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Effects of patient death on nursing staff: a literature review

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Abstract

Background:

There were 509,090 deaths recorded in England and Wales for 2008 (ONS, 2010). Of these numbers over 56% (260,000) occurred in National Health Service Hospitals, This shows the large numbers of people dying each year in hospitals. The death of a patient is an event which most if not all nursing staff will encounter during their work. This experience can elicit physical, cognitive, behavioural, spiritual and emotional responses (Parkes, 1998).

Aim:

The aim of this literature review is to explore how the death of patients in a hospital setting impact on nursing staff.

Methodology:

A review of the literature was undertaken using the online databases CINAHL, Medline and PsychInfo. The search was limited to articles in the English language and those from peer reviewed journals.

Results:

Themes arising from the literature review were: the theoretical context, the emotional impact, the culture of the healthcare setting, staff's previous life experiences and support available for healthcare staff.

Conclusions:

The death of patients does have an impact on nurses. This can affect them both in their work environment and outside of work. Education around grief theory and support from others are helpful for staff in developing strategies for coping with patient deaths.

Key Words: staff grief, psychosocial factors and patient death, emotional support and staff and death

The effects of patient death on nursing staff: a literature review

Over 260,000 patients die in National Health Service (NHS) hospitals each year in England and Wales. This is 56% of the total number of deaths recorded in 2008 and is in contrast to 16% of people who die at home, 9% who die in hospices, and 18% who die in community establishments (Office for National Statistics,2010).

It is acknowledged that the death of someone known to an individual has an impact on the person experiencing the bereavement. (Kubler-Ross 1973, Parkes, 1975).

There has been research over many years identifying the impact of bereavement on individuals. This has developed from Freud (1949) with his work on melancholia through to recent theorists who have identified the importance of making sense of the death (Neimeyer, 2001). A way of doing this involves the bereaved person creating a story enabling them to integrate the memory of the dead person into their ongoing life (Walters 1996).

Nurses are identified as having more extensive contact with patients than any other healthcare professionals (Costello, 2001). In some areas of acute care in hospital settings patients will have several episodes of hospital admissions or prolonged stays in hospital. This will enable them and their families to become known to both nursing and other healthcare staff.

The importance of this review is to identify if there are responses from nursing staff which may have a detrimental impact on their lives at work or home and to identify any support mechanisms which may be helpful.

The question which formed the basis for this search is, how does the death of a patient impact on nursing staff and what support do they find helpful?

Search Strategy

The existing literature published on this topic was systematically searched for using three main databases. The databases selected were the Current Index of Nursing and Allied Health Literature (CINAHL), Medline and PsychInfo. Together these three databases were thought to provide access to a wide range of texts which could be relevant to this subject. Other sources of literature were sought from reference lists contained in articles obtained from these three databases. The following inclusion criteria were used in selecting articles; peer reviewed articles from professional journals written in the English language, research based literature, non peer reviewed articles, non research studies and grey literature relating to this topic. Key terms used to search the databases were 'nurses' grief' 'patient death and staff', 'psychosocial factors and patient death', 'staff grief', 'emotional support and staff and death' and 'social support and health personnel'. This resulted in a total of 73 articles from CINAHL, 62 from Medline and 34 from PsychInfo. Articles were rejected for a variety of reasons. Some were concerned with grief issues for patients and family members, not healthcare staff and others were not research but subjective accounts of nurses' experiences of grief.

Following a comprehensive review of the literature, 17 studies complied with the inclusion criteria for this review.

Following a thematic analysis of the literature, five themes consistently emerged.

These themes were the theoretical context, the emotional impact on staff, the culture

of the work environment, personal life experiences of staff and coping strategies. These themes are discussed below.

Theoretical Context

Throughout the last century there has been a steady increase in the amount of research concerned with loss and grieving. This has included the psychological, biological and sociological aspects of loss and has covered a range of issues such as physical, cognitive, behavioural and spiritual aspects of grief. Theorists who have produced work on this topic are Freud (1949) who wrote about melancholia following the death of someone close; Bowlby, (1980) who identified attachment theory and discussed the notion of separation anxiety when a person dies and Lindemann (1944) who produced work on the importance of rituals surrounding death and of group mourning. These theories could be applicable to staff caring for patients, particularly nursing staff who are likely to form attachments to those they care for and are often excluded from any involvement in the rituals surrounding death and formal farewells as in funerals and memorial events.

Kubler-Ross (1973) was the first to formulate the stages of grieving as a result of her work talking to dying patients in a hospice setting. Others who have developed models following their studies of grieving include Parkes (1975) and Worden (1991) who identified tasks that the grieving person needs to work through in order to successfully grieve. Stroebe & Schutt (1999) developed the Dual Process Model to explain how grieving people alternate between behaviours that are related to grieving and those related to adjustments in their lives to live without the person whom has died. These theorists concentrated on how the bereaved express their grief with the assumption that there is an acknowledgement of the loss to the

individual and their right to grieve is validated both by those around them and the cultural norms of their society.

It was not until 1987 that Kenneth Doka developed the concept that some people who are bereaved feel unable or are not allowed to express their grief. Doka (1987) studied the impact of grief in non traditional relationships, that is for people cohabiting or in- extramarital or homosexual relationships. The results showed that whilst feelings of grief may be intense in these relationships, resources for resolving grief may be limited. Informal and formal support systems may not be able to be utilised as the relationship may have been secretive or unacknowledged by family and friends and religion and rituals may constrain rather than assist the grieving process. Doka called this concept disenfranchised grief, which he defined as a grief experienced by an individual but which is not openly acknowledged, socially validated or publicly observed (Doka, 2002) Healthcare staff may experience disenfranchised grief in feeling it is not acceptable to express their emotional response to a patient's death in the workplace environment. They may be called on to support others in their loss with no acknowledgement that the death is a loss for them as well.

Emotional impact of a patient death on healthcare staff

Rickerson et al (2005) conducted a quantitative study surveying 203 staff working in six long term care institutions in the United States of America (USA). This research found that staff experiencing the most grief related symptoms were those who had worked longest in institutions and had closer and longer relationships with the patients who died. The symptoms investigated in this research were physical, emotional, relationships with family and co-workers and, effects on work

performance. The most common reported effects were feeling sad, crying and thinking about death and the negative impact the death had on their relationships and performance both at home and at work. A limitation of this study was that as it was restricted to set questions in a survey and it did not allow the staff to report other effects they may have experienced but were not asked about. As it was conducted in a long term care setting and in the USA these findings may not be generalisable to an acute setting in the United Kingdom (UK), but may shed light on the possible range of effects that can be present in staff.

Meaders and Lamson (2008) studied compassion fatigue in nursing staff in paediatric intensive care units. Results of 185 completed questionnaires from paediatric staff found that as children live longer with chronic conditions, nurses and other care givers have increased and prolonged exposure to suffering and dying children, which can lead to compassion fatigue. This is where staff lose the ability to provide the same level of compassion to patients and their families as they have previously (Figley, 2002). It is arguable that the same effect could happen with nurses caring for adults with chronic conditions. As nurses care repeatedly for patients with chronic illnesses it may be that they feel unable or unwilling to feel compassion as the patients they care for suffer and die.

Elizabeth Kubler-Ross (1973) surveyed over 5,000 health care workers to discover their experiences with death and also included how they worked with dying patients. This study involved a range of health care workers including physicians, nurses, social workers, psychologists and chaplains. The findings showed that 98% of the respondents had difficulty with some dying patients. Trends were identified that were associated with the different professions. Nurses identified that dealing with young patients and those of their own age and gender was particularly difficult for them.

Psychologists and social workers reported pain as a difficult issue for them and they identified this as being outside their area of expertise, knowledge and their professional role. Although chaplains had usually worked with many people who were sick, several expressed discomfort in actually talking about dying and felt unable to answer certain questions patient's asked about their imminent death. (Kubler-Ross, 1973).

Feldstein and Gemma (1995) studied whether nurses who left oncology wards to work in other areas had a higher level of grief experiences than those who stayed in this speciality. This was a quantitative study for which the researchers used a tool called the Grief Experience inventory. The findings from 50 nurses who responded showed both those who stayed and those who left this area of nursing experienced social isolation, somatisation and despair as a result of caring for patients who died. From the literature there is evidence that there is an emotional impact on nursing staff who care for dying patients. Although this has been studied in a range of settings no evidence was found of this topic being researched in acute adult wards. The focus for most research studies seems to be the responses of healthcare staff caring for children and babies or those working in palliative care settings. Much of the research found is quantitative consisting of questionnaires and surveys. This methodology does not allow the participants to relate their own individual experiences but only to answer the questions set, many of which require a one word answer. As seen from the statistics there are many more deaths that occur in adult acute hospital settings; however the majority of the research concerning deaths in this setting concentrates on supporting patients and their relatives and not on the nurses themselves.

Impact of culture on the work environment

Culture is here defined as the patterns of behaviour, customs, beliefs and knowledge of a group of people (Spradley, 1979).

Doka (2002) identified in his studies on non traditional relationships that the culture where individuals live or work contains norms of behaviour that people adhere to in relation to their response to death. These govern areas of behaviour, affect and cognition. They also dictate what losses should be grieved over, how the grief is expressed and who is eligible to grieve.

In accordance with these social norms those seen as being the most eligible to grieve are family members of the person who has died. This may exclude friends, colleagues and professionals such as healthcare workers who may have relationships with the deceased but feel their grief is unacknowledged. Anderson and Gaugler (2006) found this to be the case in their study of 136 nursing assistants working in 12 nursing homes. Some staff perceived their grief to be disenfranchised whereas others felt more able to openly express their emotions around death and as a result reported less prolonged grief related symptoms.

The types of loss that can be disenfranchised according to Doka (2002) are divided into three main categories each of which can be applied to healthcare staff.

The first is where the relationship between the bereaved and the deceased is not recognised. Folta & Deck (1976) recognised that there was an underlying assumption that closeness in relationships exists only amongst spouses and immediate kin and that other relationships including care givers are often not

recognised. In the case of healthcare workers they may be viewed as having a professional relationship with their patients and not an emotional one.

The second type of loss is where the loss itself is not recognised. Healthcare staff may not acknowledge even to themselves that there is a loss in a patient dying. It may be seen that it is part of the role of a nurse to care for patients who die, and then to move on with their professional work without recognising that the death has impacted them.

The third type of disenfranchised grief is where the griever is excluded, either stopped from attending a funeral or engaging in grieving rituals or they may prevent themselves from having any involvement. Health care staff may not be recognised as having the status of a person who experiences grief or they may not permit themselves to be involved in any grieving rituals.

Roper and Shapiro (2000) describe how cultures develop and are maintained in medical and nursing settings which affect the behaviour and responses of healthcare staff to certain situations in order to comply with what are seen as cultural norms.

They also write about how ward areas and units can develop and maintain a cultural system. Hutchinson (1984) studied the cultural system of a neonatal unit exploring the interactions of nursing staff to discover the patterns of behaviours and beliefs held by staff in this area. This research concluded that perceived cultural norms can have a strong influence on staff behaviours, attitudes and beliefs.

The impact of personal situations and life experiences

Nurses and other healthcare workers will have socio-cultural influences and personal life experiences that they bring into their professional roles. The role of these factors in influencing their response to death at work has been researched in a few settings.

Kubler Ross (1973) found that the difficulties identified by nurses when working with dying patients were specifically of working with those of their own gender and age and with young people. However as this research was conducted over 30 years ago and in a hospice setting it may not be relevant to the current time and in an acute setting.

Katz and Johnson (2006) claim that many nurses choose to work in end of life care because of their own experiences of death, trauma and loss in their lives. Having had a personal experience of the death of someone close to them is seen as creating a personal-professional interface for the nurse between their own life events and professional interactions (Genevay and Katz, 1990).

Papadatou et al (2001) compared the experiences of 63 nurses working with dying children in Greece and Hong Kong and asked about their personal life experiences. Ninety-seven percent of Greek nurses and 54% of Hong Kong nurses in this study had experienced the death of a close relative. Most of the respondents reported that these losses were well integrated into their lives, though a few acknowledged that the experience of death in their personal lives remained unresolved. The researchers found that nurses who reported difficulties in accepting the death of someone in their personal life were more vulnerable when faced with the death of a patient. This was particularly the case if the death of a patient had features which reminded them of their own personal loss.

These studies do not indicate that personal experience of death has a definite effect on the response to a patient dying, however research by Fisher (1991) found that working with grief and bereavement in palliative care can put staff in touch with their own losses and can heighten mutual empathy and identification.

Grief support and education for healthcare staff

Fessick (2007) reports that a staff retreat for 20 nursing staff from medical oncology wards was found to be helpful in supporting staff through grief and helping them to manage this aspect of their work. The retreat involved an education session on theories of grieving and identifying coping strategies which could be used by staff. Findings from interviews following the retreat showed that staff felt they had been given key tools to improve their ability to cope, had been able to share their feelings with others and an unplanned benefit was the development of a closer and stronger team. These results indicate that creating a forum where staff can articulate their feelings in a safe and supportive environment has benefits to individuals and the group as a whole.

Research was conducted through qualitative narrative interviews with 14 nurses working with pregnancy loss in gynaecology wards (McCreight 2004). This indicated that education for staff in training or those qualified can help them to manage feelings of grief and loss resulting from their work experiences. However they also found that some staff did not want formal support or education as this could imply they were unable to cope emotionally with their work. They would prefer relying more on informal networks of talking to colleagues and friends both in and outside of the work situation. This finding could suggest that there are strong cultural norms that staff feel they have to adhere to.

Rickerson et al (2005) surveyed 203 staff in elderly care homes and found that over 80% of staff used informal support mechanisms such as talking to colleagues and friends to help them cope with their response to a patient death and most said they would use additional forms of support for example support groups and individual counselling. As this research was carried out in the USA it may be that counselling

and support groups are more prevalent and acceptable there than in the UK. The research by McCreight (2004) described above was conducted in Northern Ireland and their findings do not support the provision of formal support groups.

Moore et al (2007) investigated the reactions of 188 doctors to memorable deaths for them in three hospitals in northern England and their need for support. They found that doctors who had received training on dealing with emotions showed similar responses to those with no training. However no details were given of the type of training received by the doctors so it is not possible to evaluate this finding.

Discussion

The studies reviewed acknowledge a range of responses to these experiences. The death of a patient can have an impact on nurses both inside and outside their work environment and can affect their relationships with others. Their personal experiences of death outside work can contribute positively to their work situation if these have been well integrated into their lives. However if personal experiences of death are unresolved or there have been difficulties in accepting the death of a relative or close friend then this can result in nursing staff being more vulnerable when confronting the death of a patient. The culture of the work environment was seen as a factor in determining how freely staff feel able to express their emotions around patient death.

Compassion fatigue has been highlighted as a feature for some staff caring for patients who are in pain, seriously ill and dying (Sabo, 2006). This has led to research into what interventions could help staff to manage this condition. Aycock and Boyle (2009) conducted a national survey of nurses who were members of the oncology nursing society in the United States of America (USA) asking about

interventions available to manage this in their place of work. They concluded that optimally organisations should provide pro active and preventative support services. These could include counselling and educational input for nursing staff along with retreat participation.

Education around grief theory and support from others were found to be helpful for several staff in developing strategies for coping with patient deaths. This could be in the form of formal teaching sessions or less formal staff meetings. It could involve time away from the ward for staff to share their experiences and support each other.

Implications for practice

These findings could have implications for practice in terms of the provision of continuing professional development for nursing staff. This review has indicated that the education of staff around grief theory, support from others and the development of coping strategies could help support nursing staff in this area of their work.

Awareness of their personal responses to loss and of the impact of the culture in which they work may also contribute to their understanding and therefore their responses following the death of a patient.

Conclusion

All the studies discussed above show that the deaths of patients do impact on the nursing staff whom have been caring for them. Further research into some of the areas mentioned above could provide useful information regarding how to support nursing staff in these circumstances. This could include research into how compassion fatigue can be diminished or prevented in differing hospital settings and cultural environments.

The studies found in this review are from a small range of care areas and specialities. Several are from oncology units, hospices and intensive care units which are associated with a high incidence of patient deaths. Some of these areas have support systems in place for staff. Other care areas covered by this review are less acute settings including long term care facilities where patients can be present for months or years. Further research is needed to guide practice in acute general hospital wards and to identify the responses and needs of nursing staff in these areas.

KEY POINTS

- The death of a patient can have an impact on nurses both in their work environment and outside of work and can affect their relationships with others.
- From the literature, five themes consistently emerged. These themes were the theoretical context, the emotional impact on staff, the culture of the work environment, personal life experiences of staff and coping strategies.
- The findings from this review could have implications for practice in terms of the provision of continuing professional development for nurses.
- Further research is needed to guide practice in acute general hospital wards and to identify the responses and needs of nursing staff in these areas.

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