Spring 2021

Grieving Nurses' Need for Support

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by

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A project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the
Master of Science in Nursing Degree

Boiling Springs, North Carolina

2021

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Abstract

Veteran nurses vacate their positions after more than 20 years of nursing experience due to the chronic emotional grief experienced after patient death. Nursing programs lack the curriculum support to sufficiently instruct student nurses how to appropriately deal with patient death. This lack of understanding leads the way for nurses to develop unhealthy coping mechanisms and withdrawing from the profession. A needs assessment was conducted and confirmed the desire and demand for support of nurses experiencing grief. A method was developed to support grieving nurses who are experiencing or will experience grief. A peer support group was established to assist these nurses during times of grief, by sharing strategies to maintain self-care and encourage healthy coping actions. The implementation included minimal financial funding, as an adjunct to Code Lavender, through a TEAM'S platform monthly meeting. Use of TEAMS allows nurses to listen and obtain information while remaining anonymous, from a computer of choice and location. The information and shared stories by peers would be invaluable to the nursing population.

Key Words: grief manifestations, nursing emotional support, peer support, nurse's grief, healthy coping mechanisms, grief emotions, nursing stigmas, grief theories

Acknowledgments

Throughout the writing of this thesis project, I have received a great deal of support and assistance.

I would first like to thank my former manager, Anita Byrum, whose expertise was instrumental in formulating the research project. Your insightful feedback pushed me to sharpen my thinking and brought my work to a higher level.

I would like to acknowledge my colleagues from my clinical rotations at Atrium Health Union for their wonderful collaboration. I would particularly like to recognize Missy Baker and Billy Carnes. I would like to thank you for your patient support and for all the opportunities I was given to further my research.

I would also like to sincerely thank my thesis advisor, Dr. Candace Rome for her valuable guidance throughout my studies. You provided me with the tools that I needed to choose the right direction and successfully complete my thesis project.

In addition, I would like to thank my parents for the continued support and sympathetic ear. You are both always there for me. My sister, who I always look up to and has provided me the inspiration to further my nursing career. All my children and friends who have been patient and supportive through various discussions, as well as happy distractions to rest my mind outside of my research. Lastly, to my loving husband who always encourages and promotes furthering my education and career path. You are understanding, reassuring, and my biggest supporter!

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CHAPTER I

Introduction

Death and dying are unavoidable life encounters, but a nurse's first experience with patient death may pose substantial cognitive, emotional, and clinical challenges (Anderson et al., 2015). Patient's deaths not only affect patients and their families, but also the nurses that care for them, both during the continuum of treatment and at the time of death. Nurses frequently experience deep emotional reactions to patient demise but may be compelled to disregard or conceal their feelings because of professional responsibilities (Rice et al., 2014).

Problem Statement

A veteran registered nurse vacates her position after 20 years of nursing due to the deep-seated emotional grief that she experienced after the death of a patient. Nurses are not adequately taught how to deal with the death of a client in nursing programs at the University or facility levels. This lack of knowledge leads to the use of inappropriate coping techniques.

Case Study

During a night shift in the newborn nursery, a novice registered nurse, charge nurse, and one nurse aid were assigned to care for eight newborns. After working several months having experienced only uneventful births and healthy newborns, the night finally came that peers warned about. This nurse recalled, after 20 years, the exact details of the code blue alarm sounding, and quickly going to the labor suite to assist a mother who was delivering, the baby displayed signs of distress on the monitor. She recalls gloving and waiting anxiously as the mother pushed one last time to deliver her child. Baby boy D

was born, the umbilical cord clamped and quickly cut, the cord left longer than usual; the infant was abruptly placed in that nurses' arms to be placed in an open warmer for rapid assessment. The baby was stimulated to breathe; however, he did not display any signs of gasping or attempts to breathe. The nurse initiated cardiopulmonary resuscitation (CPR) on the tiny infant; it was her first encounter with CPR. The nurse panicked inside and questioned whether she performed how she was taught. The baby was rushed to the neonatal intensive care unit (NICU) for continued resuscitation efforts. More personnel joined the efforts; however, ultimately the baby succumbed to death after a lengthy attempt to save his life. While the infant went from being a "living being" to lifeless, the nurse recalled just staring at the infant. She was unable to move, "emotionless", with so many thoughts running through her head. She questioned, "Was enough done?", "Was something done incorrectly?", "Why did this occur?" She recalled these anxieties; it was seen on her face that she still did not know the answers to these questions. The charge nurse encouraged her to begin the post-mortem care and guided each step. The nurse recollects the steps involved in post-mortem care; however, steps were much different than what she had learned in nursing school. The baby was given a bath, hair combed, hand and footprints were taken, and a lock of hair gathered; each sentiment placed in a memory box for the parents.

The nurse's understanding from nursing school was primarily on post-mortem care; she was fully aware that paperwork needed to be completed for a death, toe tags had to be applied, and that the body would be placed in a body bag and sent to the morgue. Baby D was wrapped in blankets and taken out to the parents for viewing and closure. Baby D was handed gently into his mother's arms, the mother weeping uncontrollably.

The nurse was speechless. She ran directly to the bathroom and heaved with tears. When the baby returned to the nursery, she observed that the parents had dressed the infant in a sleeper, the nurse recalled each detail. Baby D looked perfect; his sleeper was all white with an angel embroidered on the left chest; she remembers thinking "how appropriate". The infant was swaddled in blankets to "carry to the morgue in the basement" and meet a security guard. It was this nurse's first time carrying a dead baby and being in a morgue, it was very cold in the room. The security guard opened a long cold metal "drawer" and asked the nurse to place the infant in the drawer.

This nurse went directly to the locker room and cried, alone, and unsupported. Once back in the nursery, the nurse remembered it was like business as usual and the charge nurse made the nurse feel as if she was now "christened" to newborn death and stated it would "get easier" each time. This nurse was in turmoil, once home with her family, the feelings of guilt, sadness, anger, professional incompetence, and overwhelming grief had a grave impact on her psychological health.

What Nurses Can Experience

The emotions and grief that nurses encounter are clearly problematic and its occurrence in healthcare settings can cause harm, not only for the nurses, but also for their patients' quality of care (Anderson et al., 2015). "Professional nurses' work-related grief is associated with a series of unfavorable outcomes, such as depression, secondary traumatic stress disorder, compassion fatigue, burnout, and high turnover rates eventually" (Chen et al., 2018, p. 105). Coetzze and Klopper (2010) described the occurrence of unidentified stress due to caring for critically ill and dying patients as detrimental to the nurses' ability to continue effective care, a sense of emotional

exhaustion. Coetzze and Klopper (2010) continued to explain that compassion fatigue can be intrusive and controlling, and if unaddressed, can limit nurses' ability to function. However, Coetzze and Klopper (2010) did recognize that if nurses' grief and stress are recognized and signs of compassion fatigue are noticed and addressed appropriately, nurses could continue effectively in their role with self-care and supportive services in place.

Registered nurses have long delivered end-of-life care and support to adult and pediatric patients and their families. While the effect of death on family members has been thoroughly documented in the literature, the reaction, response, and grieving process of nurses throughout and following the death of a patient has not been researched extensively (Brunelli, 2005; Gerow et al., 2010).

> In fact, the grief process for nurses appears to be very different from the grief process of a family member. When experiencing grief, nurses find themselves in conflicting roles. On the one hand, they are the ones that must remain strong and give support; on the other hand, they are often very much affected by the loss of someone with whom they were intimately involved (Gerow et al., 2010, p. 123)

As a result, many nurses may adopt ineffective coping mechanisms such as avoidance and compartmentalization of the experience that can result in burnout, compassion fatigue, and other physical and emotional problems as opposed to healthy grieving (Brunelli, 2005; Gerow et al., 2010).

Significance

Nurses will be confronted with grief and loss throughout their professional careers. If grief is not recognized and left unattended, it may result in many other

complex problems (Wenzel et al., 2011). “Symptoms of cumulative grief may include physical illness, substance abuse, suicidal thoughts, apathy, poor self-esteem, depression, and anxiety” (Houck, 2014, p. 455). Competence in grief and the process of grief is essential for nurses, since they will all be threatened with grief at some point in their careers (Oates & Maani-Fogelman, 2019). Grief can be confounding throughout entire careers, in all healthcare settings (Oates & Maani-Fogelman, 2019).

The healthcare facility for this project is a 175-bed hospital in the southeastern United States, which provides comprehensive emergency services and specialty medical care. The hospital offers a variety of medical care, including an outpatient surgery center, cancer treatment center, long-term care facility, behavioral health center, specialty clinics, a community wellness and outreach program, and a women and children’s center. Registered nurses at Atrium Health Union were invited to take anonymous, voluntary needs assessment regarding patient death, grief, and self-care education, and to indicate the type of support they would like to have provided after a patient death.

This needs assessment survey was completed by 75 registered nurses and revealed that 48% never attended a class or any education for grief, 11% were unsure of any education on the topic of grief, whereas 38% never attended or received education for self-care and 7% were unsure. Nurses reported at 80% remembering their first patient’s demise, with 3% not yet experiencing a patient expiring. Nurses surveyed reported at 87% experienced feelings of sadness, followed by substance abuse, guilt, and sleep disturbances. The needs assessment demonstrated that 81% of registered nurses were talking to others about the death and their personal feelings. More than 50% of the nurses

reported that speaking to a teammate or peer would be most helpful in processing their feelings.

Debriefing, a tool that allows a team to self-correct, build cohesiveness as a team, enhance performance and gathers immediate factual information; however, it does not support a teammate's ability to acquire healthy coping skills. A peer support group, on the other hand, does not have time constraints, and groups are available for staff for as long as they need. Every critical incident, such as the death of a patient, would be reported through the peer support group. After which a contact would reach out within one week of the event to check on the staff's personal well-being and coping skills. A support group would also decrease stress levels often felt by staff after these situations, and at the same time decrease staff turnover due to burnout.

There is great significance in allowing time for debriefing to occur after every crisis, providing education for available resources and removing the stigma that asking for self-help is a sign of weakness. "Debriefing is a critical conversation to reframe the context of a situation to clarify perspectives and assumptions, both subjectively and objectively" (National League for Nursing (NLN), 2015, p. 3). At the core of debriefing is reflection, which is central to being critical and allows for the ability to examine information to see the entirety of the reality (NLN, 2015). Debriefing is a fundamental approach to fully foster thinking along a continuum from 'knowing what' to 'knowing how and why' (NLN, 2015).

Purpose

The purpose of this project proposal was to develop a method to provide support for nurses who are grieving or will experience grief. This project developed a method that

can be used to educate nurses on available resources to assist them during times of grief, helping the nurse to develop strategies to maintain self-care, and produce healthy coping strategies.

There is significant literature to suggest that grief is a process for nurses and that there is not enough support to guide them, in recognizing unhealthy behaviors when they are grief stricken. “A high rate of turnover in nursing staff is seen when nurses’ grief is not adequately acknowledged and when few resources are provided to adequately assist those who are grieving” (Wisekal, 2015, p. E103).

Although debriefing should occur after stressful events, it is not routinely performed in all clinical areas. Current limitations for debriefing at this project’s local level are time constraints, the need to document the event accurately and timely, the need to support the patient’s family, having too many inter-disciplinary departments involved during an attempt at return of spontaneous circulation (ROSC), and no one staying after the event, due to other patient’s needs.

There are currently no peer support groups or formal education programs to teach self-care at the facility being evaluated for this project. This can affect nursing staff with higher odds for burnout, higher levels of stress, and lack of self-care. Educating nurses about these types of crisis situations, the importance of self-care, and how to recognize personal grief can provide powerful tools. This type of educational support will consist of peers that can relate to the situation due to skill set, knowledge, communication skills, and proper follow-up for each situation. Peer grief support after a death or crisis situation, can create healthy coping mechanisms and increase self-care activities for nurses.

Theoretical Framework

Jean Watson's Theory of Human Caring argues that caring revitalizes all of life vitalities and enables our capabilities (Blasdell, 2017). "The interventions of Watson's Human Care Theory are associated to the human care process with complete participation of the nurse/person in conjunction with the patient/person. These interventions require an intention, a drive, a relationship and actions" (Blasdell, 2017, p. 2). Caring is an experience that is beneficial to both the patient and the nurse, as well as between all health care associates. Caritas support and enhance the patients' caring experience (Watson, 2009). Watson's caritas is provided as nurse-patient guidelines that can be utilized to support and improve the overall caring experience (Watson, 2009) Watson defines caring as:

> The moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity. Human caring involves values, a will and a commitment to care, knowledge, caring actions, and consequences. All of human caring is related to inter subjective human response to health-illness; environmental-personal interaction; a knowledge of the nurse caring process; self-knowledge, knowledge of one's own power and transaction limitations (Blasdell, 2017, p.1).

One of Watson's 11 assumptions related to Human Care Values in Nursing is that "as a beginning we have to impose our own will to care and love upon our own behavior and not on others. We have to treat ourselves with gentleness and dignity before we can respect and care for others with gentleness and dignity" (Blasdell, 2017, p. 2). The benefits are immeasurable and promote self-actualization on both a personal and

professional level (Blasdell, 2017). Leadership recognizes that nurses require self-care and healthy coping mechanisms in order to appropriately care of themselves and then others.

Summary

Grief is an experience that every individual will face at some phase of their lives and processing that grief can be overwhelming. Emotional reactions to grief can include anger, denial, guilt, anxiety, sadness, despair, and depression. Death is an unavoidable, unpreventable event that will occur at some time in the career of a nurse. Nurses that lack education on how to handle these emotional responses to grief, can exhibit unhealthy coping habits, cumulative grief, and lack of self-care. Jean Watson's Theory of Human Caring consists of 11 assumptions in regards to Human Care Values in Nursing. The assumption that directed this project was nurses needing to first indulge themselves with "gentleness and dignity" before they can share those attributes with others.

CHAPTER II

Literature Review

The topic of nurse grief is one which clearly requires more attention and research. Recognizing grief and knowing how to process grief emotions effectively through health coping mechanism can be challenging. There is an abundance of research studies regarding grief and its effects. However, the studies are extremely limited for nurses who experience grief or how to support a grief-stricken nurse. Throughout the literature, grief is conveyed through emotional expressions and processes in which a person will experience. There are numerous theories and frameworks to support the existence of grief, and models to assess the concepts. Real-life experiences of registered nurses are shared and explanation to stigmas.

Literature was retrieved from CINAHL, MEDLINE, PROQUEST and, Google Search databases from January 2009-2019 in the English language only. The timeframe selected allowed for the most recent articles of research to reflect current changes in clinical and administrative practices, available education and supportive measures, and nursing exposure to grief. To conduct the literature review, key words such as: nurse's grief, types of grief, effects of grief on nurses, emotional support, healthy coping mechanisms, and self-care were used. The search terms were deliberately kept general to prevent important publications from being excluded.

Grief

"The word "grief" is derived from the Lain gravare, meaning to burden or to cause distress" (Dunne, 2004, p. 45). Merriam-Webster (n.d.) defines grief as "deep and poignant distress caused by or as if by bereavement; a cause of such-suffering."

Synonyms of grief are affliction, anguish, heartache, sorrow and woe, while the antonym includes joyfulness, cheer, gladness, joyousness, blessedness, bliss, happiness, and pleasure (Merriam-Webster, n.d.).

Grief is best understood as an emotional reaction to change, such as experiencing a loss or perceived loss (Wisekal, 2015). Grief is a natural progression, not an illness or disorder that is experienced. All individuals are impacted by grief at some point in their lives and often nurses experience grief when patients die in their care (Oates & Maani-Fogelman, 2019). While caring for patients, nurses make close personal relationships to the patient and their family members. This relationship turns into an attachment that can be strong, and after the death of the patient, nurses may experience a vast sense of grief and loss. Grief can include many unusual feelings and changes in behavior (Wisekal, 2015). Once nurses develop these relationships and experiences of loss or perceived loss, they begin to go through a grieving process, which is the defining characteristic of nurses' grief (Wisekal, 2015).

Theories and Frameworks

Theorists have created grief models to assist in measuring concept. Many theories and models hold mutual themes or stages (Freud, 1961; Lindemann, 1944; Kubler-Ross, 1969; Parkes, 1975, 1998; Bowlby 1973, 1980; Worden, 1991). Freud (1961) proposed the original "grief work" theory, which regarded grief as a private process, whereby grievers withdrew from humanity so that detachment from the deceased could be a gradual process. The psychological purpose of grief was thought to release the individual from their attachment with the deceased (Buglass, 2010, p. 44). Freud's (1961) theories about grief were based on clinical knowledge with people who suffered from depression.

Freud's (1961) ideas about grief and the necessity to confront grief to permit detachment have remained an attribute of successive theory and procedure (Buglass, 2010).

Lindemann (1944) suggested that grief work, the psychological process of coping with a significant loss, required the bereaved person to become emotionally detached from the deceased person and adjust to a different environment, in which the deceased was not included (Buglass, 2010). Lindemann (1944) recognized the five characteristic symptom groups in the grieving process. First, somatic symptoms occur in surges and are prompted by remembrances of the deceased. Second, there are changes in sensorium, such as a feeling of unreality, hallucination of the deceased and a feeling of distance from other people. Third, there are feelings of guilt, searching for the deceased and a certain responsibility. Fourth, there are feelings of hostility toward others, and fifth, difficulty in accomplishing normal routines (Dunne, 2004).

Kubler-Ross's (1969) proposed the stage theory of grief, which included five stages of grief: denial, anger, bargaining, depression, and acceptance. Denial is considered a defense mechanism in order to try and disregard the reality or deny it. Anger is manifestation of profound pain and a way to articulate the devastating emotions. Bargaining is the stage when one attempts to make a deal to stop or reverse the loss. Depression is the expression of emotional sadness. Lastly, acceptance is recognizing the death and beginning to move forward (Wisekal, 2015, E104). Although this model was introduced initially as a linear model, it is now believed by other theorists that, one can pass these stages in any order and may revisit stages several times before grief process is completed. Some people experience all five stages in order, while others may bypass some of the stages, while many experience the stages numerous times (Durall, 2011).

Bowlby's (1973) theory of attachment accentuates the significance of human attachments and bonds that are fostered early in life. Grief develops through a system of four coinciding, flexible phases: shock, yearning and protest, despair and recovery. This theory describes the common human need to create solid affectionate attachments with other people and the emotional distress or reactions triggered by the spontaneous separation of these attachments and loss (Buglass, 2010). Bowlby (1980) reinforces the concept of phases and contends that the "bereaved person must pass through a series of phases before grieving is finally resolved" (Dunne, 2004, p. 47).

Worden (1991) offers an alternative approach to the experience of loss, "which concentrates on tasks of grieving that have to be worked through (grief work) if resolution of grief is to take place: task one—to accept the reality of the loss; task two—to experience the pain of grief; task three—to adjust to an environment in which the deceased is missing; and task four—to withdraw emotional energy from the lost one and reinvest in another relationship" (Dunne, 2004 p. 47). Worden (1991) suggests that grieving occurs from months to years, and while life will never be exactly the same again, it can be meaningful, after the cognitive and emotional facets of grieving have been experienced (Dunne, 2004).

Parkes (1998) theory of grieving is comparable to that explained by Bowlby (1973) and distinguishes four phases of bereavement: shock or numbness, yearning and pining, disorganization and despair and recovery. "Grief is described as the transition of the bereaved person from incomprehension and denial, through a distressed state of confrontation with reality and finally to some form of resolution (Buglass, 2010, p. 45-6). Parkes (1998) suggested that "grief is not a state, but a process that does not involve

symptoms that begin after a death and then fade away, but rather a succession of phases that merge into and replace each other" (Buglass, 2010, p. 46). Parkes (1998) concentrated on a person's emotional and physical responses to death, stressing the frequency of anxiety, searching conduct, anger and guilt, and the essential need of functioning through those feelings to adjust to the death.

Visual images such as the "grief wheel" are often used to describe the process or stages involved in grief, suggesting that it is rarely a stationary process (Dunne, 2004). However, a more flexible approach to the interpretation and management of grief is provided by the dual process model of coping with bereavement (Buglass 2010). The dual process model describes "how a bereaved person copes with the experience of loss in everyday life, along with other lifestyle changes that develop as a result of that loss" (Buglass, 2010, p.44). This model is based on the principle that when people are grieving, the manner of coping is a two-way process: "The person moves between grieving and trying to come to terms with the loss (Dunne, 2004, p. 49).

Stroebe and Schut (1999) proposed the dual process model with grief being a process of fluctuation between two methods, a loss orientation method when the griever engages in emotion-focused coping, and a restoration orientation method when the griever engages in problem-focused coping. This process suggests that a grieving person will work through their grief actively, rather than experiencing it in a passive method (Buglass, 2010).

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 studied the impact of grief in non-traditional relationships that was for people residing together, and

in adulterous or homosexual relationships. The findings revealed that while 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 used, as the relationship may have been secretive or unacknowledged by family, friends, religion, and rituals, which 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 recognized, socially supported, or publicly advocated (Doka, 1987). In 2007, an empirical examination of the stage theories of grief was conducted over a 2-year period by Maciejewski et al. (2007) suggested "that a more common pathway is disbelief, yearning, anger, depression, and acceptance, and that these negative psychological issues peak at approximately 6 months post-loss" (Maciejewski et al., 2007, p. 722).

Grief and Its Manifestations

In order for nurses to offer support to another experiencing grief, it is important that they understand the concepts, attributes, and its consequences. "Individual reactions to death are unique, there are instances when there is a divergence from the customary grief experience, either in intensity, duration, or both" (Durall, 2011 p. 270).

Types of grief reactions can include common or normal grief, anticipatory, and prolonged complicated and/or disenfranchised grief (PDQ, 2002). Normal or common grief can be described as a psychological condition that includes deep physical, emotional, and behavioral symptoms (Casarett et al., 2001) Some of the symptoms of acute grief include: fatigue, chest pain, nausea, dizziness, hair loss, sadness, apathy, anxiety, panic, numbness, fear, shortness of breath, muscle weakness, tightness in throat,

loneliness, emotionally distant from others, insomnia, absentmindedness, difficulty concentrating, obsessing over the person's death, and trouble keeping up with normal daily activities. Acute grief is the grief typically felt immediately after a loss or death. This type of grief can pass or expand to complicated grief (PDQ, 2002).

Complicated grief occurs when a person's ability to transfer through the grieving process is lengthened by inappropriate behaviors, obsessive thoughts, and uncontrollable feedings (PDQ, 2002). Signs of complicated grief include: intense sorrow and pain that doesn't go away, obsessive thoughts about the death, inability to accept the death, feeling detached, inability to trust others, isolation, depression, pervasive feelings of sadness, sense that life has no purpose, and thinking it should have been you that died. "Complicated grief differs from normal or uncomplicated grief, not in terms of the nature of the grief reaction, but in terms of the distress and disability caused by these reactions and their persistence and pervasiveness" (PDQ, 2002, p. 7).

Disenfranchised grief occurs when "a person experiences a sense of loss but does not have a socially recognized right, role, or capacity to grieve" (Doka, 1987, p.460). Doka (1987) explains "disenfranchised grief as the loss of an individual to whom one does not have a socially understood relationship. It is considered insignificant; consequently, one's emotions should not be expressed concerning the loss. Disenfranchised grief often occurs in the healthcare field, when patients die in healthcare workers care, but no formal relationship is established. These nurses undergo the experience of two losses: the patient and the loss of recognized suffering. The nurses that experience disenfranchised grief will deny symptoms of feelings, such as anger, sadness,

depression, guilt, numbness and loneliness, which can lead to compassion fatigue, burnout and leaving the profession.

Nurse's Grief Experience

Nurses experience grief for patients, similarly to a familiar loss. Often times the death of a patient is unexpected and there is not time to mentally prepare for the loss. For some nurses, even when death is inevitable and expected, they still require additional time to process the death. They rationalize over the death to better understand the "why" death occurred. After a patient dies, a nurse goes through a process called bereavement. This is a period of mourning, but does not have an exact length of time. "Symptoms of grief relating to a patient death reported by nurses include: overwhelming sadness, tearfulness, decreased self-esteem, anxiety, anger, aggression, fatigue, sleep disturbances, difficulty concentrating, guilt, fear, uncertainty, nightmares, chest pain, decreased appetite, gastrointestinal problems, social withdraw, and feelings of decreased professional competency" (Loos et al., 2014, p. 191).

According to Gerow et al. (2010), occurrences of nurses surrounding the death of a patient were depicted by nurses inventing a "curtain of protection" to reduce the grieving process and allow them to provide supportive nursing care. Gerow et al. (2010) found that "significant death experiences early in a nurse's careers set the foundation for how the nurse began caring for future dying patients" (p.7). Depending on the death experience, nurses formed the type of "curtain" that would protect them in the future. All nurses surveyed in this study, recalled "vivid and clear" memories of earlier death experiences, to the point that that story created emotional feelings even when the events occurred decades earlier.

Patient death and occupational exposure to death are the current realities for nurses. Technological advances and improvements in healthcare do not change this reality, even with longer patient survival, and cure rates from previously terminal illness (Muliira & Muliira, 2016). The majority of human death still occurs in healthcare facilities that are away from the public eye and this converts into steady patient death encounters by nurses.

Nursing Stigmas

Eliminating death from normal daily life into the sanitary healthcare environment has in a way created an air of mystery to patient death and intensifies the nurse's emotional responses. This may be one of the reasons why death is often seen as a failure by nurses and a foundation of guilt feelings. As a result, where the purpose of hospitals is to support life and not to ease death, there is much reluctance to speak about death (Muliira & Muliira, 2016). The death experience for nurses is not enjoyable because it prompts feelings of anxiety, guilt, fear and discomfort when it occurs (Loos et al., 2014). Nurses frequently experience deep emotional reactions to patient demise, but may be compelled to disregard or conceal their feelings because of professional responsibilities (Rice et al., 2014).

Gerow et al (2010) explained "that increased grief felt by nurse for a deceased patient may be related to the relationship they developed" (p. 2). "However, a professional stigma exists among nurses. Some nurses may view grieving as unacceptable and expect their colleagues to remain strong and supportive for patients' families while maintaining professional distance (Wisekal, 2015). "This stigma prevents nurses from properly processing the loss of patients because they are expected to immediately

continue providing care to other patients and fulfilling their other responsibilities" (Wisekal, 2015, p.E104).

Another reason that nurses may be reluctant to speak about patient death is the lack of knowledge and necessary skills to handle these situations. Literature confirms that many practicing nurses did not receive detailed education, training, or preparation to deal with the death of a patient (Brunelli, 2005; Gerow et al., 2010). The lack of knowledge and skills to deal with patient death and dying, do not only escalate the anxiety levels and emotional discomfort (Polat et al., 2013), but also "makes nurses unable to effectively cope with their personal feelings and care for others in situations of patient death" (p. 13).

Literature shows that witnessing patient death and the quality of death seen; influences the anxiety level nurses' experience (Bryan, 2007). While nurses identify patient death in distinct ways (terrible, relief, or mixed emotion), there are specific deaths that have a negative impact. For instance, patient deaths that occur in obstetrics and pediatrics are correctly reported to be extremely traumatic to nurses, due to the unanticipated nature. Regardless of where a death takes place, the responsibility of the nurse to provide comfort and care to the family members and to continue to care for other assigned patients simultaneously (Gerow et al., 2010). In truth, some nurses do not get proper time to stop and reflect about the meaning of what is occurring (Brosche, 2007). The integration of role expectations, lack of time to consider death of a patient, and lack of training on how to handle the death or family member needs, can cause personal internal conflict and stress to the nurse's mind (Gerow et al., 2010).

Unhealthy Coping

Gerow et al. found that "nurses experienced conflicting feelings in caring for dying patients" (p. 9). The nurses believed that they had a responsibility to provide the best quality care to patients and their families, but that they should not grieve when the patient died. According to Brunelli (2005), "there were few studies and articles related to how the nurse deals with the loss of a patient" (p.124). Brunelli (2005) included a study of Greek nurses, and found that nurses fluctuated between experiencing and avoiding grief" (p. 125). "Reactions ranged from crying, sadness, anger, and recurring thoughts of dying conditions (pain/suffering) and the actual death" (Brunelli, 2005, p.125). Similarly, "Lenart, Bauer, Charise, Brighton, Johnson and Stringer (1998) found that nurses mainly "repressed grief and that their support systems were mainly from other nurses. Some nurses reported grief responses such as fatigue, sleep disturbances, anxiety, sorrow, moodiness, and difficulty concentrating" (Brunelli, 2005, p. 125). All being documented resolved grief responses.

As Brosche (2007) tells us, the consequences of not going through the grieving process for the nurse can range from burnout to potentially harmful addictions, such as alcohol and drugs or even thoughts of suicide or self-harm. "Furthermore, staff morale and delivery of patient care can be affected" (Brunelli, 2005, p. 125). The hospital outcomes can lead to increased staff turnover and decreased patient satisfaction (Brunelli, 2005).

Strengths and Limitations of Literature

There is much literature to support that nurses' grief is a common occurrence and one that significantly affects job satisfaction, turnover rates, personal and professional

relationships, and employee engagement. “Recognizing that nurses need to work through the grieving process and come to a healthy resolution with a patient’s death is the first step to helping maintain physical, mental, and spiritual health” (Brunelli, 2005, p. 128), as a result, the strength in literature demonstrates, maladaptive grieving can lead to emotional detachment and depression, non-caring, anger, and burnout. This maladaptive grieving causes the loss of nurses to other professions or nurses who deliver inadequate nursing care.

Limitations to the literature review are the lack of demonstrated educational strategies and the development of proper resources for nurses who are experiencing grief and grief manifestations. “After obtaining a greater understanding of nurses’ grief, the nursing profession can effect positive changes in nursing environments, leading to improvements in nurses’ grief management” (Wisekal, 2015, E106).

Summary

This chapter discussed the definition of grief and theories and frameworks of grief. Grief and its’ manifestations including types of grief reactions that can consist of common or normal grief, anticipatory, and prolonged complicated and/or disenfranchised grief. Nurse’s using a “curtain of protection” to assist in coping with a patient death as grief is experienced. Stigmas that prevent nurses for soliciting help to process their grief included: Nurses feeling as if they failed their patients when they die and the need to remain strong as grieving is unacceptable. The consequences of not dealing with a patient death and taking the proper time to grieve can have grave consequences.

There is an abundance of literature regarding grief and the impacts of grief. Registered nurses have written descriptive papers about how it feels following a patient

death, but there are inadequate studies to support interventions to assist in the grieving process for nurses. There is significant literature to suggest that grief is a process for nurses and nurses lack support to guide them in recognizing unhealthy behaviors when grief stricken. “A high rate of turnover in nursing staff is seen when nurses’ grief is not adequately acknowledged and when few resources are provided to adequately assist those who are grieving” (Wisekal, 2015, p. E103). However, there is insufficient evidence regarding nurses’ grief and the type of support required to promote healthy coping mechanisms and self-care activities after a patient death is experienced.

CHAPTER III

Needs Assessment

Patient death is inevitable in the hospital setting and the impact on registered nurses and their coping mechanisms is not sufficiently known. The reason for conducting a needs assessment survey was to help with direction in service that would best benefit the nurses, address the problem of grief amongst registered nurses, and to recognize gaps in knowledge, resource availability, and educational opportunities.

Target Population

The healthcare facility in this needs assessment was a 175-bed hospital in the southeastern United States, which provides comprehensive emergency services and specialty medical care. Registered nurses at this facility were invited to voluntarily complete an anonymous needs assessment survey regarding patient death, grief, and self-care education, and to indicate the type of support they would like to have provided after a patient death. Registered nurses from inpatient, emergency department, and outpatient surgery areas were included as the target populations.

This needs assessment survey was completed by 75 registered nurses and revealed that 48% never attended a class or received any education on grief or its manifestations, and 11% were unsure of any education on the topic of grief. Whereas 38% of the registered nurses responded that they had not attended or received education for self-care and 7% were unsure if they ever received education on self-care. Nurses reported at 80% remembering their first patient's demise, with 3% not yet experiencing a patient expiring. Nurses surveyed reported 87% experienced feelings of sadness, followed by substance abuse, guilt, and sleep disturbances. The results contributed to 81% talking to others

about the death and their personal feelings. More than 50% of the nurses reported that speaking to a teammate or peer would be most helpful in processing their feelings.

Target Setting

The target settings for future implementation include all inpatient areas, such as Intensive Care Unit (ICU), post-surgical floor, Women and Children's Center, Emergency Department (ED), all medical floors, and the Outpatient Surgery Center at the facility. No areas will be excluded when designing this project, as a patient can die in any area of the hospital. Some areas are more subject to patient death, which include ICU, ED, and Women's Center. Within the past 2 years there have limited deaths that have occurred in the operating room and post-anesthesia care unit (PACU). Immediate debriefing occurred to gather facts of the failed rescue event, but the nurses reported not feeling supported by their peers or managers in a way they desired.

Sponsors and Stakeholders

The main project sponsor is the healthcare facility nurse educator. The nurse educator has agreed to assist in this project development and has provided necessary information, by sending out the needs assessment and assisted in filtering the responses. The nurse educator supported this project development to provide additional education, support, and resources to the registered nurses who experience grief after a patient death at the facility.

Stakeholders include the registered nurses who experience patient death, chaplain, nurse educators, patient experience team, and department managers at the facility. The chaplain is currently involved in Code Lavender at this healthcare facility and is encouraged that future implementation of this particular project will be an adjunct to

assist with grieving nurses. Additional stakeholders will be future patients and their families that will be affected by the quality of care provided.

SWOT Analysis

The strengths, weaknesses, opportunities, and threats of the project's design are depicted in Table 1.

Table 1

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
Reputation	Investment of time	Direct and indirect impact on hospital objectives	Current Covid-19 restrictions
Cost advantage	Needs leadership support	Strong multi-specialty support (cancer center, hospice, long-term care), Strong education programs	Technology advances (simulation labs)
Reputable facility	Needs in-service educational activities	Employee assistance program (EAP)	Not a current program
Highly-skilled clinical staff	Staff turnover	Overall staff satisfaction	Change in educational leadership
Strong academic faculty	Variability in engagement and accountability	Project recognition	
Diversity of interests	High expectations of members	Project created and maintained by nurses	
Diversity of expertise	Lack of knowledge and strategies needed to improve the grief process	Improved coping and self-care skills	
Strong leadership			
Code Lavender adjunct			
Strong demand for support			
Previous successful implementation of projects			

Strengths	Weaknesses	Opportunities	Threats
Serves as a resource to the nursing staff			

Available Resources

Resources that will be required for project implementation include the use of a private room, preferably a smaller, welcoming room, such as a conference room or education suite for nurses that prefer to meet in person. Nurses that prefer to meet from outside locations, such as home, would require a computer or laptop. Monthly online team meetings would need to be scheduled. The online teams meeting would require a professionally trained facilitator. An informational flyer would be provided to all newly onboarded nurses during the mandatory hospital orientation phase. The supporting nurse educator instructs the majority of the new teammate orientation and plans to incorporate into the current agenda.

Desired and Expected Outcomes

The desired outcome of a nurse peer support group, after a patient death, is for the nurse to feel supported and have an understanding of what is being felt and experienced internally and externally. The Resilience in Stressful Events (RISE) program introduced in November 2011 at Johns Hopkins Hospital provided “a team of 39 peers responders who take turns volunteering their time to support clinicians who call the service” (Durkin, 2017 p. 2). As healthcare facilities “nationwide struggle with recruitment and retention issues, attention is given to the impact of the caregiving environment on its workforce. Wellness programs encompassing staff support are becoming essential components of health care organizations” (Catlin, 2004, p. 471).

A basic knowledge form would be completed for grief and its manifestations, available support for teammates experiencing grief, self-care activities, and how to become involved in supporting peers. After completion of six-monthly meetings, a discussion would be included to inquire if further interest is desired to become a peer support volunteer. Once peer support volunteers are identified, groups will be formed to ensure 24 hour, 7-day per week coverage for the facility. The peer support persons would be invited to further education to be devised as the program broadens.

Team Members

The key team member is the facility nurse educator. The nurse educator has helped with the needs assessment and has offered several forms of implementation for the project. The PACU Nurse Manager has provided support and feedback of nursing education needs after two grief-stricken nurses in that department reached out for assistance. The Facility Chaplain took time to explain what Code Lavender is and how it works, how it established itself, and how a peer support group for grieving nurses would be an adjunct for further collaboration. The patient experience team includes Master prepared professional counselors whom are trained specifically in psychology. This type of credentialing and certification would be required for a highly qualified facilitator.

Cost and Benefit Analysis

A similar peer support program established at Johns Hopkins Hospital, the RISE program appeared to be a cost-savings for the facility between 2015 and 2016. The “cost-savings, through retention, of $22,576 per nurse and projected that it could save the hospital more than $1.8 million each year” (Durkin, 2017, p.2). The cost savings could be

larger if physicians were included in the analysis, as the cost of losing a physician is approximately “three times the cost of losing a nurse” (Durkin, 2017, p.2).

Cost to initiate education and a peer support group for nurse grief is minimal, while the benefits could be vast. Ongoing education and improving skills and knowledge are a life-time commitment for all nurses. The time spent would be less than 90 minutes for nurses online and approximately 45 to 60 minutes for nurses during an already established orientation class.

Summary

The needs assessment confirms that there is desire and demand for support to the nurses experiencing grief and dealing with stressful situations. The collaboration between the education department, pastoral care, patient experience team and leadership to begin a nursing grief support group reveals true commitment and encouragement. Encompassing all inpatient care areas will provide a link to supply coverage for grief-stricken nurses, 24-hours per day.

CHAPTER IV

Project Design

The project will initially consist of education on grief and its' symptoms, types of grief, and examples of nurse grief. A discussion would take place after 6 months of grief education is completed. The discussion feedback will facilitate future education needs and identify candidates for a peer support group for grieving nurses.

Goals and Objectives

The goal of this project was to provide necessary and desired support to registered nurses experiencing grief following the death of a patient. Preparing nurses with education, support, and resources will develop healthier coping mechanisms and self-care to better manage the experience and future experiences of patient death.

The desired outcomes for this project are for registered nurses to have a better understanding and knowledge base for what grief is, potential symptoms, and to become empowered to utilize support systems and knowledge of healthy coping mechanisms.

Plan and Material Development

The project designer will use an online Teams meeting platform to present pre-selected monthly topics. A flyer (Appendix A) will be developed to distribute to all nurses through the hospital email system and be provided to all nursing leaders. These flyers can be placed in gathering areas, such as staff lounges and educational boards to be quickly and easily read. The development of a new protocol (Appendix B) to be used by the facility for implementation. Implementation will consist of several phases, which are detailed below.

Phase 1: Education Session for Onboarding New Nurses

All newly onboarding registered nurses will attend an in-person education session during mandatory hospital orientation, which will include a PowerPoint presentation (Appendix C), grief flyer, and a follow-up discussion will occur immediately following the grief presentation. The PowerPoint presentation will explain the definition of grief, grief symptoms, types of grief, needs assessment, and resources currently available. Each participant will be asked to complete a survey that will direct future educational needs.

Phase 2: Education Session for Currently Employed Nurses

All registered nurses throughout the healthcare facility will be sent a grief flyer that invites them to an online TEAMS meeting through their teammate email addresses. The flyer will include monthly topics, dates and times of meetings, TEAMS meeting link, which will include the audio call in number and meeting identification number to join. The type of monthly topics will include: shared nursing stories, grief symptoms, types of grief, Kubler-Ross' Stage Theory of Grief, healthy and unhealthy coping mechanism, needs assessment results, self-care activities, current support available, and future support being proposed. PowerPoint presentations, developed by the facility nurse educator, will be utilized during the TEAMS meetings to present topic information. A discussion will occur at the end of the 6 months of sessions to capture the percentage of nurses with a desire to serve as a nurse peer support person. The nurse peer support person will be part of a group of nurses that have completed 6-monthly grief sessions and expressed an interest in assisting other nurses through grief encounters. The nursing peer support group will help to ensure that any nurse in need of grief support, will have a resource available, regardless of day or time.

Phase 3: Data Analysis

The facility's nurse educator will review the discussion results with the facilitator, share with senior leadership, and make a decision whether or not to fully implement this project within the facility. The survey results will depict desired further educational needs, names of candidates that would like to help lead a peer support group for nursing grief and timeliness of interventions and support.

Timeline

Following approval from the education department at the healthcare facility selected, the formal orientation education will begin with the next orientation class that is offered for new hires. Grief information flyer will be sent to the nurse managers and team leaders through email format. Two weeks after the flyers have been emailed, they will be placed in nurse common areas, such as lounges and staff education areas by the leaders in their departments.

Budget

Initial costs will be minimal. Cost will be charged to each individual department for education, including the Administration Department for onboarding and orientation of nurses. The monthly TEAMS meeting sessions will take approximately 90 minutes to attend. Budgeting for future education will need to be determined at a later time and is dependent on need.

Evaluation Plan

The project is expected to impact the future of nursing within the healthcare facility. This project could potentially benefit all inpatient areas and outpatient areas. By the end of the first quarter of implementation, nurses would begin to offer feedback,

using an anonymous Survey Monkey link, to the educator and the development of the nurse grief support group could be established. This program could potentially extend throughout the entire organization.

Summary

This chapter discusses the minimal amount of funding that would be required to fully execute a necessary and desired support system for grieving nurses. The facility currently has a developed onboarding process in place with the facility educator. The project would be an adjunct to the Code Lavender to assure that nurses are being supported through the grieving process. Utilizing a developed online TEAMS platform, there is no additional costs for setting up an ongoing monthly planner. The TEAMS platform allows for nurses to get the support they need within their own personal comfort zones, such as from home. Using the TEAMS platform allows for nurses to listen to information, without having to respond. Additionally, an online platform allows for joining the meetings from any electronic device, at any location with complete anonymity, if desired. The project does not pose any risks to participants; however, the valuable feedback after the sessions, can affect the entire nursing population.

CHAPTER V

Dissemination

After reviewing the literature surrounding a nurse's grief, it was apparent that there is a lack of education and peer support. The registered nurse's needs assessment results echoed the need to be supported, and an astonishing 52% reported talking to a peer or teammate most helpful after the death of a patient. Having discussions with peers about the deceased patient and sharing personal feelings has been found to be helpful (Wisekal, 2015). Providing sufficient support to nurses can assist with increasing their morale and job satisfaction. In addition, meeting nurses' needs nurtures work-life balance, preventing the constant repetition of negative outcomes such as burnout, turnover, prolonged grief, and work-related stress. With the lack of assistance in preventing these negative outcomes, nurses can lose sight of the positive effects that make their role rewarding (Wisekal, 2015).

It is believed the integration of a nursing peer support group for grieving nurses, along side other valuable resources, such as the employee assistance program (EAP) and Code Lavender, would be a beneficial program.

Dissemination Activity

The dissemination activity included a formal presentation through a teams virtual platform. All stakeholders were extended an invitation to attend. Those in attendance included the facility Nurse Educator, Manager and Certified Educator Candidate for Department of Spiritual Care and Education, the Patient Experience Manager, and Grief Counselor. The formal presentation included the PowerPoint slide detailing the project, a PowerPoint presentation for onboarding new registered nurses to the facility, a developed

grief flyer that will be forwarded to nurse leaders to share with teammates the details of each meeting, a newly developed protocol for monthly presentations and several video clips of a 25-year veteran nurse, who shares her experience with grief and tools for coping.

Limitations

There were a few limitations to the project that were discussed during the dissemination. One of these discussed was that the high number of COVID deaths were not included in the needs assessment data. This affects the overall number of nurses that are now being affected by patient death. It is estimated that the number of nurses dealing with grief and not utilizing healthy coping strategies, would increase.

Implications for Nursing

The need for a grieving nurse support group is long overdue and is currently being discussed at the system level. With the COVID pandemic continuing more than a year now, the number of nurses affected by patient death and grief experience is on the rise. This project allows for structured conversation amongst peers, guided by a professional facilitator, which allows nurses to feel supported and have time to process grief in a healthy manner. Evidence shows that nurses suffering from unsupported, unrecognized, grief are either burning out and changing the care they provide patients or leaving the nursing profession.

Recommendations

One of the recommendations, which is extremely important, is having additional resources identified, in way of specialists in the field of grief counseling for nurses that are identified as needing, or asking, for further follow-up. It was discussed having a

review committee pre-screen local grief counselors, educational background, and experience, then collect business cards and allow individuals to select a counselor to follow-up with.

Summary

The stakeholders were presented with the Grieving Nurses' Need for Support background, purpose, needs assessment, project, plan for implementation, and implications for nursing. After the presentation and evidence were presented to the stakeholders, discussions followed, resulting in an overwhelming agreement for the need of a program to support grieving nurses. The hope of this project was to improve nurse's knowledge of the grieving process, manifestations and support systems available through personal grieving struggles.

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Appendix A

SST: Surviving, Striving, and Thriving Flyer

SST

SURVIVING, STRIVING AND THRIVING.....

WHEN OUR PATIENTS DON'T

WHO: All Registered Nurses

WHEN: 2nd Thursday of each month 8:00pm-9:30pm

3rd Monday of each month at 10:00am-11:30am

WHERE: In-person- Women's and Children's Center, Room 1B

Online via TEAMS

Meeting ID #0000000000

Call in number: 888-888-8888

TOPICS: January—Nurse Grief Story Sharing and Discussion

February—What does Grief Look Like; Grief models

March— Nursing Grief Needs Assessment and Results

April—Healthy and Unhealthy Coping Mechanisms

May—Self-Care Activities

June—Support Groups to Help you Through Grieving

Appendix B

Grieving Nurse's Peer Support Meeting Protocol

1. Before the meeting time, decide on the structure, outline, and purpose:
    a. Those who need to attend
        i. Nurses
        ii. Facilitator
            1. The facilitator needs to have a degree in counseling, preferably grief counseling.
        iii. Nurse educator
            1. Can be included in the meetings to learn about opportunities for future teachings, but not required
    b. Program objectives
        i. To assist registered nurses experiencing past or present grief
        ii. Provide peer support to registered nurses
    c. Length of time needed for meetings
        i. 90-minute total meeting time
        ii. Introduction: Limit to no more than 20 minutes
        iii. Present topic: 40-minute discussion
        iv. Closing discussion: 20-minute discussion
        v. Meetings to occur twice monthly on different days and times to capture more opportunity for attendance.
    d. Preparation needs to occur prior to meeting time
        i. Ensure that the TEAMS meeting ID and phone number are working
        ii. Reserve a meeting room for in-person meeting.

2. Communication is key:
    a. Develop a written agenda
        i. Use the developed Surviving, Striving and Thriving flyer to promote
    b. Send the agenda to nurse leaders to post in departments
        i. Ask nurse leaders to place the flyer in the staff lounge and bulletins boards
    c. Set expectations of attendance for virtual or in-person
        i. Let nurses know that they can attend virtually through the Teams meeting or in-person
        ii. Share that on the virtual meeting, one can remain anonymous if desired
    d. Set framing or context of the meeting
        i. At the beginning of each meeting set the context or framing to which topic is being covered that month

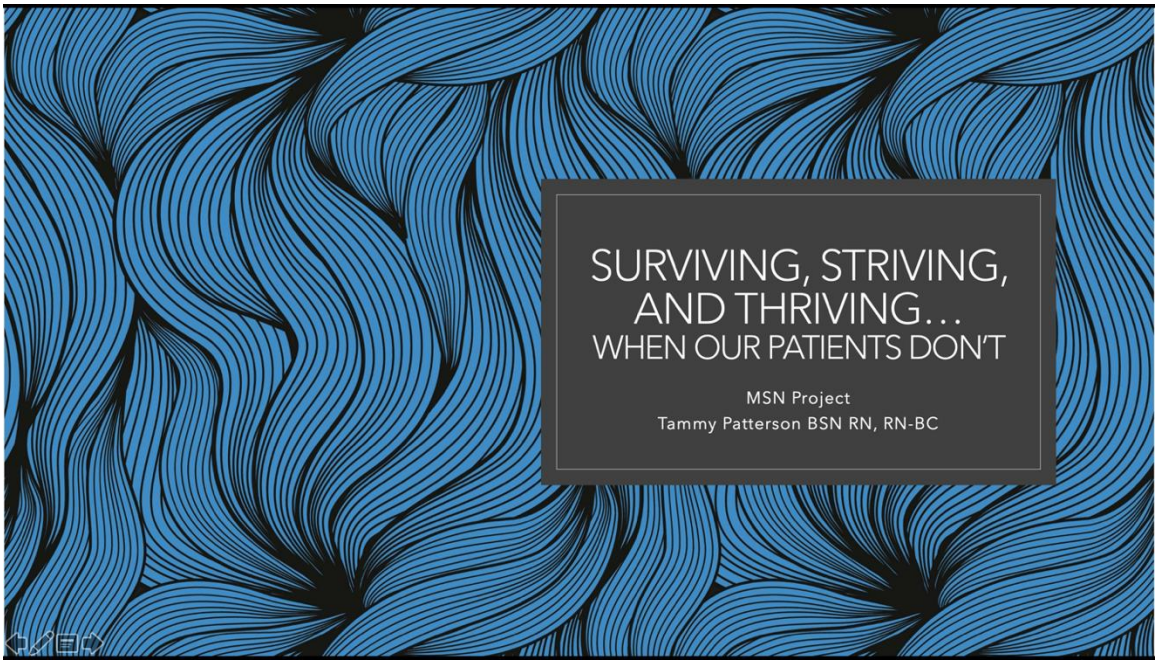
3. During the meeting:
    a. Start and finish all meetings on time
    b. Assign or ask for a volunteer to be a note taker and time keeper
    c. Context
        i. The purpose of having this meeting
        ii. To provide peer support for grieving nurses

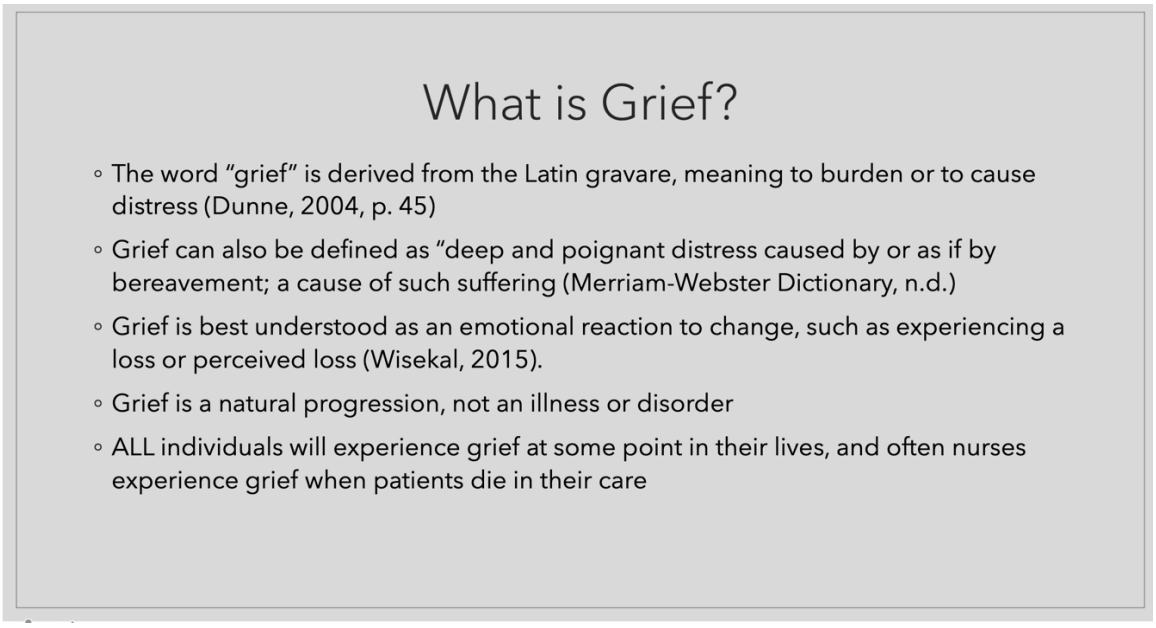
4. Managing the meeting:
    a. Make an ask by doing it early and be specific (ex. In order to support each other, we need to be open and honest)
    b. Stay focused on topic and avoid discussion wandering
    c. Use active listening skills
    d. Utilize a “parking lot” to put off-topic discussions for later, if time allows
    e. Set time limits for each individual speaking (5 minutes maximum per person)
    f. Acknowledge feelings and openness of sharing

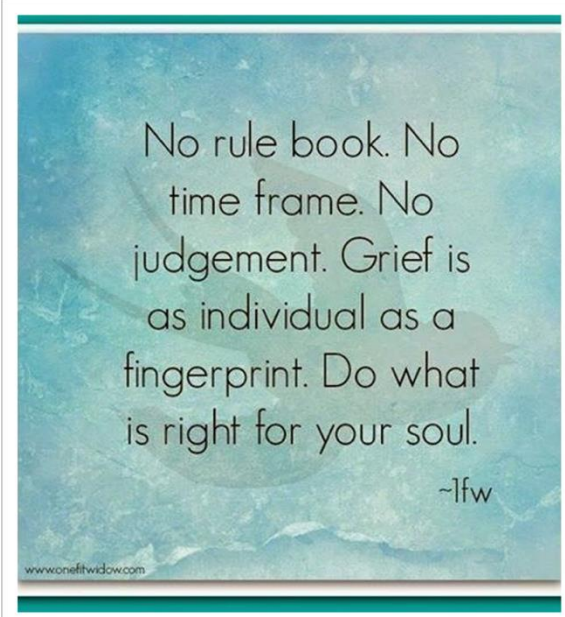
5. End of meeting
    a. Thank all participants for attending meeting
    b. Ask participants to share with peers
    c. Provide next month’s topic of discussion
    d. Share power point slide on additional resources available

Appendix C

PowerPoint Presentation







Types of Grief

Normal or Common Grief

Anticipatory Grief

Prolonged Complicated/Disenfranchised Grief

Individual reactions to death are unique, there are instances when there is a divergence from the customary grief experience, either in intensity, duration or both.

Normal or Common Grief

- Described as psychological condition that includes deep physical, emotional, and behavioral symptoms:
  - Fatigue
  - Sadness
  - Anxiety
  - Numbness
  - Difficulty concentrating
  - Trouble keeping up with normal daily activities
  - Emotionally distant from others
  - Insomnia

Complicated or Disenfranchised Grief

Occurs when a person's ability to transfer through the grieving process is lengthened by inappropriate behaviors, obsessive thoughts, and uncontrollable feelings.

- Intense sorrow/pain
- Obsessive thoughts about death
- Feeling detached
- Depression
- Isolation
- Inability to accept the death
- Sense that life has no purpose

Grief and its Manifestations

- In order for nurses to support another experiencing grief, it is important to understand the concepts, attributes, and consequences.
- Individual reactions to death are unique, there can be exceptions to customary grief experience, either in intensity, duration, or both.

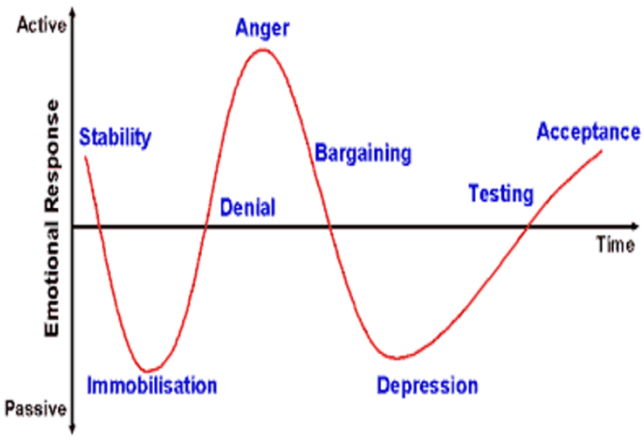
Nurse's Grief Experiences

Symptoms of grief relating to a patient death reported by nurses include:

- Overwhelming sadness
- Decreased self-esteem
- Anxiety
- Anger
- Aggression
- Fatigue
- Sleep disturbances
- Difficulty concentrating
- Uncertainty
- Nightmares
- Chest pain
- Decreased appetite
- Social withdraw
- Feelings of decreased professional competency

Grieving Nurses' Need Support

- Nurses will confront grief and loss throughout their careers
- If grief is not recognized and attended to, it can result in many complex issues
- Competence in grief and the grief process is essential for nurses due to the high incidence threat
- Grief can be compounded throughout entire careers



Kubler-Ross's Stage Theory of Grief

5 Stages of grief DABDA:

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

Although this theory of grief is well-known, too often nurses do not consider that they too can experience these stages. The stages can be experience in order, or non-linear.

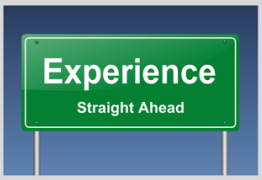
Theoretical/Conceptual Framework

Jean Watson's Theory of Human Caring

- States that caring revitalizes all of life vitalities and enables our capabilities
- One of the eleven assumptions is "as a beginning we have to impose our own will to care and love upon our own behavior and not on others"
- We need to treat ourselves with gentleness and dignity before we can respect and care for others the with the same
- Benefits are immeasurable and promote self-actualization on both personal and professional levels

Nursing Needs Assessment

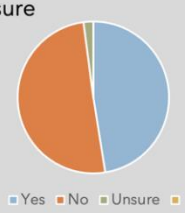
- Completed by 76 nurses in January 2020
- 46% of the nurses that completed the assessment held BSN degrees, 33% were ADN degrees, the balance were diploma, Bachelors not in nursing and MSN degrees
- 79% worked Full-time, 14% Part-time, 0.5% PRN
- 30% have been nurses over 21 years, 17% 11-20 years, 17% 6-10 years, 21% 1-5 years and 12% had less than 1 year experience
- More than 75% worked inpatient and 32% were outpatient nurses
- 30% reported being exposed to patient death at least once a month



Nursing Needs Assessment

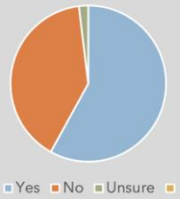
Ever attended a class or received education on grief?

- 42% Yes
- 45% No
- 11% Unsure



Attended a class or received education on Self-Care?

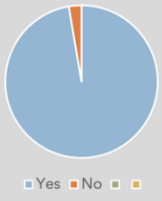
- 55% Yes
- 38% No
- 0.7% Unsure



Nursing Needs Assessment

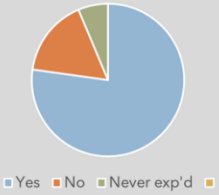
Ever exposed to a patient death?

- 96% Yes
- 0.3% No



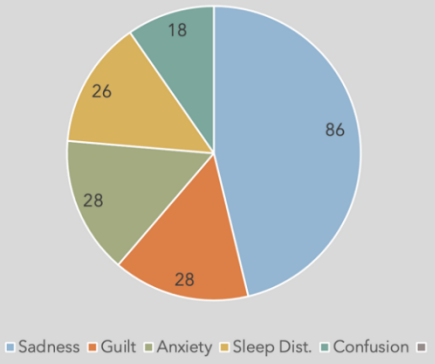
Do you remember your first patient death?

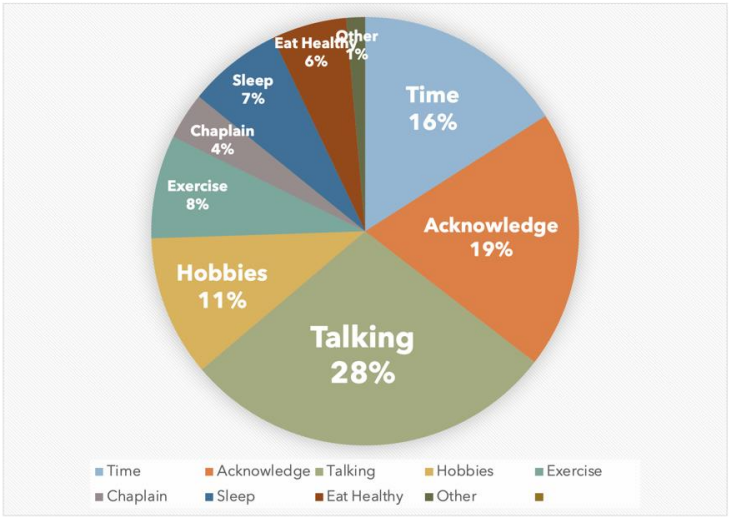
- 80% Yes
- 17% No
- 0.3% Never had a patient die



Nursing Needs Assessment

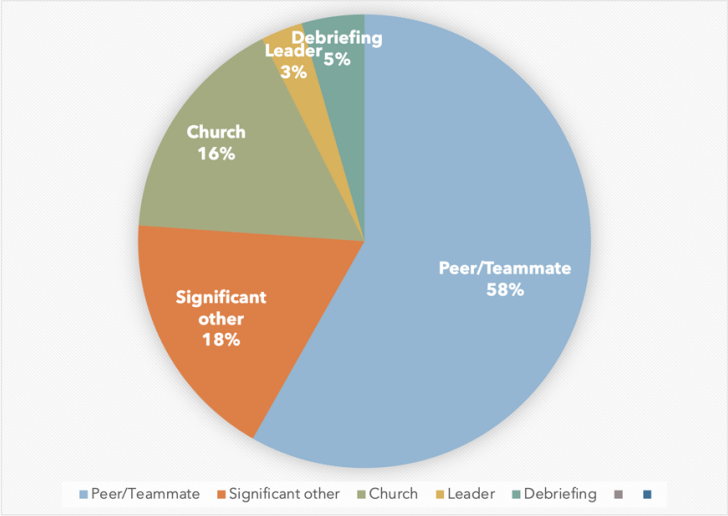
- Nurses reported experiencing these feelings after a patient death:
  - 86% - Sadness
  - 28% - Guilt
  - 28% - Anxiety
  - 26% - Sleep disturbance
  - 18% - Confusion





Reported practices following a patient death:

- Time to accept feelings
- Acknowledging that grieving is a process
- Talking to others
- Work on hobbies
- Exercise
- Speak to chaplain or religious leader

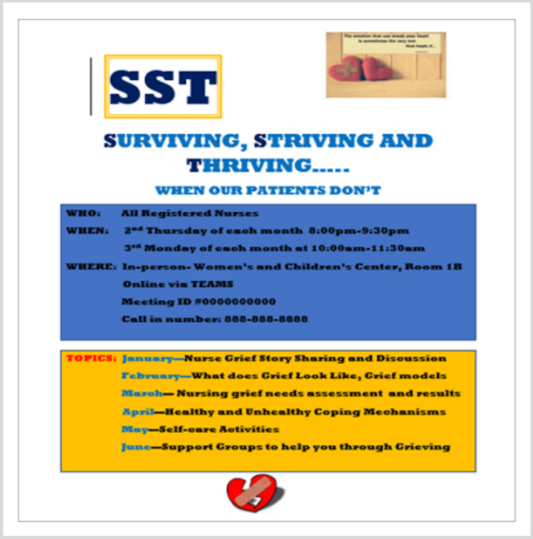


Things that helped after the loss of a patient:

- Talking to a peer/teammate
- Talking with a significant other
- Church
- Taking a break
- Speaking to a leader
- Attending debriefing

Current Resources Available

- Code Lavender
  - Call: 980-212-HOPE
  - Available 24/7
- Employee Assistance Program (EAP)
  - Call: 800-384-1097
- Atrium Health Behavioral Health Help Line
- Call: 704-444-2400
- Available 24/7
- Self-Care Activities through PeopleLink, Self-Driven Education Modules
- Book:
  - *Leading Peer Support and Self-Help Groups: A Pocket Resource for Peer Specialists and Support Group Facilitators* by Charles Drebing



Peer Support for Grieving Nurse's flyer

- Look for this flyer in nursing units
- All nurses invited
- Can attend in-person or virtually
- Can remain anonymous
- Offered twice per month
- Different topic monthly
- Adjunct to Code Lavender
- Nurse-driven