some were very clear and could identify very specifically one or at least a few colleagues they could confide in. Overall, there was a consensus that having another nurse to disclose information to was more helpful than sharing work day stressors with someone unfamiliar with the nature of healthcare. According to Sprang et al. (2011), nurses' relationship with their manager or supervisor had greater significance. Leonardo talked about the need to have senior nurses, those with more years of experience, to turn to for guidance about what

works and what does not with respect to coping with a sudden patient death. Grace, too, spoke about the need to feel safe and comfortable going to a supervisor following an event. She noted that this exchange is an opportunity to problem solve, re-group, and improve practice. She noted that when these “just in time” opportunities aren’t provided, her level of frustration increased.

Wentzel et al. (2014) reports that nurses tend to put others’ needs before their own, another consistent theme among those interviewed for this study. Although nurses could identify healthy coping strategies and had an idea what would be good self-care, the ability to carry out their intentions often was dismissed due to competing demands of family and other obligations. Nana and Gwen both discussed the obstacles that prevented them from carrying out their well-intended self-care plans. Nana spoke about needing to care for elderly family members while Gwen talked about the sheer hustle and bustle of life.

Administrative Acknowledgement is Fundamental to Nurse Well-being

With the previous discussion of competing demands as obstacles to self-care and the importance of collegial relationships, it seems imperative to present the responsibility of the hospital administration to ensure the well-being of its nursing staff. The nurses in the study had plenty of recommendations to offer. Nana, Lily, Grace, and Leonardo all discussed the elements of having additional patients to care for, a shift to finish, and the need to take time to reflect on the events that occurred leading to the death of a patient. Hanna (2004) asserts that organizations can take the lead in helping to foster good relationships between nurses and the interdisciplinary team. If hospital administration were to take the lead and acknowledge the importance of self-care, perhaps those working within the organization would also see the value of self-care.

Further, accepting the potential exposure to compassion fatigue by the sheer nature of the profession, a preventive, proactive approach seems logical. Catherall (1995), as cited by Teater and Ludgate (2014), put forth the idea that a plan should be in place before it is needed. Moreover, Teater and Ludgate profess, “one of the most important things organizations can do to prevent caregiver stress is to talk about it” (p. 127). Grace presented her own frustration with the lack of organizational response and discussion surrounding critical incidents. She emphasized her need to have an ongoing dialogue following the death of a patient. Specifically, she wanted to process not only her reactions but the potential steps that could have been taken to prevent the event from occurring. Nurses and patients alike could benefit from changing the mental model that “this is just what we do” (deal with life and death) to taking a stand to embrace the human reaction to the loss of life.

Implications and Recommendations for Practice

The following recommendations were developed from the data collected as part of this qualitative research study. Recommendations were made in three broad categories:

1. Current and aspiring nurses,
2. Nursing schools, and
3. Hospital administrators.

Recommendations for Current Nurses

Nurses involved in critical incidents in which a patient dies unexpectedly should consider the following:

1. Several of the nurses reported having to “find what worked best for them,” and this meant talking with friends, finding a co-worker to confide in, turning to their faith base, or in

some worst-case scenarios, processing alone. Identifying and developing reflective strategies to process, discuss, and debrief their reactions following the death of a patient is recommended. Ideally, this would be best practice following the exposure to any highly stressing shift or patient death. Overtime, the nurse might be able to establish a regular, consistent, tool box of coping strategies. Furthermore, once established, coping strategies could aid in reducing the long-term effects of work related stressors.

2. Nurses should request and participate in organized, evidence-based critical incident debriefing.
3. Nurses want to have their feelings normalized and feel safe when sharing their emotional reactions. Nurses should be aware of their potential grief reactions following the death of a patient. Acknowledging normal, human reactions to grief and loss can offer validation to nurses' experiences and begin a cultural shift to support voicing out loud the nurses' own grief associated with the death of a patient.
4. Nurses have been left to their own devices to identify these forms of peer support. If there was an identified group or point person, nurses would not have to navigate the process alone. They should develop peer and social support systems to lean on and share their work-related stressors and experiences of grief. This could be in the form of a structured support group, identified peer supports, spiritual community, or through individual and group counseling.

Recommendations for Nursing Schools

1. Nursing schools could incorporate in their curriculum opportunities to discuss and demonstrate healthy coping strategies associated with occupational stress. Further, simply

having a lecture or reading assignments dedicated to the topic of compassion fatigue, burnout, and vicarious traumatization could help to prepare student nurses to think about self-care strategies.

2. The nurses in this study could not recall any formal curriculum or education specific to how they themselves would respond to the death of a patient or to discuss strategies for self-care. Nursing schools could use a simulation exercise of a critical incident where simulated, a patient dies; be it an infant, child, young adult, under unexpected circumstances, or a mass casualty and then use the exercise to debrief the mental, emotional, and physical reactions of the student nurses.

Recommendations for Hospital Administrators

1. Nurses reported haphazard organization of debriefing. In their personal accounts, either debriefing did not occur at all or at best, it was inconsistent. Develop a system for consistent incident stress debriefing following a critical incident whether it was a highly stressful patient case or a patient or multiple patients die. Over time, the consistent offering of incident stress debriefing will become a cultural norm of the hospital. Ultimately, hospital administrators and nurse leaders need to demonstrate the value and importance of offering mental and emotional support to their nursing staff.
2. Following a critical incident, nurses face competing demands and the responsibility to care for additional patients. If the critical incident occurs at the start of a nurse's shift, they could still have several hours ahead of them. This was reported to weigh heavy on the minds of nurses in this study. Providing nurses the autonomy and option, without

penalty, to end a shift early as a result of their exposure to a critical incident is recommended.

3. Nurses disclosed needing opportunities to debrief or have a tranquil place to re-group. Establishing a dedicated breakroom for nurses to meditate, reflect, and use as a sacred space would further validate the value placed on self-care. Hospitals should develop a repository of resources for nurses to know when, how, where, and who they can reach out to for support following a critical patient incident, making access to debriefing and coping strategies easily accessible.
4. Nurses expressed a desire for administrators to take a proactive approach to nurse well-being. Administrators should, at the point of hire, educate nurses about their initiatives to support and engage nurse self-care. Having a prevention-oriented mind-set is important in recognizing the potential exposure to occupation stress.

Recommendations for Further Study

Additional research is recommended to expand the scope of this study. Registered nurses need early and ongoing training about their reactions to critical incidents and with coping strategies to address the mental and emotional reactions occurring as a direct result of taking care of a patient who dies unexpectedly. Further, nurses need the support of their fellow peers, supervisors, and hospital administration. Lastly, nurses need to have the opportunity to debrief and discuss the sequence of events and their reactions to a patient dying. Due to this study's limited scope, here are recommendation about research topics to further develop and that would extend the study of this topic:

1. This study was conducted with six participants; future research could be replicated with an increased number of participants to compare findings.
2. A longitudinal study of participants involved in the research could be conducted to learn how the nurses continued to experience and perceive their exposure to critical incidents, compassion fatigue, vicarious trauma, and strategies for coping with their exposure or subsequent exposure to critical incidents. Research from this study took place with nurses at various points in their nursing career.
3. The participants in this study varied in age and experience. The study of nurses could be replicated with a specific focus on a defined age range or years of experience. For instance, a study could focus on nurses in their early twenties to late thirties and another group in their early forties through late sixties and compare and contrast their responses. With respect to experience, again, a specified range could be the focus. Then, offer a compare and contrast of reported experiences.
4. The gender of nurses represented in this study was rather one sided, female. There was only one male participant. The study could be replicated either of two ways: as a balanced representation of genders or conducted as a comparative study, targeting the experience of male or female nurses, which could add another dimension to the research.
5. The nurses in this study practiced as nurses in rural settings. Future studies could focus on nurses in urban or metropolitan hospital settings.

Summary and Conclusion

Through this qualitative research, it has become clear to the researcher that nurses make significant sacrifices to ensure the health and well-being of others. They give of themselves to

mend the physical, mental, and emotional wounds of others. This self-sacrifice comes at a cost. Although the people a nurse cares for are not their family, kin, or close friends (in most cases), they make every effort to treat the patient as if they are such. This level of empathy and compassion leaves, at times, a lasting wound on the nurse once the death of a patient is imminent. As family and friends mourn the patient's death, a nurse may suffer the same grief in silence. The researcher had the most honorable privilege to allow the voices of the nurses' experience of a patient's death to be heard.

Further, among all the care and attention that is given to the patient or patients in a critical incident, there are still other patients to care for. This tug-of-war of competing demands must be minimized by the nurse to ensure ALL patients they care for are given the same level of attention and care. It is critical that we understand the implications of these ongoing demands. As presented in this research, nurses may not look out for themselves as they are too concerned with taking care of everyone else. We must advocate for nurses and whenever possible, we should thank them for, as we may grieve in our own way and move on in the business and chaos of our lives, nurses can forever keep the image of our loved ones in their grasp.

Ultimately, the dismissal of the lasting impact on a nurse's overall well-being cannot be ignored. Self-care, self-preservation, and prevention must become a central focus. At some point, either we will be the patient or it will be one of our loved ones. Nurses need to have support early and often to debrief, share their experiences, connect with their colleagues, and be celebrated for the lifesaving work they do. Also, nurses need to be accountable to themselves and one another to practice self-care, take time to grieve, and acknowledge and voice their reactions

to a patient's death. If all professionals were all to take responsibility for caretakers, our healthcare organizations and our communities would be healthier places.

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Appendix A

Dear Nurse Colleagues,

On the behalf of Shantel Sullivan, LMSW, I am writing to share an opportunity to participate in a voluntary research opportunity. Shantel is currently a Social Work doctoral student at the University of New England in Portland Maine and is interested in contributing to nursing research.

Why is this study being done?

- Her goal is to understand how registered nurses in rural upstate New York recall their experiences of exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult) and how do these experiences impact their life.

Who will be in this study?

- People chosen for this study will have met the following inclusion criteria:
 - Is a current employee at a community hospital in upstate New York?
 - Function as a registered nurse (RN)
 - Have you been a registered nurse at least for one year?
 - Have participated in direct patient care that has involved one or more of the following:
 - unexpected outcome, (death);
 - mass casualties
 - death of an infant/child/young adult
 - At least eight participants will be involved with this study.

The use of these two broad questions will support the process of connecting themes and deriving the commonalities shared between the participants. The participants will be asked two general broad questions:

- “What have you experienced in terms of the phenomenon?”
- “How has this experience impacted your life?”

If you are interested, and meet the inclusion criteria, please contact Shantel Sullivan either by phone, at (315) 842-1213 , or email at, Swood5@une.edu

Appendix B

University of New England Participant Consent Form

Project Title: The Nurses Story: A Qualitative Phenomenology Study

Principal Investigator(s): Shantel N. Sullivan, student, University of New England, Swood5@une.edu. Joanne Cooper, Ph. D., faculty advisor, University of New England, jcooper5@une.edu

Introduction:

General requirement language:

- Please read this form, you may also request that the form is read to you. The purpose of this form is to provide you with information about this research study, and if you choose to participate, document your decision.
- You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. You can take as much time as you need to decide whether or not you want to participate. Your participation is voluntary.

Why is this study being done?

- My goal is to understand how registered nurses in rural upstate New York recall their experiences of exposure to critical incidents (unexpected outcomes, mass casualties, and/or death of infant/child/young adult) and how do these experiences impact their life.

Who will be in this study?

- People chosen for this study will have met the following inclusion criteria:
 - Is a current employee at a community hospital in upstate New York;
 - Functions as a registered nurse (RN);
 - Has been a registered nurse at least for one year;
 - Has participated in direct patient care that has involved one or more of the following:
 - unexpected outcome, (death)
 - mass casualties

- death of an infant/child/young adult
- At least eight participants will be involved with this study.

What will I be asked to do?

- People chosen for this study will have to do the following:
 - Sit through 2, one and half hour interviews while I ask the person questions about his or her experiences and reactions to having been exposed to critical incidents as a registered nurse.
 - Questions asked during these sessions will help me understand what nurse's experience and how they cope with their experiences.
 - The first interview will happen during August 2016
 - The second interview will happen during September 2016
- All interviews will be recorded with an audio recorder and I will do some note taking as well.
- As the researcher for this group, I will administer the interviews.

What are the possible risks of taking part in this study?

- There are no foreseeable risks associated with participation in this study.
- If you do recall a painful memory, a list of licensed mental health and social work professionals will be provided to you. A free consultation with a professional will be available to help you deal with your feelings.

What are the possible benefits of taking part in this study?

- There are no direct benefits to you for participating in this study. However, one may consider having their story and experience listened to as a benefit out of the sheer opportunity to share their feelings and reactions.

What will it cost me?

- Participants will not accrue and fees associate with participating in the study.

How will my privacy be protected?

- Your interview will take place at a setting where you are most comfortable and secure (ex. Reserved room at the public library).
- The results from the study will be shared with you, the other participants in this study, my dissertation committee, editors, and anyone interested in ready about these results.

How will my data be kept confidential?

- This study is designed to be anonymous, this means that no one, can link the data you provide to you, or identify you as a participant.
- All data collected for this study will be kept in a locked file, including names of participants and their employer's name.
 - This locked file will be kept in a locked room at my house.
 - Only I will have access to your data.
 - After the completion of this study, all data resulting from this study will be destroyed.
 - Including audio recordings, hard copies, and electronic data will be destroyed.
 - Data will be stored on a password protected computer.
 - Data will be coded.
 - Data will be encrypted using industry standards.
 - No individual recognizable information will be collected.
- You will create your own pseudonym to protect your identity.
 - Only you and I will know your pseudonym.
- Your employer will not be directly mentioned in this study.
- Please note that regulatory agencies and the Institutional Review Board may review the research records.
- A copy of your signed consent form will be maintained by the principal investigator for at least 3 years after the project is complete before it is destroyed. The consent forms will

be stored in a secure location that only I will have access to and will not be affiliated with any data obtained during this project.

- Audio recordings created from your interviews will be made accessibly to me and Rev.com, a trusted transcription agency.
 - These audio recordings will be destroyed as soon as the project is complete.
- The results from my study will be shared with you, the other participants in this study, my dissertation committee, editors, and anyone interested in ready about these results.
 - If you would like a copy of the results, please request a copy by emailing the researcher at Swood5@une.edu.

What are my rights as a research participant?

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University of New England or your employer.
- You may skip or refuse to answer any question for any reason.
- If you choose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive. You are free to withdraw from this research study at any time, for any reason. If you choose to withdraw from the research, there will be no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.

What other options do I have?

- You may choose not to participate, your participation is completely voluntary.

Whom may I contact with questions?

- The researchers conducting this study are Shantel N. Sullivan and Joanne Cooper, Ph. D.. For questions or more information concerning this research you may contact me at 315-842-1213, Swood5@une.edu or Joanne Cooper, Ph. D. at 207-221-4960, jcooper5@une.edu.
- If you choose to participate in this research study and believe you may have suffered a research related injury, please contact Shantel N. Sullivan at 315-842-1213, Swood5@une.edu or Joanne Cooper, Ph. D. at 207-221-4960, jcooper5@une.edu.

- If you have any questions or concerns about your rights as a research subject, you may call Olgun Guvench, M.D. Ph.D., Chair of the UNE Institutional Review Board at (207) 221-4171 or irb@une.edu.

Will I receive a copy of this consent form?

- You will be given a copy of this consent form.

Participant's Statement

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily.

Participant's signature or
Legally authorized representative

Date

Printed name

Researcher's Statement

The participant named above had sufficient time to consider the information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

Researcher's signature
Shantel N. Sullivan

Date