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Effective Coping Mechanisms for Nurses Following Patient Death

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Introduction

Dying is a natural process of life, however, it is rarely discussed and often ignored. The importance of acknowledging death allows one to realize how meaningful this moment can be. It can even be recognized as a significant event in one’s life even though that life has now come to an end. The concept of death is infrequently deliberated over, but the effect of death on professional caregivers is less often discussed. The impact that caring for the dying can have on a worker is substantial and needs to be addressed. DeSpelder and Strickland (2009), state that “caring for seriously ill and dying patients involves attending not just to a patient’s physical needs, but also to his or her mental, emotional, and spiritual needs” (p. 177). This statement details a nurse’s scope of practice and what is expected of a nurse when their patient is seriously ill and may possibly die while in their care. Previously, the standard was for people to die at home while surrounded by their family. Since then, a trend has been to have people die in hospitals surrounded by healthcare professionals. However, with the development of hospice the most recent trend is returning to dying within one’s home, in a familiar environment. DeSpelder and Strickland (2009) stated “according to the National Hospice and Palliative Care Organization (NHPCO), about 4,100 hospice programs in the United States provided care to over a million patients in 2005 and about 800,000 Americans died while receiving hospice care, roughly one-third of all deaths in the United States that year” signifying families are returning to the lifestyle of bringing their loved ones home before they die (p. 178). Another common healthcare specialty to die within is an Intensive Care Unit in a hospital with “mortality rates in adult intensive care units (ICUs) range from 19.1% to 21.8% (Shorter & Stayt, 2009, p. 159). From being cared for on an Intensive Care Unit (ICU) or receiving hospice services, a nurse cares for these patients in some of the most difficult of times. It is essential that nurses are knowledgeable and capable of coping in a positive manner. The purpose of this research paper is to elicit effective coping mechanisms for practicing nurses. Through a literature review and interviews conducted with two ICU and two hospice nurses, a comparison was
conducted to determine if specialty effects how one copes following patient death. It is imminent that positive coping mechanisms are identified and implemented into all fields of nursing.

**Literature Review**

Following a patient’s death, a nurse is not sent home to rest. They are expected to continue their shift until the next nurse. Other patients remain requiring a nurse’s care and support. Gerow, et al. (2010) uses the analogy of ‘pulling a curtain’ as a successful coping mechanism for immediate coping after a patient dies. When a nurse ‘pulls the curtain’, not only is the patient’s vulnerability shielded, but the nurse’s as well (Gerow et al., 2010, p. 123). The ‘curtain’ “enveloped the patient and nurse together as a special relationship was forged, allowing vulnerability to be both expressed as well as constrained” (Gerow et al., 2010, p. 124). The dying process is kept between the nurse and the patient. Through 11 nurse interviews, four themes were identified under the ‘curtain’ mechanism. These themes include “reciprocal relationship transcends professional relationship; initial patient death events are formative; nurses’ coping responses incorporate spiritual worldviews and caring rituals; and remaining ‘professional’ requires compartmentalizing of experience” (Gerow et al., 2010, p. 124).

**Reciprocal Relationship Transcends Professional Relationship**

Nurses reported the level of connection formed with the dying patient affected their response following a patient’s death. The ‘curtain’ protects the nurse in this time where they recognize they are humans before nurses. A nurse that was interviewed stated, “If we didn’t love and become attached and have relationship, then we...we wouldn’t have to have grief. So I view it as very positive even though it is painful” (Gerow et al., 2010, p. 124). This nurse recognizes that developing a connection can complicate the grieving process, but it reminds her that these relationships are what make the job so fulfilling and worth the grief that she endeavors. Shorter and Stayt (2009) conducted a study with eight critical care nurses identifying that “the depth and duration of sadness they felt was dependent on the level of
attachment with the patient and family” (Shorter & Stayt, 2009, p. 163). As a part of a nurse’s practice, they are required to develop rapport with the patient, which often leaves one feeling this sense of connection. This has been shown to complicate one’s ability to cope but also enables them to empathize with patients providing a greater capability to care for their needs.

**Initial Patient Death Experience**

Another theme identified under the ‘curtain’ coping mechanism is derived from a nurse’s initial patient death experience. If a nurse has a negative first encounter, then they are predicted to ineffectively cope and avoid patients who are likely to die. This theme states that nurses who “felt supported, mentored, and not alone” were more likely to develop positive coping mechanisms for future patient death encounters. Studies also show a correspondence between coping abilities and the amount of interactions with a dying patient. Shorter and Stayt (2009) found, “that regular exposure to death meant that it became part of normal life to them-part of their everyday work” (p. 164). Increasing experience in taking care of dying patients correlates with one’s ability to cope following the patient’s death. Dunn, Otten, and Stephens (2005) examined the relationship between duration and ability to cope determined that nurse with “more experience caring for dying patients reported less uneasiness interacting with these patients” (Dunn, Otten, & Stephens, 2005, p. 98). This shows that increased experience caring for dying patients and their families after the patient dies, improves one’s ability to effectively cope.

**Spirituality and Worldview Caring Rituals**

The third theme contributing to the ‘curtain’ coping mechanism involves one’s spirituality worldview and caring rituals. Nurses reported feeling comforted after a patient’s death if they believed in an afterlife. It also shows that by performing caring rituals, such as providing oral care or fresh linens, nurses felt as if the coping process was less complicated because they were able to “detach from the
experience and reach some closure” (Gerow et al., 2010, p. 126). A nurse contributed that her spirituality belief positively impacted her coping abilities. She stated, “knowing that everything happens for a reason and that they’re moving on to a better place and that I did the best job that I possibly could” impacted the process of taking care of a patient as they progressively get closer to death. A study with a sample of 403 working nurses, identified that those “who viewed death as the gateway to a happy afterlife had more positive attitudes toward caring for dying patients” (Dunn et al., 2005, p. 98). One’s spirituality can provide a nurse with understanding or another means of making sense of the situation. A study of health professionals’ addressed that by using spirituality, one “may prompt a reconsideration and re-evaluation of assumptions about the world and life’s purpose” (Forster & Hafiz, 2015, p. 297). With spirituality, interviewed professionals are able to apply meaning to patient death. Using religion or one’s beliefs can alleviate feelings of sadness or confusion and allow a nurse to properly compartmentalize their grief and continue caring for their patients.

**Boundaries**

The remaining theme details the need to consistently stay “professional” and how compartmentalization and the development of boundaries is a necessary component. These “boundaries provided a way for the nurses to compartmentalize the experience and move on” (Gerow et al., p. 126). It allows one to separate their emotions and understand that death can be a part of the job. Another nurse “learned by crossing the boundary and becoming too close to the patient and family that the experience could be exhausting and emotionally draining” so she needs to retain this professional relationship to prevent the onset of these emotions (Gerow et al., 2010, p. 127). This nurse then “created a curtain to protect her so that she could remain professional” and further effectively cope (Gerow et al., 2010, p. 127). A nurse interviewed for a study by Shorter & Stayt (2009) described their view on how they emotionally dissociated themselves from the occurring situation. They described
having, “a work mode, if you like that I employ, and I can turn that on and off” (p. 164). Another nurse said, “You’d be an emotional wreck if you let it bother you or affect you all the time” (Shorter & Stayt, 2009, p. 164). Establishing boundaries to promote compartmentalization will promote positive coping mechanisms and allow nurses to provide safe and effective patient care following the death of one of their patients. Foster and Hafiz interviewed nurses that detailed death related experiences. Forster and Hafiz (2015) wrote that participating nurses “described ‘boxing or curtaining off’ their feelings when caring for dying patients in order to maintain a professional outward demeanor and to continue to perform their caring role” (p. 296). This fosters the professional relationship and allows for a nurse to compartmentalize immediately after the death in order to maintain emotional stability throughout the rest of their shift.

Support from Other Healthcare Professionals

As helpful as creating a ‘curtain of protection’ is for individuals, the literature also touches upon formal and informal support from fellow healthcare professionals. The use of formal support varies from site to site. Nurses reported a “general feeling that it would be more difficult to ‘open up’ in a formal setting whereas they find greater comfort by partaking in informal support which is defined as talking freely among other nurses and healthcare professionals (Shorter & Stayt, 2009, p. 163). A study detailing the responses of 10 health care professionals found the most commonly used coping mechanism to be “confiding in peers and seeking peer support” (Foster & Hafiz, 2015, p. 295). Participants identified a need to talk amongst other healthcare professionals who can relate to possible emotions they may be feeling following their patient’s death. By talking informally with other people, nurses interviewed “described the process of sharing their grief experiences with colleagues as contributing to the camaraderie within the team” (Shorter & Stayt, 2009, p. 164). This type of support enables one to effectively cope while also strengthening work and personal relationships. Critical care nurses surveyed
reported “formal de-briefing sessions to be useful” (Shorter & Stayt, 2009, p. 163). During formal support, hospice nurses showed evidence of “interpersonal learning, catharsis and self-understanding” (Shorter & Stayt, 2009, p. 163). However, even with the availability of formal support, these services were not utilized to the full expectation.

Literature Review Conclusion

The development of a nurse’s ‘curtain’ is done through experience and can change based on each nurse’s personal beliefs and attitudes. It is recommended that in order for a nurse to effectively cope following patient death, they must develop each subpart of the ‘curtain’. It is also essential for nurses to engage in informal or formal support from coworkers or fellow healthcare professionals. Talking and relying on peers for support allows one to express their emotions so that they may be emotionally capable of taking care of further patients who may die while they are in the hospital or receiving hospice services. It is essential that nurses of all specialties are able to effectively cope following patient death because death can become a part of the job responsibilities at any moment.

Interviews

Four nurses were interviewed to further determine effective coping mechanisms utilized by current practicing nurses. Each interview was conducted on April 7th, 2016 at a time and location agreed upon mutually. Two RNs worked for hospice agencies and two worked in intensive care nursing. All four nurses were asked the same questions. Interviews were recorded and transcribed verbatim. The names of nurses and their affiliated organizations are exempt from this paper. Each nurse was asked their current position title, highest level of education, numbers of years working as a nurse and years in that current position. Each of the four women was also asked previous floors they may have worked on.

First/Most Significant Patient Death Experience
The first nurse interviewed has been a registered nurse for two years and working on the Surgical Intensive Care Unit (SICU) for six months. When asked to detail her first or most significant patient experience, she immediately recalled a terminally ill patient who was admitted with COPD. She began by saying he was a patient in room six who was comfort measures only (CMO). She could recall his personality, his looks, how the room felt when she walked in it. When the patient died, she admitted to crying immediately. She wept with the family as they each gave her a kiss goodbye. It was at that moment that she realized “how special I was to be involved in the end of someone’s life”. Another nurse who worked on a dialysis unit and now PACU, detailed similar feelings. She cared for a chronic dialysis patient who she knew was nearing the end. She called the family to come but they did not arrive in time. She held his hand and comforted him so “he didn’t die alone”. This nurse provided history on the development of dialysis and in the 1980’s, dialysis treatments potentially gave these patients another year or two to live, if they were lucky she says. Patients were critically ill when they came into this nurse’s care. Following a patient’s death, this particular nurse immediately “went back to work”. The SICU nurse did the same after two of her coworkers supported her and assisted with the postmortem care. A hospice nurse who has been working five years as a nurse said following patient death, she “had to go on. There were other patients that had to be taken care of.” Patient death is not a reason a nurse can prematurely end their shift or even allow them to take a prolonged break. The nurse is still responsible for their other patients’ care which is why nurses must realize the importance of effectively coping in order to safely continue out the remaining hours of their shift.

Immediate Coping Mechanisms and Fellow Nurse Support

Following her patient’s death, the hospice with 5 year experience carried on with her caseload and said she did that by realizing “you compartmentalize it”. One must put their feelings of grief aside and wait to feel the wave of emotions. When the SICU nurse’s shift ended, she turned to her mother
who has shared these experiences herself being an oncology nurse. This nurse turned to her mother not only because she is family but because she “understands”. A hospice nurse with 22 years of being a nurse stated similar feelings when a young patient of hers died after a long battle with leukemia. She described immediate relief for the young woman because “she was suffering both psychologically and physically”. After the death of this only child, the hospice nurse recalls how her agency “functions as a team” and “there has always been a lot of support from each other so I was able to talk to another nurse about it”. The dialysis nurse bonded with each of the other three nurses that worked on her unit. This nurse stressed the importance of venting and emphasized she never hesitated to call a fellow nurse. In regards to her relationship with the other nurses she stated, “we were friends, besides being coworkers”. Utilizing other healthcare professionals as an outlet provides the nurse with the opportunity to express their concerns and let of emotions and thoughts that may linger after the patient dies. It is demonstrated through these testimonies that all nurses, regardless of specialty, rely on coworkers for support after the death of a patient. Nurses need to have an understanding outlet they can feel comfortable venting to in order to make sense of the events they are experiencing.

Spirituality and Attitude Regarding Death

A nurse’s spirituality can affect their immediate and long term coping mechanisms. It can give a nurse hope or provide closure that their dead patient may now be at peace. The dialysis nurse believes it helps the coping process if one has “faith that something else is out there”. It does not matter what that faith or religion is in, as long as there is hope that this patient has now moved on to a happier and more comforting place. The hospice nurse with 22 year experience said that she also has a spiritual belief “and that sustains me and kind of helps me deal with a lot of stuff that I don’t understand”. Spirituality allows one to have hope and provides a means of closure and acceptance of the death. The hospice nurse then continued by saying that nurses need to be “aware of their attitude toward death”. She then added
upon that statement that “if you are aware of how you feel about then you can use that awareness to either change it or go in a direction that makes sense for you”. It is important to address weaknesses in order to continue to provide optimal care to these dying patients. Each nurse identified the need for a certain type attitude when taking care of a dying patient or patient who is rapidly declining. The SICU nurse specifically said in order to care for a patient receiving comfort measures only, “you have to be completely open”. The hospice nurse who has been a nurse for five years said when she cares for her hospice patients, she has developed this “compassion and a sense of empathy for them”. When the patient then does die, she feels as if she did everything she could to assist the patient and their family in this difficult time. She realizes that “every family is different and they dynamics are different” meaning each case will vary in understanding of the dying process and acceptance of the concept of death.

Through faith, hope can be derived. The degree of hope can differ from nurse to nurse but it clearly enables one to cope more effectively and promote closure following patient death. By recognizing one’s attitude toward death, a nurse is able to adjust their mentality to further assist with the idea that their patient is going to die and that death is a natural part of life.

**Duration of Time Cared for Patient and Connection/Bond Formed**

Death does not have a specific timeline. People enter the ICU when they are severely ill but most do not expect to die on that floor. Hospice patients enter the program with expected six month expectancy, but some people exceed that prediction and continue to receive hospice care until they do die. The hospice nurse working five years states that the duration of patient care affects the way a person copes because the duration has an effect on the bond/connection that was formed. She said “when it is a patient that I don’t really know, it is so much easier”. She addressed that regardless of the time spent with the patient, she shows compassion and empathy but the shortened duration of time does not allow her to “have emotional involvement”. The complication with not forming connections
she specified is that she wishes these people had received hospice services earlier. By receiving hospice care sooner, “they could have got better pain control and utilized the hospice benefit to the full capacity”. The dialysis nurse supported these statements by saying, “you don’t build the same bond with someone you just meet.” The level of connection affects the nurse patient relationship therefore prolonged relationships require further coping mechanisms because the grief may become more complicated when compared to a nurse patient relationship that had just begun and had yet to form a bond. The hospice nurse of 22 years agreed with the previous nurse statements. She thinks, “if you are physically present to the patient more often than not than you are going to develop a closer bond” therefore suggesting the longer a nurse gives care to a patient, the more grief they will experience. The SICU nurse answered the question in a more broadened way and addressed the time spent with any dying patient. She believes “the more time I have had with patients that are dying, I change the way that I cope” indicating that her coping mechanisms adapt and adjust to what works most effectively for her. As a nurse encounters more dying patients, they are able to develop a plan or routine as to how they are going to immediately cope and what they may do once they finish their shift to further effectively cope. As the nurse patient relationship develops, a nurse should also be able to curve their coping mechanisms according to the duration of time they may provide care.

**Family Connections**

Not only does the connection with the patient affect one’s need to cope, but also the relationship formed with the family members of the patient. The focus of the ICU is to direct care towards the patients; however, family connection can develop when the family is present and involved in their member’s health. The SICU nurse said regardless of the family’s presence, she will “act professionally and provide care”. Regardless of the connection made with the family, she is going to grieve for her patient. The dialysis nurse answered in a similar manner. She thinks, “I’m the same either
way” meaning if the family is present or nonexistent her coping mechanisms will not be affected. The hospices nurses both supplied answers supporting a family connection requires a greater need for effective coping mechanisms. The hospice nurse who has been a nurse for five years responded that, “reality is all of these [hospice patients] are going to die and I know that. I know that going in so it puts me in a place where I’m constantly on a state preparing for that”. This nurse approaches the situation with a mindset of what the end goal is going to be so she is aware of what needs to be done following the patient’s death. The hospice nurse of 22 years answered that a connection with the family sometimes affects the grieving process. She said, “the patient and the family are the whole unit you are caring for. You are taking care of the whole family”. This means this nurse is developing a connection with not only the patient but the family as well. She is addressing the physical and mental needs of both parties to assist in this transition. She then touched upon the fact, that even though she may have taken care of dying patients previously, this family may be experiencing the loss of their mother, son, or grandmother for the first time. She needs to develop rapport with not only the patient but the family. The family is using this nurse as a resource for understanding and as a guide through this complicated life event. Through these interviews, it can be seen that family involvement has a different effect on coping mechanisms according to nurse specialty. The nurses of the ICU field do not base their coping mechanisms upon the relationship formed with the family but mostly with the patient. The hospice nurse cares for and provides support for the patient and their family as a whole. So even after the patient dies, the nurse is responsible for promoting effective coping among the family therefore the relationship continues even without the existence of the patient. Family connection can affect how a nurse copes but the extent to which one needs to cope depend upon the relationship that is developed.
Organization Support and Debriefings

Hospitals and agencies recognize patient death is not a concept that all nurses are prepared or have experience with in nursing school. Even after years of training, a nurse may still not be sure of how they best cope when a patient of theirs dies. To promote retention and well-being of their nurses, some hospitals and agencies provide, even require, support groups or sessions to facilitate grieving and facilitate closure. The hospice nurse of 22 years said her agency does quarterly team engagements. These can range from various ‘fun’ activities that do not revolve around the idea of death. In the past, the team has held barbeques or enjoyed a night of bowling. This provides the agency with the ability to vent if they need to with other healthcare professionals or merely enjoy the company of their coworkers in an environment outside of work. The hospice nurse of five years touched upon the array of services her agency provides. She mentioned the availability of a chaplain and bereavement counselors for the nurses and other workers to utilize. The hospital of the SICU nurse did not require nurses to attend any support classes or meetings following a patient’s death. Her hospital offered a Continually Education Unit (CEU) class that focused on the dying process and how to care for these patients. The class covered a range of topics including healing touch and how to properly explain the dying process. Outside of the optional class, no formal support was provided by her hospital. The dialysis nurse reported attending a monthly meeting with her nurse coworkers and a social worker present. There they discussed the patients who passed away that month, what went well and what did not. However, the social worker relocated and following that, the dialysis nurse said “I don’t think the nurses get the support they need. I don’t know if they get any”. Through these four interviews, it can be determined that hospice agencies provide more formal support and options for nurses to engage if needed after a patient dies. It is also important to consider that patient death typically occurs more frequently in the hospice field.
Another form of organization support is debriefings. These can occur for any reason and can include any profession as long as they have had involvement with the patient. Debriefings can be used following patient death, traumatic events, or even to identify why a fall happened. The hospice nurse of 22 years did not identify any formal debriefings. It occurred when “bizarre things happened like gun threatening” but when it does everyone related to the case is involved. The hospice nurse of five years gave a similar response of debriefings only occurring after “emotionally charged cases”. She added that all of those involved in the care of these patients recognize they are “doing everything we can when we know that everything we are doing is doing nothing”. These professionals were providing the best care they could but they each knew nothing was going to sustain the patients any longer. The nurse of the SICU also did not detail any routine occurrences of debriefings, however, she said “it is a good idea. I think it would help”. The dialysis nurse added that when she worked in the 1980’s, debrief did not occur. At this time, her current position in the PACU requires constant debriefing. It is not necessarily about patient death but can involve incidents such as falls or misplacing patient papers in inappropriate charts. Overall, debriefings are not commonly used as a mechanism after patient to facilitate initial coping among the healthcare professionals involved in the event.

**Recommended Coping Mechanisms**

Each nurse may utilize different coping mechanisms to effectively cope following the death of a patient. Regardless of specialty, nurses need to identify coping mechanisms most effective for them. The hospice nurse of 22 years detailed her need for “prayer and physical exercise”. It is also important for her to set and know these limits. In regards to future nurses and those that need direction with coping mechanisms, she advised that no matter the specialty, one “can’t do any nursing if you don’t take care of yourself”. Self-care is important to acknowledge. A nurse needs to put their own well-being ahead of their job responsibilities otherwise the nurse is most likely to burnout and switch fields, careers, or
develop ineffective coping mechanisms such as drug and alcohol abuse. The hospice nurse of five years also detailed the need for “really good self-care”. She included aspects such as exercise and getting enough rest because the hospice job can be “an emotionally wearing field”. Without these concepts in mind, she recognized the risk of burnout and acknowledged one might burnout quicker if they do not partake in self-care. This hospice nurse also discussed boundaries and having an outlet whether it being working out or reading, as long as if does not involve thinking about what just happened. She supported this statement of letting the mind wonder by saying “you have to process it and let it go”. One should not dwell on the event because this will delay the coping process and further complicate future cases that may involve patient death.

The dialysis nurse touched upon the advantages of therapy. Mainly, she emphasized the effectiveness of “talking to other people”. It allows her to release her feelings onto people who have experienced similar situations and felt similar emotions. The SICU nurse also stressed the importance of talking to other nurses. She also partakes in yoga in distress. It supports the hospice nurse of five years statement of being able to “let it go”. The SICU nurse also mentioned how she believes the more experience one has with caring for patients who are dying or have died, increases one’s comfort in caring for future patients. Through these interviews, it can be seen that the hospice nurses both acknowledged the importance of self-care where the ICU nurses recognized the importance of talking to coworkers and people who may understand the feelings they may be experiencing. Overall, it can be seen that effective coping mechanisms differ from nurse to nurse regardless of specialty or years in practice.

**Limitations**

Certain limitations occurred during this qualitative study. Limitations include only two specialties were interviewed and analyzed. Nursing includes a range of specialties and each field can experience
patient death. The age of the patient who died and the effect that has on the nurse was also not analyzed. Also, the organization and agencies of which the nurses were interviewed from were not varied indicating a lack of analysis for differing organizations in terms of available coping resources.

Conclusion

Through these interviews, it is evident that nurses of different specialties cope in many similar yet also different ways following patient death. Each specialty can have various levels of experience encountering dying patients. Regardless of a nurse’s field, each professional identified the need for support from fellow healthcare professionals or friends who could possibly understand what they may be feeling following their patient’s death. Other similarities include the need to acknowledge one’s spirituality and attitude toward death in order to provide better quality care to those who are dying. A difference among hospice and ICU nurses is the effect the family connection may have upon one’s ability to effectively cope. The hospice nurses included the family as part of their patient assignment whereas ICU nurses do not feel they are able to develop the same bond with the family therefore not affecting their coping process following the patient’s death. In conclusion, the interview portion supported the literature review. Debriefings were not routinely conducted at any of the hospitals or agencies in regards to patient death so this mechanism in the literature review cannot be evaluated with the nurses’ testimonies. In conclusion, nurses effectively cope in a variety of ways. Yet the most beneficial and most discussed mechanism was venting and talking amongst other nurses and healthcare professionals. Typically done in an informal way, but also facilitated through formal support such as groups. One must develop and modify their own effective coping mechanisms in order to properly handle their grief following the death of a patient.
References


