THE LIVED EXPERIENCE OF NURSES
WHO ENCOUNTER THE UNEXPECTED DEATH OF A PATIENT

By Teresa L. Mumbrue

Nurses are the primary caregivers for patients while in the hospital. Regrettably, stable patients often experience complications that were otherwise unanticipated. Often times, patients die and the nurse is left to cope alone and try to understand the emotional stirrings that are often unsettling. While many studies focus on improving patient quality of care provided by the nurse, few, if any, examine the nurse and the perspective they may have on the dynamic healthcare environment and unexpected patient deaths. Grief is common among nurses and is often heartfelt when a patient dies, but that grief is often ignored (Brosche, 2007). The negative impact of this phenomenon may lead to nurses experiencing moral issues, specifically moral distress as well as compassion fatigue. The emotional reaction of nurses who experience a patient's death that was unexpected has largely been unexamined.

The purpose of this study is to describe the lived experience of nurses who care for patients who unexpectedly die. The research question is; what is the lived experience of nurses who encounter the unexpected death of a patient? The theoretical framework that provides the foundation for this study is Lazarus' theory of stress, coping and adaptation along with Spiegelberg's approach to understanding phenomenon as lived by the person experiencing the phenomenon.

A naturalistic paradigm coupled with a descriptive phenomenological approach was used in order to describe the meaning of the experience many nurses face when exposed to patients deaths. The participants for this study are nurses that are currently employed in a hospital setting and have experienced this phenomenon. Data analysis consisted of Spiegelberg's method of interpretation of the qualitative data.

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To my husband Todd, without his love and support and words of encouragement, this project would have never have been completed. To my sons Tristan and Troy, when the upper limits of frustration would begin to take its hold, they would tell me "you can do this Mom". To my father, Dave Teske, who's complete and unconditional understanding of my efforts gave me the strength to further my education. To my siblings, Sharon, Michael and Patrick, thank you for being proud of me. Finally, to my mother Pat, my grandfather Lala and my father-in-law Chuck.

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CHAPTER I

INTRODUCTION

Registered nurses (RNs) are instrumental in providing quality care to patients that are in need. Many RNs have the education and skills to provide the technically necessary expertise needed to provide patient care, but nurses also provide emotional support through compassion and caring. The emotional side of nursing is an aspect that most nursing schools do not teach. This side of nursing is one that comes with experience, learning as you work and dealing with challenges as they come. Emotional responses of nurses who experience a patient's death that was not expected may include, but are not limited to fear, grief, guilt, anxiety, apathy, burnout, compassion fatigue, moral distress, powerlessness, frustration and the stress cascade (Brosche, 2007; Ewing & Carter, 2004; Yang & Mcilfatrick, 2001).   A patient's death is not always expected.   An unexpected death of a patient is a traumatic event, most importantly for the patient and surviving family members. The nurse providing care for such patient's often times is forgotten. Many of these RNs will become the next nurse up for an admission due to the loss of their patient and may not have the time to contemplate their emotions and feelings. The nurse may feel, due to time constraints that there is no time to cry or to begin the grief process. Policies and procedures must be followed.   The nurse needs to notify the nursing supervisor, the funeral home needs to be contacted, and the paperwork needs to be done (Brosche). Nurses may not always have the opportunity to reflect on the death of

their patient whether the death is anticipated or unexpected. While many studies have been conducted in an attempt to understand the role of the nurse in providing quality care to dying patients, few studies have examined nurses and their experience when caring for patient's as they die, especially when the death is unexpected. The specific purpose of this study is to describe the perceptions of nurses as they experience the unexpected death of a patient.

Critical Analysis

A good proportion of the literature focuses primarily on the nursing role, nursing satisfaction or the quality of care provided by the nurse. Some studies have examined the value of the nurse in caring for patients in a high acuity environment. A nurse quoted in a grounded theory study describes the perception of value by stating; "I don't think they [administration] truly understand the value of nursing and where it comes from. I just don't think they truly understand what it takes to be a nurse in this day and age" (Ray, Turkel, & Marino, 2002, p. 10). The perception that nurses have regarding their own value is an important concept to consider when understanding what it is like being a nurse in today's dynamic healthcare environment. Many nurses experience moral distress as their values clash with those of the organization (Nathaniel, 2006). Nathaniel (2006) states that "scant research exists on this important subject; the concept of moral distress is used often to describe the pain nurses feel during these troubling times" (p. 419).

Pain experienced by a nurse may be associated with, but is not limited to, unresolved emotional reflection after the death of a patient. The scant research that is available regarding the description of the lived experiences of nurses and patient death suggests that little research has been done to explore this phenomenon. "Although approximately 58% of patients in critical care units die despite of resuscitation efforts, the experience of nurses who participate in unsuccessful patient resuscitation has been largely unexamined" (Isaak & Paterson, 1996, p. 688).

Connections with patients and their families are often considered routine and part of a nurse's practice in caring for the patient. Bonds are established and emotional ties are created. When patients die, not only is it difficult for the family, but for the nurses as well. "Nurses, because of their occupation and professional ethics, often go unacknowledged as grievers of patients who die…" (Grove, 2008, p. 322). According to Halpern, Lev and Thiedke "as individuals working in Western medicine where the emphasis is on curing patients, death is often traumatic for the healthcare professional" (cited in Grove, p. 329). The perception of the experience that nurses may have regarding the unexpected death of a patient has not been fully explored.

Significance of Problem

As nurses experience a multitude of emotions when patients die, many issues may arise as a result of unresolved moral and emotional conflicts. While many studies focus on better care for the patient and their families, a nurse that is emotionally grounded and

that has the essential coping skills is equally important. Nurses must also have the ability to recognize for themselves, when there needs to be an intervention with either counseling or debriefing. When emotional turmoil is not recognized and addressed, the stress cascade begins and leads to "maladaptive coping skills, emotional distancing, anger, labeling of the nurse, decrease in staff morale, decrease in efficiency of care, decrease in customer service and increased turnover, [increased] cost to the hospital and nursing shortage" (Brosche, 2007, p. 22). The stress cascade not only affects the nurse but the institution as well. Hospitals strive for optimal patient care in an ever competitive healthcare market. One of the core fundamentals of patient care is the nurse. The nurse provides care to the patient, follows doctors' orders, and is a liaison between family and physicians as well as providing immediate emotional support to the surviving family members in times of emotional crisis. If the emotional well being of the nurse is challenged and shaken, what may happen to the quality of care that is provided to patients by that nurse?

<div align="center">Statement of Problem</div>

There is a lack of research regarding the nurse's response to an unexpected death of a patient. Since negative consequences may result from unrecognized stress or unresolved emotional grief, the exploration of this phenomenon is necessary in order to gain a better understanding.

Purpose of Study

The purpose of this study is to gain an understanding through nurses' narratives as described by their personal experiences, of what it is like to care for patients that unexpectedly expire.   This is an attempt to better understand the experience that may or may not emotionally affect the nurse and as such has implications for practice as well as personal life.

Research Question

The research question is what is the lived experience of nurses who encounter the unexpected death of a patient? The researcher's goal is to describe what it is like to have a patient suddenly die while under the care of a nurse. In order to understand this phenomenon, a naturalistic paradigm will be used with a descriptive phenomenological approach. Interviews will be conducted in the hopes of providing a rich and subjective account of the personal experiences of nurses by way of their own narratives.

Conceptual Definitions

A conceptual definition "presents the abstract or theoretical meanings of the concepts being studied" (Polit & Beck, p. 59).   An abstract definition supports the naturalistic paradigm in that the concept is within the reality of the study itself as described by the participants. An attempt will be made to define the concepts as

subjectively understood by the author but the definitions may change as the study progresses through immersive data analysis.

1. The lived experience, theoretically defined as the perception of the individual's reality in the context of the experience itself.

2. The nurse is defined as one who is a registered nurse that provides care to patients.

3. A patient is defined as someone who is an inpatient in a hospital that does not have a terminal illness.

4. An unexpected death is an unforeseen outcome of an otherwise stable patient.

<div align="center">Operational Definitions</div>

Polit and Beck state that an "operational definition of a concept specifies the operations that researchers must perform to collect and measure the required information" (Polit & Beck, 2007, p. 59). Spiegelberg's method of interpretation will be used in order to capture a rich description of the lived experience of nurses.

1. The nurse is one who has been a nurse for greater than one year in a hospital setting, whose primary role is to care for patient's that are acutely ill.

2. The patient is operationally defined as one that is an inpatient.

3. An unexpected death is one that was not foreseen.

Participants in this study will be RN's who currently work in a hospital setting and have cared for patients as a primary nurse. The nurses will be chosen by their

experience of having a patient death that was not anticipated. The core concept for this study is to describe an experience and to comprehend the meaning of that experience for those who lived it.

Assumptions

1. Interrelationships between the researcher and the participants require interactions and fluid subjectivity as this is the essence of capturing the meaning of what is understood to be real as seen through the eyes of the participant.

2. The participants are nurses that are currently working in a hospital setting who will be honest as well as having the ability to speak, read and write English.

3. Nurse's experience distress when exposed to the unanticipated death of a patient.

Summary

The existence of reality is held within the context of the perceptions of individuals that experience phenomena that is meaningful to them (Polit & Beck, 2007). What is held meaningful is how important the phenomenon is to the person experiencing that moment. The purpose of this study is to capture the true meaning of nurses when they experience an unexpected patient death. The death of a patient may affect a nurse more than what the current literature indicates. The death of a patient, as described by Grove (2008) indicates that "nurses often recall, even after many years, in great detail, certain patients and their deaths" (p. 322). The impact of a patients' death may have implications

for the emotional well being of the nurse and affect the ability to cope. A qualitative

study conducted by Gunther and Thomas (2006) describes an oncology nurse's

experience with an unexpected patient death; "you sort of relive the experience and you

think, 'what should I have done different?'…Guilty, guilty! I mean what did I do?" (p.

373). Nurses have the capacity to care and establish strong emotional ties with their

patients and when patients die, nurses are affected.

CHAPTER II

THEORETICAL FRAMEWORK

Introduction

This chapter summarizes the theoretical framework and the established review of literature which will provide the rationale and foundation for this proposed topic of research.

Theoretical Framework

Theories are defined by Dickoff and James as "intellectual inventions designed to describe, explain, predict or prescribe phenomena" (cited in McEwen & Wills, 2007, p. 39). The description of a phenomenon is an attempt to gain an understanding of the lived experience as perceived by the nurse. The concept of understanding delves into what the reality is for the person who experiences the stimuli and how they attach meaning to the event.

The use of theories with qualitative research is to postulate which theory is best suited for the phenomenon in question. As data analysis occurs, themes may emerge that are unexpected and potentially may not fit the original assumed theory. Phenomenology is considered a "philosophy as well as a method" (Streubert Speziale & Carpenter, 2007, p. 81). As a philosophy, phenomenology may be used to support the theory in question, not solely as a method. Spiegelberg defines descriptive phenomenology as involving the

"direct exploration, analysis, and description of particular phenomena, as free as possible from unexamined presuppositions, aiming at maximum intuitive presentation" (cited in Streubert Speziale & Carpenter, p. 82).

Congruent with Spiegelberg is Lazarus' theory of stress, coping and adaptation. Lazarus' theory, for the purpose of this study, is based on the assumption that the unexpected death of a patient is a stimuli or stressor and as such, may cause distress to the nurse.

Lazarus' theory is a borrowed theory from the behavioral sciences (McEwen & Wills, 2007). Although Lazarus' theory is considered a borrowed theory, components within the theory itself are transferable to the profession of nursing. With borrowed theories, the application to nursing practice is such that "it is transformed into nursing theory because it addresses phenomenon within the arena of nursing" (McEwen & Wills, 2007, p. 41).

Nursing as a profession is a dynamic process that includes a multitude of stimuli whether it is interactions between the patient, family or physician. The focus of the stress, coping and adaptation theory is "how a person copes with stressful situations" (McEwen & Wills, 2007, p. 316). The concept of the person, as described above, is the nurse and the concept of the stressful situation is the unexpected death of a patient (see Appendix A for this author's interpretation of the theory).

According to Lazarus; "stress is much more complicated than just stimulus and response" (McEwen & Wills, 2007, p. 316). The general adaptation syndrome of Hans

Selye focuses on the physiological responses of stress, Lazarus' theory focuses on the psychological responses of the person experiencing the stress and how successful that adjustment and adaptation is (McEwen & Wills, 2007). The core concepts not only include the nurse and the stimuli, but also the factors such as person-environmental relationships and three cognitive processes of appraisal that address the demands and emotions associated with the stressor, a patients' unexpected death. Person-environmental relationships include aspects such as character, values, beliefs, commitments, social interactions and support, constraints, cultural factors and life time milestones. Primary appraisal is defined as the concept of the person and how they form an opinion or possibly a perception about a stressful event. Secondary appraisal is how the individual assesses the stressful event and reappraisal is a restructuring of the original event after new information has been added (McEwen & Wills, 2007).

A fabricated example for the purpose of this study, exemplifies the congruencies of this theory with application to the nursing profession. A nurse working in an emergency room admits a young patient that was involved in a motor vehicle accident. The patient is a female teenage driver, who was wearing a seatbelt and is alert and oriented and is without any obvious signs of outward injuries. The nurse and patient interact as the nurse asks her about her high school activities and upcoming prom. As time progresses, the patient begins to complain of mid scapular pain that is mild yet steady. The nurse informs the physician and a CT scan that had been ordered is immediately done on an emergent basis. The patient dies before getting to the CT exam

and expires as a result of a dissected aorta due to the nature of the accident. The nurse experiences emotional turmoil and feels that there must have been something she missed in her assessment skills. The nurse approaches this patient's death through primary appraisal and emotion focused coping and makes a judgment regarding her own skills. Through secondary appraisal, an evaluation is made in regards to how the nurse responds to the death. With reappraisal, after new or additional information has been received, such as an intervention through the organizational support team, the nurse begins to change the meaning of the situation and adjustment begins with progression to adaptation. This example supports the appropriate use of Lazarus' theory of stress, coping and adaptation.

Literature Review

An extensive literature review was completed. The focus of nursing has been on the curing and the saving of patients. A study conducted by Cooper and Mitchell found that more nurses in a hospital based setting had higher levels of dissatisfaction than those nurses in a hospice setting (cited in Yang & Mcilfatrick, 2001). The higher levels of dissatisfaction were associated with death and dying and the issues that come with that such as the unexpected death of a patient and the removal of a life support system. These levels of dissatisfaction were vastly different than the perspectives and expectations of hospice nurses in their work, due to being in a setting with a focus of saving lives and

cure and dealing with relatives and their emotional reactions (Yang & Mcilfatrick, 2001, p. 436).

While many studies focused on patients death and the quality of care they receive by the nurse, few if any focused on the topic specific to this study. The gap in the literature is clearly indicated by several studies, one of which supports this suggesting that "few studies have investigated the extent to which health care professionals suffer from such symptoms" such as grief, anger and hopelessness when the symptoms are directly related to a patient's death (Taubman Ben Ari & Weintroub, 2008, p. 622).

Taubman and Weintroub (2008) wished to understand the adversity of death and dying for pediatricians and nurses caring for terminally ill children. This study interestingly indicated that these professionals experienced a higher level of satisfaction as well as self esteem, but the authors postulated that when caring for sick or terminally ill children, facilitating a peaceful death could lead to greater job satisfaction as well as enhanced self esteem (Taubman Ben Ari & Weintroub, 2008).

Other studies implied that limited research has been conducted or exists on how a patient's death affects the nurse who is providing care and that chronic exposure to death can be emotionally, physically and professionally harmful to nurses (Grove, 2008; Nathaniel, 2006; Yang & Mcilfatrick, 2001). Yang and Mcilfatrick explored the phenomenological experience of ICU nurses caring for patients who died. The findings indicated that it is important to acknowledge that death and dying is a presence in the ICU setting and that the frequency of such may lead to an increase in moral distress for

many ICU nurses. A suggestion has been formulated that intensive care nurses may require structured education that is specific to the ICU setting and addresses ethical and moral dilemmas that the nurse may not have encounter while in nursing school (Yang & Mcilfatrick, 2001).

The emotional well being of nurses who work in a variety of settings and who experience distress while caring for patients should be further examined with a focal point on a patient's unforeseen death. Much of the literature review examines patient care events that consist of trauma, terminal illness, pediatric deaths and other patient deaths that were considered unexpected. When nurses are unable to verbalize their uncertainty or accept their grief because it is not openly recognized or socially accepted, disenfranchised grief ensues. Doka described that disenfranchised grief often leads to compassion fatigue and moral distress (cited in Brosche, 2007; Ewing & Carter, 2004; Grove, 2008). Other elements that were described throughout much of the literature included compassion fatigue and moral distress, but also secondary traumatic stress and post traumatic stress disorder.

Compassion Fatigue

Compassion fatigue is a concept associated with people who provide care for other people. Professions that care for other people include, but are not limited to, the nursing profession, physicians, emergency medical responders and chaplains. Burnout and compassion fatigue are often used interchangeably yet compassion fatigue is a process that extends past the burnout stage of an emotional challenge and can be

distinguished by how caregivers begin experiencing symptoms similar to patients and their families (Brosche, 2007; Flannelly,et al.,2005; Stevens-Guille, 2003b; Worley, 2005). A distinguishing difference between burnout and compassion fatigue is that while some people experience burnout by having emotional withdrawal and decreased empathy, those with compassion fatigue continue to care for people and lack self care (Abendroth & Flannery, 2006; Stevens-Guille, 2003a). According to Worley (2005); compassion fatigue "refers to a physical, emotional, and spiritual fatigue or exhaustion that takes over a person and causes a decline in his or her ability to experience joy or to feel and care for others" (p. 416). Nurses are caring people and as a result expend energy by providing emotional care that is deep rooted in the nursing profession. A nurse provides care that is emotional and reflects their values. The sudden death of a patient may affect that emotional side of nursing. Burnout and compassion fatigue may occur.

<center>*Moral Distress*</center>

Moral distress is associated with exposure to certain elements within the nursing profession that may distort personal values and ethical views. Death and dying are the greatest contributors to moral distress; anxiety, apathy, and stress are psychological elements that affect nurses and lead to moral distress (Brosche, 2007; Ewing & Carter, 2004; Nathaniel, 2006). Nathaniel (2006) completed a study with nurses who experienced conflict with death and dying and how they approached their emotional balance by dealing with their values and beliefs and that of the organization. Nathaniel's

study was a grounded theory study that led to the development of a new and original theory of moral reckoning.

Moral reckoning is similar to moral distress but it is a deeper process that is used to reflect on the nurse's experience and how that experience troubles them. The three stages as described by Nathaniel (2006) are ease, resolution and reflection. The stage of ease is defined as the core values a nurse may have and when a troubling patient care situation arises such as the sudden death of a patient, that stage of ease is interrupted. Nurses must either take a stand or give up in the stage of resolution. The next stage of reflection allows the nurse to return to the stage of ease by telling their story, remembering and examining the external conflicts that are different from the nurses' values and beliefs. Nursing as a profession would benefit greatly from an enhanced form of nursing education that focuses on such (Nathaniel, 2006).

Death and dying are the greatest contributors to moral distress. A nurse experiencing moral distress may feel unhappy with their job, the integrity of their values and ethics may become nebulous and affect patient quality of care leading to a detrimental effect on the relationship that nurses establish with patients and their families (Brosche, 2007; Nathaniel, 2006). Moral distress is an element that should not be ignored as the emotional health and well being of the nurse is important in providing quality patient care.

Secondary Trauma and Post Traumatic Stress Disorder

Nurses who experience grief, anxiety, stress, anger and hopelessness when they are unable to express such emotions may have physiological responses such as, sleep disturbances, irritability, and eating disorders (Grove, 2008). These symptoms when not treated often lead to post-traumatic stress disorder (PTSD). The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* defines symptoms of PTSD as "intrusive memories, confusion, or lack of concentration" (cited in Taubman Ben Ari & Weintroub, 2008, p. 622). While PTSD is an extreme, the potential for this diagnosis has not been thoroughly investigated in the healthcare profession. Secondary traumatic stress is more often seen in the healthcare environment and a potential risk factor is "a person's empathic vulnerability to the suffering of others" (Flannelly et al., 2005, p. 214). An otherwise stable patient suffers a cardiac arrest and is aggressively resuscitated without success, this can been seen as a traumatic event through the eyes of the nurse caring for this patient. A traumatic stress reaction may be attributed to the physical action of helping, the desire to help along with strong emotional and empathetic investments (Abendroth & Flannery, 2006; Taubman Ben Ari & Weintroub; Worley, 2005). Deleterious effects may result from unresolved conflicts that are experienced by nurses working in an environment that has exposure to death and dying.

Summary

The theoretical framework chosen for this study is congruent with the literature that has been reviewed. Death is understood to be a traumatic or stressful event in the lives of healthcare professionals, especially if the death is unexpected. Lazarus' theory of stress, coping and adaptation addresses how people respond to a stressful event. Unresolved stress leads to ineffective coping and may contribute to nurses developing compassion fatigue, moral distress, secondary traumatic stress and PSTD. When the emotional well being of the nurse is at risk, patient care quality may diminish as seen by nurses "distancing themselves from patients, becoming emotionally unavailable, avoiding going in patients' rooms and leaving the unit or nursing altogether" (Nathaniel, 2006, p. 421). The focal point of nursing is the patient and providing care. Nurses are considered vital and necessary in the healthcare environment. The emotional needs and well being of nurses needs to be further investigated by determining what it means to the nurse who cares for a patient that unexpectedly dies.

CHAPTER III

DESIGN

Introduction

Methodology: A description of the study design, population of interest, data

collection instruments and procedures, data analysis and protection of human subjects

will be explained and reviewed.

Design

The naturalistic paradigm supports the effort to understand, describe and provide

meaning in the context of the participants (Polit & Beck, 2007). Under the naturalistic

paradigm, a descriptive phenomenological approach will be used to obtain the richest

possible data as described by nurses as they experienced the phenomenon in question; the

unexpected death of a patient. The naturalistic approach assumes that "if there are

always multiple interpretations of reality that exist in people's minds, there is no process

by which the ultimate truth or falsity of that construction can be determined" (Polit &

Beck, 2007, p. 15). How nurses perceive their personal experience is a reality within

their personal realm. An attempt will be made to subjectively understand that reality and

attach meaning to the experience. The purpose of phenomenology as a method, is to

capture and describe a particular phenomenon and for this study, the lived experience of a

patient's unexpected death through a nurse's description (Streubert Speziale & Carpenter,

2007).   Descriptive phenomenology as defined by Spiegelberg "involves direct

exploration, analysis, and description of particular phenomena, as free as possible from

unexamined presuppositions, aiming at maximum intuitive presentation" (Streubert

Speziale & Carpenter, 2007, p. 82). A three step process is used in descriptive

phenomenology; intuiting, analyzing and describing. Intuiting is the complete immersion

in the data by the researcher and as such becomes a tool in the process by reviewing the

data repeatedly. Analyzing is the second step and requires that the researcher becomes

absorbed within the data as themes emerge, thus ensuring clear descriptions that are pure

and deep. The final step is describing. As themes emerge, it is within the describing

stage to accurately provide a transition from the verbal interview to written

communication of the decisive essentials of the phenomenon (Streubert Speziale &

Carpenter, 2007). Inductive reasoning, used with phenomenology, is the process of

looking at specific observations or realities within the context of an individual and

making generalizations, such as attaching meaning specific to that individual. It is the

hope, that with this approach, a rich, deep and encompassing description will formulate

emergent themes in an effort to better understand the meaning of reality for nurses who

experience the unexpected death of a patient.

Population, Sample and Setting

Population

RN's provide most if not all the primary care activities associated with inpatient care in an acute care hospital setting. The population of interest is nurses, who are RN's and who provide primary care and have experienced the sudden unexpected death of a patient.

Sample

A purposive sample of RN's who have experienced caring for a patient that unexpectedly expires was sought. Three processes were used to obtain such participants. The first process was to place an advertisement in a local hospital employee newsletter, stating the purpose of the study and participant requirements. Contact information included a cell phone number, a working email address and a mailing address. The second process that was used was "snowballing", asking participants if they know of someone else who has experienced the same phenomenon. When adequate participant size was unsatisfactory, an effort was made through the internet, specifically networking to attain more participants. The internet sites that were used are Allnurse.com, a nurse blog site and Facebook. A posting was placed, and again a statement was placed with concise study purpose and participant requirements, including face to face interview, along with contact information. Any participant recruited from the internet was chosen locally for the purpose of meeting in person.

Setting

Participants were recruited from an acute care hospital setting. Nurses came from any clinical area within the hospital such as the emergency room, medical surgical, cardiovascular lab, cardiac, intensive care. Inclusion criteria were any nurse that was licensed in the state of Wisconsin who had been a nurse for at least one year and experienced the phenomenon of interest. RNs were diploma, associate degree or baccalaureate prepared. Exclusion criteria were having less than one year experience and not working in a hospital setting.

Data Collection Instruments

A tape recorder was used to obtain the participants word for word description of their experience. The tape recorder was visible throughout the interview. Field notes were taken during the interview and this process was explained prior to beginning the interview. A demographic questionnaire was used prior to the interview. A pilot study was conducted with the first participant in order to see if the question used was appropriate. The open ended question that was asked of participants was; what was it like to care for a patient that unexpectedly died? Subsequent questions were only asked for clarification purposes. As this is a qualitative study, rigor was established with data analysis.

Data Collection Procedures

Data collection was obtained through face to face interviews with the participants. Data analysis began with the first interview and was ongoing throughout the research study with a focus on complete immersion in the data that was obtained. The location was determined by the participants in order to increase their level of comfort and ease with being interviewed. File folders were used and labeled numerically and within each folder contained the necessary documents to begin the interview such as the informed consent and the demographic questionnaire. Informed consent was obtained prior to the interview. One tape was used for each participant and the tapes were labeled accordingly to correspond to the file folders used for each participant. Prior to recording, the researcher stated on the tape what number participant was being interviewed. Participant confidentially was assured by not using names on tapes or file folders. All documents and tapes were enclosed in a locked box only accessible by the researcher. All documents were destroyed at the end of the study. Tapes were transcribed by this author. All personal information was kept off of the taped interviews to ensure confidentially with transcription. For the protection of Human Participants, a certified counselor was contacted. Counselor information was made available in every participant's folder with contact information for the purpose of addressing emotional turmoil with the interview process. If emotional turmoil was such that immediate referral was needed, a phone call was made by the researcher to contact the counselor.

Data Analysis Procedures

Data analysis began as data was being obtained through face to face interviews. Complete immersion in that data occurred with complete attention given to the participants as they described their experience. Interrogation and interruptions were avoided. The researcher practiced "bracketing" throughout the data collection and analysis by remaining "neutral with respect to belief or disbelief in the existence of the phenomenon" (Streubert Speziale & Carpenter, 2007, p. 80).

Reflexivity was also used. The researcher reflected on previous knowledge about the topic of this study and refrained from biasing the participants with personal views or experiences that may have related to the experience. Journaling was practiced by the researcher as views, values and experiences were detailed. Further reflection prior to participant's interview was practiced in order to have continued neutrality throughout the entire study. Spiegelberg method of data analysis and interpretations were used for this study. Spiegelberg's three step process of descriptive phenomenology includes intuiting; "requiring the researcher to become totally immersed in the phenomenon under investigation", analyzing; "identifying the essence of the phenomenon under investigation based on the data obtained", and describing; "to communicate and bring to written and verbal description distinct, critical elements of the phenomenon" (Streubert Speziale & Carpenter, 2007, p. 85-86). Data analysis continued until data saturation had been achieved with repetition of data and themes.

Trustworthiness was established in order to support rigor in this study. Trustworthiness included credibility, dependability, confirmability and transferability. Credibility ensured that what the participants were attempting to convey was actually captured by the researcher. Dependability ensured that the results were in fact dependable. Confirmability was established by leaving an audit trail. Transferability means that what was learned in this study had purpose or meaning for others in similar situations (Streubert Speziale & Carpenter, 2007). Using Spiegelberg and Colaizzi's method of interpretation, along with establishing trustworthiness, ensured that the lived experiences of the participants and what that experience meant to them was accurately portrayed in this study.

Limitations

1. A limitation for this study is that qualitative research is subjective. Subjectivity lends bias by either the researcher interpreting data based on their own experience or beliefs about the subject. According to the naturalistic paradigm, subjectivity is a welcomed tool in qualitative research because it builds and strengthens the research or phenomenon in question.

2. Another limitation includes acquiring enough participants to ensure data saturation.

Summary

A naturalistic paradigm along with descriptive phenomenology design was used in order to understand and attach meaning to nurses who experience the sudden or unexpected death of a patient. Participants for this study were nurses that worked in the hospital setting that had had an experience of losing a patient suddenly. Interviews were conducted in private. Data analysis began with the first interview and was ongoing throughout the study.Although the limitations of this study include subjectivity, it is a quality that is useful for the analysis of the data obtained. Further research on this topic would further validate the importance of this topic and the implications for nurse practice and patient care. The methods and design chosen for this study were appropriate and congruent with the conceptual and operational definitions of the lived experience of nurses that encounter the unexpected death of a patient.

CHAPTER IV

RESULTS

Introduction

Nurses are on the frontline of healthcare, providing quality care to patient's that are in need. The expectation from the healthcare organization, the family and patient is that they receive the best care possible. The nurse delivers this care as an expectation of their job responsibilities. Many, if not most nurses also include emotional care, with a sincere sense of empathy, and rally as the patient's and families' advocate and interpreter, becoming the liaison between multiple disciplines in a hospital setting.

While the care of the patient is unarguably the most important aspect of healthcare today, consideration must be given to the emotional response that nurses encounter when a patient becomes unstable and dies. Stress is a component of healthcare. Nurses who care for patient's that unexpectedly die and that were otherwise stable, experience stress. The center of emotional caring within a nurse may potentially be drained with unrelenting stress and may be exhibited as fear, grief, guilt, anxiety, apathy, burnout, compassion fatigue, moral distress, powerlessness, frustration and the stress cascade (Brosche, 2007; Ewing & Carter, 2004; Yang & Mcilfatrick, 2001). The purpose of this study is to better understand the phenomena of the nurse who experiences the sudden and unexpected death of a patient.

Sample

The Institutional Review Board reviewed the research proposal and approval was received through the University of Wisconsin Oshkosh. The purposive sample consisted of four nurses who worked in a hospital setting. The sample was obtained through the posting of a recruitment flyer, describing the research and the criteria for inclusion in the study. A pilot study was conducted with the first participant and the question used was deemed adequate for the purpose of obtaining information regarding the lived experience of nurses who encounter the unexpected death of patient.

Demographic Data

The age of the participants ranged from 27 to 31 years, mean age was 28.75. Nursing experience ranged from 4 to 9 years in the acute hospital setting. All of the participants were female. Three of the participants had a Bachelor of Science in Nursing and one had an Associate Degree in Nursing. Two of the nurses continue to work in the same setting (Table 1).

Demographic Data

Characteristics Participants (N=4)	Data
Age	Range 27-31 yrs
Mean Age	28.75 yrs
Gender	100% Female
Ethnicity	100% Caucasian
Education	75% BSN, 25% ADN
Practice Setting	50% Cardiovascular Lab, 25% NICU, 25% Float
Nursing Experience	Range 4-9 yrs
Mean Experience	5.7yrs

Table 1

Data Collection

Informed consent was obtained. An emphasis was placed on ensuring confidentiality. The locations of the interviews were at the discretion of the participants and were conducted in private. Interviews were tape-recorded and transcribed verbatim. Field notes were taken during the interview process. Interviews lasted approximately 30 to 60 minutes. Emotional distress was the only risk associated with the interview process. All participants received an informative handout with key points regarding grief and an

available healthcare provider should the participants experience emotional distress during

or after the interview (see Appendix C).

Data Analysis

Data analysis began with the first interview and was ongoing throughout the

study. An open ended interview was conducted with the question; what was it like to

experience the sudden or unexpected death of a patient that you were caring for?

Participants were asked to also describe in as much detail as they wished, the experience

itself and how they felt. Although only four participants were included, data saturation

was achieved as no new themes emerged and data became repetitive. A descriptive

phenomenological approach was used to capture the rich depth of data from the

subjective description of the nurse's experience. Spiegelberg's three step process of

descriptive phenomenology was used to interpret data; intuiting, analyzing and describing

(Streubert Speziale & Carpenter, 2007). Data immersion was undertaken while the

interview process was ongoing, transcribed interviews were read and reread many times

and critical elements that emerged were documented and grouped together as themes.

Findings and Discussion

Data analysis revealed an overarching theme; dynamic changes: the continuum from stable to unstable. Three core themes were identified; understanding the event, guilt versus hope, and reaching out. Subthemes were identified and grouped according to relevance under the three main themes. The ten subthemes are as follows: fears of the unknown, upheaval and chaos, swift change, trauma, foreseeing the future, optimism, self blame, help me, aloneness and grief (Table 2).

Themes and Subthemes

Dynamic Changes: The Continuum from Stable to Unstable	
Themes	Subthemes
Understanding the Event	• Fear of the Unknown • Upheaval and Chaos • Swift Change • Trauma
Guilt versus Hope	• Foreseeing the future • Optimism • Self Blame
Reaching Out	• Help Me • Aloneness • Grief

Table 2

Overarching Theme; Dynamic Change: The Continuum from Stable to Unstable

The overarching theme; dynamic change: the continuum from stable to unstable refers to the patient and the spectrum of their healthcare status. At one moment, a seemingly stable patient, quickly declines and the nurse is forced to understand the situation, use critical thinking and must quickly become an aggressive caregiver in moments of high stress and uncertainty. The three core themes and ten subthemes support the overarching theme in such a way that the many facets of the nurse are described by their personal experience with a rich description of their perceived reality of the experience (see Appendix E). Lazarus' theory of stress, coping and adaptation is congruent with the data obtained from this study. The nurse and the patient become partners in healthcare and the environment that supports them is a dynamic process full of change. A patient who suddenly becomes unstable and who was not expected to die may leave the nurse who is caring for that patient, experiencing feelings of emotional and psychological stress. Lazarus's theory may be utilized in the essence that the nurse is the primary front and the sudden loss and the experience associated with unexpected loss is the stressful stimulus. The stressful stimulus is met with the demands of the workplace and is compounded by emotions such as fear, grief, and high anxiety (McEwen & Wills, 2007). An example of such a dynamic process is a patient in a code in a hospital setting. How that nurse copes with the problem or stressful situation is dependent on whether or not there is help available, such as counseling. Successful coping leads to adjustment,

adaptation and allows for the nurse to be emotionally strong and prepared for the next dynamic patient event.

<div align="center">*Theme One: Understanding the Event*</div>

Nurses who care for patients, who were not expected to die, experience an array of emotions and thoughts. There is a strong desire to understand what happened to their patient. Why did the patient become unstable? There is fear of the unknown associated with a patient that is rapidly deteriorating. That fear may be all encompassing. The event itself, the patient coding, suddenly dying, brings forth upheaval and chaos but most importantly is how quickly things change. One minute a patient may be talking and the next minute being ventilated by bag method. Another key aspect is the trauma of the event itself, how does a nurse interpret that experience? Watching someone being intubated while they are blue or the experience of witnessing chest compression is not an everyday occurrence. An experience that is sudden and traumatic and ends with the loss of a patient, leave nurses to contemplate and wonder about the event itself. Nurses try to make sense out of the unknown and use that opportunity in an effort to cope. Distress is experienced with such events and nurses examine the care that was given in an effort to do better the next time (Gunther & Thomas, 2006). Understanding the event was a key theme that emerged through the data analysis as nurses appeared to be focused on understanding what had happened. Several of the nurses interviewed used the same phrase: "What just happened?" The key aspect of understanding the event may lead to a more successful coping adaptation.

Subtheme: Fear of the Unknown. Data analysis revealed that when a patient became unstable, fear of the outcome and of the actual experience was prevalent:

We didn't know what we were going to get… [My] hands were just shaking! Shaking!...I was afraid I was going to stab myself with the needle trying to draw up the EPI…I mean, I am just shaking, I'm ready to throw up or piss my pants, I don't even know which one (Nurse 1).

Another nurse describes the experience as "it was the scariest thing I have ever seen in my life, I have only been a cath lab nurse for less than two years but it was just so scary" (Nurse 2). Fear may be an aspect that affects many nurses when confronted with the challenge of an event that has an unknown outcome. The demands of such an experience are compounded by the emotional fear and the trepidation of the unknown. Coupled with fear are anxiety and high stress levels, which after time if not duly addressed may lead to emotional exhaustion and compassion fatigue (Worley, 2005). Fear is also a symptom of the grieving process and should not be left untreated (Help Guide.org, 2009).

Subtheme: Upheaval and Chaos. A dynamic environment was noted by the nurses interviewed as they were caring for someone that unexpectedly becomes unstable and progresses to an untimely death.

Then next four hours are craziness, I remember having to be so focused, absolutely not acknowledging the situation what so ever…I remember the dad at one point was crying...I couldn't' think about it because I had to do way too many

tasks and thinking about this…and the fact that his family is falling apart is not going to help me get anything done (Nurse 1).

A chaotic environment is often the result of an unstable situation and patient. A nurse that becomes the center of that chaotic environment recalls her perception of the experience:

The code was called, and there's all these people in there, doing CPR, doing the airway, I was giving drugs, we got him onto the cart and I came with to do the drugs on the way down…somebody was straddling him, doing CPR, somebody was bagging, somebody else was doing something and the surgeon came with us and then we went flying out into the hall way and there was this transport guy out there and it was just…you know…to see that coming down the hallway (Nurse 2).

Secondary traumatic stress reaction, also known as compassion fatigue, is a potential outcome for nurses whose job and desire is to physically assist and help a patient that is coding (Abendroth & Flannery, 2006). Nurses invest much emotional energy into such an event as well as experiencing empathy for the patient and family. A study conducted on the chaplains who responded to the victims and survivors of the attacks on the World Trade Center's found that there were high levels of compassion fatigue. The authors speculated that these results could be applicable to the hospital setting, but further research is warranted (Flannelly et al., 2005).

Subtheme: Swift Change. Another theme associated with the overarching theme of trying to understand the event is the rapidity of the event itself, how quickly things happen. According to those nurses interviewed, it appeared that there was not enough time to understand what exactly was happening, only enough time to react and use skills to intervene. Two nurses describe their experience:

Everything happened really fast, I don't even remember a lot of it…so unprepared for that...I have been in a couple of other codes and had patients die…this was just so quick, I remember I was drawing up the heparin and I was just shaking, I don't know why, but I just knew…gotta be quick here and go (Nurse 2).

From the time [the doctor] asked me what his blood pressure was to when I saw, said he wasn't breathing, was less than a minute. Less than a minute! I looked over at my EKG, I still had some paced rhythm but he wasn't breathing…so started bagging him and I said were going to need someone to do compressions…I still remember saying that..We tore everything off…I think we called a code right away…I mean this guy was talking to me! You know? It's scary how fast that changed (Nurse 3).

An experience that quickly becomes unstable is very unsettling to a nurse. Nurses remarked in amazement about how their patient was talking one moment and then next, that patient is not breathing. Nurses rapidly become a part of a crisis situation, without the time to reflect, only to deal with the situation and to react (Gunther & Thomas, 2006).

To some nurses, this swift change is incomprehensible, outside of the lines of definition and understanding.

Subtheme: Trauma. An element that was also experienced by nurses was the visual perception of the environment:

There was literally garbage everywhere and blood, you know, smeared on things…I mean not a horror movie scene but just because we were…doing a lot of work, real quick, thank god one of the other nurses cleaned it up for me and I finished my charting (Nurse 1).

It was kind of gruesome because we had blood coming out of the ET tube and at one point it was really foamy, he was in pulmonary edema…It was coming out foamy and it was spraying everybody, this is why family should not watch codes (Nurse 3).

The perceived experience of the trauma of the event is one that is not a routine part of their work. To have the visual of blood everywhere, blood spatter, foaming pulmonary fluid is a provocative factor that may lead to higher levels of psychological distress. A study conducted by Abendroth and Flannery (2006) suggests that the lack of support after a patient's traumatic death will impact the nurse caring for that patient and increase their risk for compassion fatigue.

Theme Two: Guilt versus Hope

A predominant element that emerged from the data analysis was guilt. The nurses voiced concerns regarding their ability to recognize that something was wrong with their

patient, or was there something that they had missed? The nurses that were interviewed also had a strong desire for optimal outcomes. When optimal outcome was not achieved, many if not most, looked for clarification and absolution. Guilt and self blame are symptoms of grief and is a natural course of the process (Help Guide.org, 2009). Nurses may not understand or know that they are grieving over the sudden loss of a patient, yet when they postulate about the care that the patient received, whether or not the course of care was appropriate or if anything could have been done differently, may affect the nurse in the future.

Subtheme: Anticipating the Future. Several nurses commented on how they felt regarding not being able to foresee the event prior to it occurring. "The patient told his family that this was goodbye" (Nurse 2). Another nurse expressed:

The patient had [told another nurse]… said I am going up for a pacemaker and I guess this is good bye and [his brothers] said no this isn't good bye, he goes, I think it might be, I just have a feeling I am not going to make it out of this hospital and he said I am ok with that that. The fact that he [the patient] had this premonition didn't necessarily make me feel better, because obviously, we didn't want that outcome for him. We wanted him to do well. Finding that out afterwards, would I have done anything different? Would I have sedated really light? I don't know and even if I had sedated light, would it have truly made a difference? (Nurse 3).

Nurses carry a sense of responsibility for their patients and often experience a "gut feeling" regarding the overall well being of a patient. When a patient experiences a bad outcome, nurses may feel that they should have anticipated that event whether it was listening to the patient when they state that this is "good bye" or pick up on clinical clues.

Subtheme: Optimism. Nurses vest emotional energy into the care of their patients. Not only do they provide quality care that is skilled, they also provide emotional comfort and ensure that the patient feels safe. One nurse describes her investment in a patient's well being by this description:

> At that point, I had strong hope that he was going to make it because we got him down there so quickly and I really wanted him to make it because this was so unexpected, I was praying for him…it was a couple hours later and we heard that they were waiting to get him off the pump, to see if his heart would regain its electricity, but it wasn't pumping…so then they just let him go (Nurse 2).

Emotional energy that connects a patient to a nurse is a strong bond. Once that bond is weakened, a nurse may fall back on her values, to pray and hope. Values and beliefs are instrumental in the coping process to successfully adapt to a stressful situation (McEwen & Wills, 2007). Religious beliefs may also help the nurse to cope as stated by the nurse above by decreasing their perception of distress that is experienced over the death of a patient. Yang and Mcilfatrick (2001) suggest that religious beliefs help alleviate anxiety, depression and distress over the death of a patient. Religious support is a component of counseling that could be provided to the nurse should there be an opportunity.

Subtheme: Self Blame. Many nurses reflect on the care that their patient received and most will wonder if there was some part of that care that was not good enough. Nurses experience guilt when confronted with the unexpected death of a patient.

What did I miss? I think that was the biggest thing, was I supposed to notice something, and was there a step that I missed that…I could have caught sooner…or not caught it sooner but…I don't know. Then you think, did I respond appropriately? Did I call the code soon enough? Did I …get her hooked up, did I do chest compressions? Did I feel for the ABC's of CPR? (Nurse 4).

Whether a patient death is expected or unexpected, nurses most often replay the events leading up that death. A nurse may question their own care that was given to patient and wonder if there was anything that could have been done differently. Despite every effort made available to the patient in their time of need, nurses feel responsible on some levels.

Theme Three: Reaching Out

The unexpected death of a patient is a difficult time for everyone involved, including the surviving family members, staff, physicians and nurses. Nurses experience grief, feelings of being alone and express the desire to have help in dealing with the emotional distress that is evident with having such an experience.

Subtheme: Help me. Several of the nurses interviewed had elements of their lived experience of wishing that they had help in dealing with the experience after the unexpected death of their patient.

I called about a debriefing and there weren't going to…well they maybe were

going to have one and they were maybe going to call me back. I did call another

nurse, we talked for a while and felt like we talked our way through it. It kind of

sucked there wasn't a debriefing…it was two years ago, harder to remember how

everything all went down, but it was so obviously not ok with everything that had

happened. I ran off, called in sick, did some erratic behavior. I talked to another

nurse who had been there as well, I had mentioned it to her and she said that for

months she had struggled with it too and I couldn't believe that I did not want to

talk about it, I wasn't the only one struggling and it was a revelation to me, I had

no idea that other people were feeling the same way (Nurse 1).

One nurse describes her perception of her lived experience after the death of her patient;

"where did everybody go? I mean everybody's gone! There were a couple people in

there but I remember feeling very empty, everybody just left, what do I do?" (Nurse 3).

I think it was just probably a fleeting question, are you ok? But after that, it was

nothing more of you know, how are you doing? Are you going to be ok for the

rest of the shift? Do you need to go home? It was nothing like that. More so like

are you ok? Then a couple of hours later you are going to this floor. So then it was

work the rest of your eight hours and then go home (Nurse 4).

Throughout the interview process, one element seemed to dominant above all and that

was the ability for the nurses to tell their story, especially to someone who was willing to

listen. Nurses wanted to be heard and to have others understand what it was like to have

gone through such an experience. Debriefing was mentioned by one nurse specifically and the research indicates that this would be a useful tool in helping nurses cope with the sudden loss of a patient. Abendroth and Flannery (2006) indicate that not being able to debrief affects the nurse's ability to use inherent coping mechanisms. Without having the ability to adequately cope, unsuccessful adaption occurs and may lead to nurses experiencing unresolved grief, anxiety and moral distress.

Subtheme: Aloneness. Another essence that emerged strongly from the data analysis was the feeling of being alone, that the nurses were left to deal with their emotional energy and stress alone.

[I] just felt an overall sense of…I guess abandonment, thanks a lot to the hospital, you know? Thank you, you punched in, you punched out, you go home and deal with it. I felt like I had been maybe just letting this bother me to much, like I really needed to be a professional and just get over it (Nurse 1).

I came back upstairs and it was like right back to work and it was like nothing had happened. All these people were going about getting ready for the next cases…I was like "Was anybody else in that room with me?" [Another nurse] and I were like, ok, let's recap this and what just happened and then I had to go scrub another case or something, which was fine (Nurse 2).

Another nurse who had to float to another floor after her experience relays; "As a float nurse it was more difficult, because you got to a different floor and you work with different people, they have no idea what you were just through, unless you tell them

(Nurse 4). When a code is called, an insurmountable surge of help is available. Once the patient expires, the people that were there helping, disappear. Despite having many people working alongside during a code, the nurse is often left alone afterwards, feeling isolated and alone. This isolation was evident through all of the nurses interviewed.

Subtheme: Grief. This final element focuses on how a nurse perceives the loss of their patient and the feelings attached to that experience. One nurse makes a simple statement; "I was off for a few days so I just you know, got over it" (Nurse 1). Another nurse recalls the emotional ties that had been established with the patient:

I was in shock! It was like some family member that…he certainly wasn't young…I went home at the end of the day and it's that same feeling after, well it was a code, I mean it's that same feeling when you go home no matter where the code or what department…you go home, you are in a low after all that adrenaline being gone and I just sat there and I felt like a bump on a log, I didn't know what to do. My best friend called me and we were talking and she was like what's the matter? I just started crying…I don't know if it made it better or worse to have the weekend off…(Nurse 3).

One nurse describes her perception of an unexpected patient death for whom she cared for; "You still wonder, if you could have, could have done something to give the husband a little bit more time, let him have that time while she was alive to say goodbye instead of while she was dead" (Nurse 4). Grieving is a natural process in healing the internal loss that anyone may suffer. An exception to this is within the healthcare environment. The

loss of a patient is considered part of the nurse's job and with that many nurses feel that it is inappropriate to openly grieve or mourn the loss of their patient. This concept is termed disenfranchised grief and was used by Doka to describe a patient loss that cannot be openly recognized because the bond that had developed between a nurse and patient is not recognized as one to be mourned over (cited in Brosche, 2007). After the dramatic and sudden loss of a patient and nurse is usually expected to continue on and either take the next patient up for admission or be the nurse on the next procedure. Suppressing feelings over the loss of a patient over time may accumulate to feelings of emotional and psychological distress and could lead to compassion fatigue and moral distress.

Summary

Data analysis revealed key elements that are consistent with grief and loss as well as the many components entailed in understanding the experience of suffering the sudden and unexpected loss of a patient. Themes that were evident strongly support key aspects of emotional loss and distress. If left untreated these may eventually lead to compassion fatigue, burn out, anxiety, depression, secondary trauma, post traumatic stress disorder and moral distress. Although few studies focus directly on the relationship that is established between a patient and a nurse and the effects of an unexpected death may have on that nurse, the few studies that are reported indicate consistent themes that emerge from personal experience as told by these nurses. Studies that appear consistent

with this study are Nathanial (2006), Gunther and Thomas (2006) and Yang and

Mcilfatrick (2001).

      There are many frontlines in healthcare, but the nurse is on the frontline specific

to patient care. Many nurses develop relationships and bond with patients and their

families. A relationship is established even if for a few moments with a simple smile and

kind eyes and a warm handshake. The nurse-patient relationship is often denied the

socially accepted mourning process that takes place within society. Nurses must be

allowed to grieve and to have access to tools necessary for coping and successful

adaptation, such as debriefing or counseling.

CHAPTER V

DISCUSSION

Introduction

A descriptive phenomenological study was conducted in order to understand the

lived experience of nurses who encounter the unexpected death of a patient. The themes

that emerged were clearly evident and were consistent with other similar studies that

focused on death, dying and the nurse. Few if any studies were completely devoted to the

sudden, dramatic and unexpected patient loss and the effect that had on the nurse.   The

nurse's ultimate responsibility is the care of the patient and to be their advocate and

liaison and often times incorporates many disciplines while at the bedside. The nurse

becomes an interpreter for the physician who may step in for a few short minutes and

leave the patient and family with many unanswered questions. Dr. Francis W. Peabody, a

physician who practiced in the 1920's was once quoted as saying, "…the secret of the

care of the patient is caring for the patient" (Drazen, 2003, p. 1110).   That is a simple

quote that is the foundation of nursing practice today and that caring for the patient in

more ways than one.

Summary of Study and Findings

The study undertaken was to understand the lived experience of nurses who

encounter the unexpected death of a patient. This was a qualitative study using a

descriptive phenomenological approach. A purposive sample of four registered nurses who worked in a hospital setting were recruited and interviewed face to face. The interviews were taped and transcribed verbatim. Themes that emerged through data analysis consisted of an overarching theme of dynamic changes: the continuum of stable to unstable. The three main themes that emerged were; understanding the event, guilt versus hope and reaching out. Subthemes were grouped according to relevance under the three main themes. The ten main subthemes were; fears of the unknown, upheaval and chaos, swift change, trauma, anticipating the future, optimism, self blame, help me, aloneness and grief. Many of the key elements were consistent with symptoms of grief as well as precursor to compassion fatigue, such as anxiety and high levels of stress. Compounding these effects was the fact that none of the participants interviewed either received counseling or some form of debriefing. Of the participants interviewed 50% do not remain in the same area where they experienced the sudden loss of a patient that was clearly not expected. During the interview process it is noteworthy that many nurses spent a major portion of the interview explaining the details of the events leading to the death of the patient for whom they were caring. They wished to tell their story and to be heard along with being validated regarding the stress and trauma associated with experiencing the event. The results indicate that the sudden and unexpected loss of a patient may have deleterious effects on nurses when left untreated.

Conclusions

Nurses have a strong desire to provide the best care possible to patients when their status quickly becomes unstable. Events transpire quickly and the nurse is left with many questions, concerns and a high level of anxiety and stress. The theoretical framework for this study included Lazarus' theory of stress, coping and adaptation as well as Spiegelberg's philosophy as phenomenology as a tool, not only as a design, but a tool to describe and support the theoretical framework. The nurses in this study began their experience by caring for a patient. When the patient suddenly became unstable, the situation became immediately stressful and was compounded by demands and emotional distress. The nurse was affected by how the stressful stimuli were perceived and those factors that supported this; the person-environment relationship and the three cognitive processes of appraisal. The single most evident factor in the person-environment factor was social support and this may have been associated with providing emotional support after the death of the patient. It was important to consider taking the nurse aside, allowing time for reprocessing through verbal communication or counseling. It was clearly evident that nurses were affected and that the experience may have been a harmful event that left untreated could have caused job dissatisfaction, depression, compassion fatigue, burnout and a traumatic stress reaction.

Nurses are clearly valuable and instrumental in the care of the patient and are the cornerstone in today's healthcare. With today's nursing shortage, many nurses leave their jobs because they feel that they are not supported by the organization and do not feel

valued. Nurses are inherently caring and after time, that caring may turn to apathy when there is a delayed response in providing emotional support for grief, stress and anxiety that is received while in the line of duty. Through organizational support, nurses may ultimately feel emotionally stable and satisfied with their job and wish to continue working in the same environment providing valuable service through their experience and expertise.

Implications

Implications for practice include providing support to all nurses who care for patients who die, whether it was expected or sudden. Death is a distressing aspect of life, most importantly for those who die, but also those who are surviving family members. Those who often get forgotten are the nurses as well as physicians and support staff.

According to Brosche (2007) developing a grief team that is within a healthcare system would prove beneficial to those who care for patients that die. The grief team would be instrumental in "minimizing the effects of compassion fatigue, moral distress and the stress cascade" (Brosche, 2007, p. 22). When nurses and all healthcare workers know that there is a protocol established within the organization to allow for debriefing, grief and communication they may feel assured that it is socially accepted to acknowledge the loss of a patient as well as the opportunity to share their feelings of loss. The goals of establishing a grief team within a healthcare system are described as follows but are not limited to; to protect the nurse and promote healthy behaviors, to support,

comfort and acknowledge the nurse, to enhance staff morale and camaraderie. The benefits would include but are not limited to; demonstrating commitment to the nursing staff, improving caring relationships among staff and patients, increasing retention, decreasing cost to hospital, decreasing the nursing shortage and incorporating components of Magnet accreditation into actual practice (Brosche, p. 23).

Nursing education could benefit by preparing nurses specifically to recognize the elements of compassion fatigue, moral distress, grief, anxiety and traumatic stress reaction after the loss of caring for a patient who dies. Having nurses prepared prior to practice would be beneficial because the nurse may come to understand that it is socially accepted to grieve no matter what the circumstances and that having the ability to recognize the signs and symptoms of emotional distress may lead the nurse to seek counseling or specifically ask help from the organization itself.

Administratively, supporting the organization through support and counseling would potentially cause for better retention rates which is valuable in today's nationwide nursing shortage. One of the many important goals of achieving Magnet status is to build policies that support and protect nurses (The Center for Nursing Advocacy, 2008).

Recommendations for further Research

There is a limited amount of research available specific to this study. Recommendations would include a more extensive phenomenological study with a larger

group of nurses, from all different aspects of healthcare including hospice, emergency

departments, medical and surgical floors as well as intensive care units and acute care

departments such as surgery. Further research that is quantitative would further support

this study by using the Compassion Satisfaction and Fatigue test to see how prevalent

compassion fatigue is among nurses (Worley, 2005). Lastly, further research could

include not only nurses, but physicians as well as support staff such as licensed practical

nurses, certified nursing assistants and even housekeepers. All levels of an organization

get to know patients and their families and death may affect an entire department, not just

the nurse who cared for that patient.   This could be a large area of patient care that could

benefit from further investigation and research for the benefit of the providers whose

ultimate care profoundly affects patients and their families.

Summary

    Interesting and provocative results were found with this study.   It is important to

understand that only four nurses were interviewed and that further research is greatly

warranted to understand what it is like to care for a patient that suddenly dies.

Everything about healthcare is important, all elements are equal in value, the nurse is not

the only aspect of patient care but the nurse is on the front lines and is instrumental in

facilitating good quality care in the efforts to promote the best possible patient outcome.

The nurse who is emotionally stable and satisfied will provide emotionally sound care

rather than lapsing into in apathy and indifference. To many families and patients that

essence is immeasurable when caring for their loved ones.

Appendix A

Stress, Coping and Adaptation Theory: Lazarus
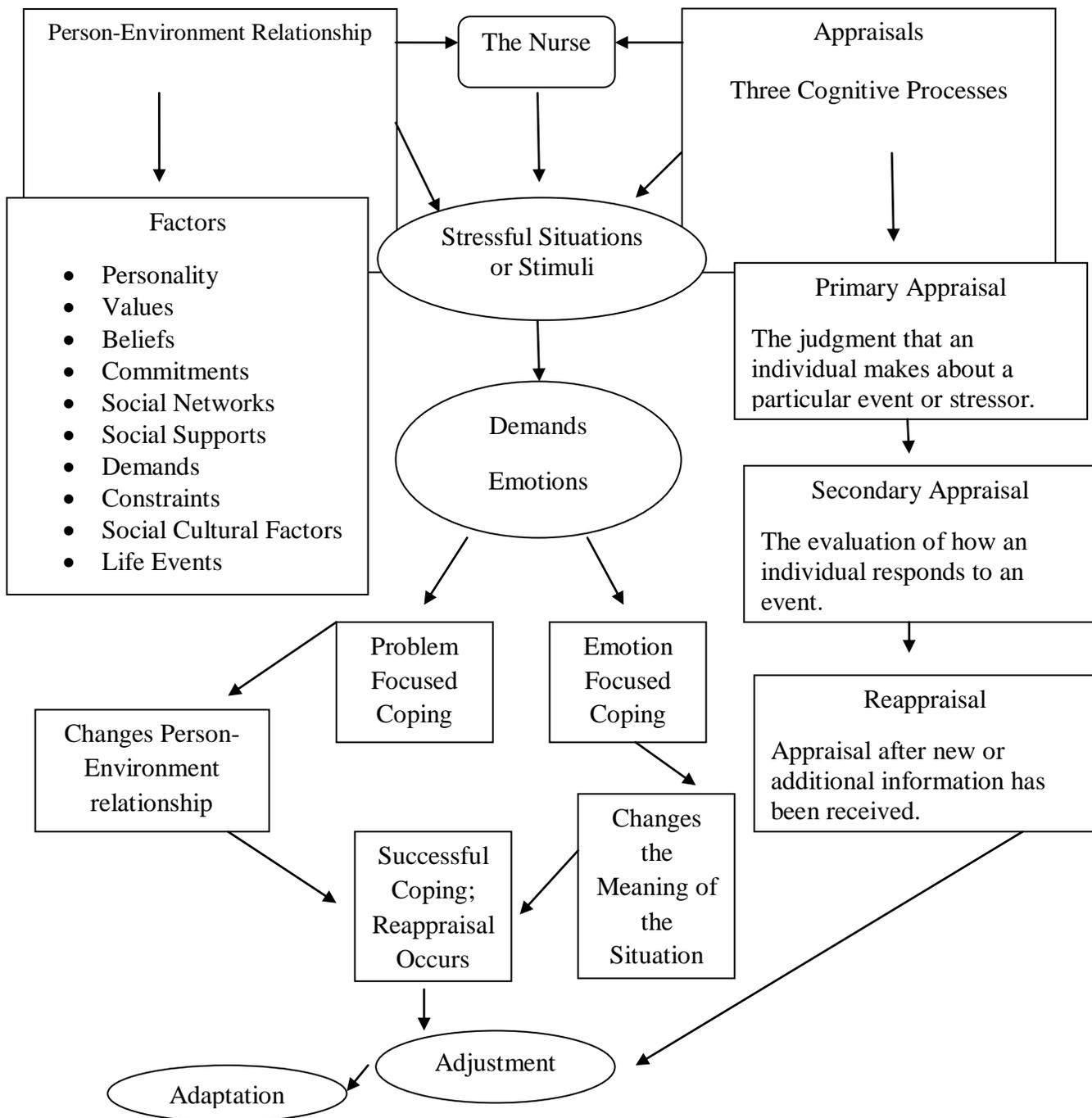
McEwen, M., & Wills, E. M. (2007). *Theoretical basis for nursing* (2nd ed.).

Philadelphia: Lippincott Williams & Wilkins, p. 316

Appendix B

Informed Consent

Professor Mary Ellen Wurzbach, of the Department of Nursing in the University of Wisconsin Oshkosh and her student Teresa Mumbrue, R.N., B.S N., are conducting a qualitative study in an effort to describe the phenomenon of nurses who experience the unexpected death of a patient. We would appreciate your participation in this as it will assist us in making recommendations for improving how nurses are supported in their organization as well as recommendations for how to deal with death and dying in the workplace through either organizational education or nursing education.

As a part of this study, we would like to record your experience of having experienced an unexpected patient death. To do this, Teresa Mumbrue will record your oral recollection of your experience with a tape recorder. Information from this taped interview will be transcribed verbatim and will be analyzed.

Although this information could be attained through questionnaires, or a written dialogue, it is felt that the experience is best represented by a face to face interview.

We do not anticipate that the study will present any medical or social risk to you, other than the inconvenience of extra time required for you to answer questions. Participation in this may not benefit you directly.

The information we gather through interviews will be recorded in anonymous form. We will not release information about you to anyone in a way that could identify you.

If you want to withdraw from this study at any time, you may do so without penalty. The information collected from you up to this point would be destroyed if you so desire.

Once this study is complete, we would be glad to give the results to you. In the meantime, if you have questions, please ask us or contact:

Mary Ellen Wurzbach, RN, PhD
John McNaughton Rosebush Professor
College of Nursing   N/E 311

University of Wisconsin - Oshkosh
800 Algoma Blvd.
Oshkosh, WI 54901
Phone: (920) 424-1077

If you have any complaints about your treatment as a participant in this study, please call or write:

Chair, Institutional Review Board

For Protection of Human Participants

c/o Grants Office

University of Wisconsin - Oshkosh
800 Algoma Blvd.
Oshkosh, WI 54901
920-424-1415

Although the chairperson may ask for your name, all complaints are kept in confidence.

I have received an explanation of the study and agree to participate. I understand that my participation in this study is strictly voluntary.

PRINTED NAME: _____DATE:_____

SIGNATURE:_____DATE:_____
This research project has been approved by the University of Wisconsin Oshkosh IRB for Protection of Human Participants for a 1-year period, valid until December 22, 2010.

Appendix C

Grief and the Health Care Provider

GRIEF IS OFTEN EXPERIENCED BY A HEALTHCARE PROVIDER UPON THE DEATH OF A PATIENT, BUT IT IS OFTEN IGNORED

Grief is an emotion experience by many nurses upon the death of a patient, and, far too often, the nurse may not know how to deal effectively with his or her grief.

Disenfranchised Grief: Mourning over the death of a patient is not typically a part of the culture of healthcare. Nurses, therefore seldom talk about their grief and often do not feel they have a socially recognized right, role, or capacity to grieve over their patients.
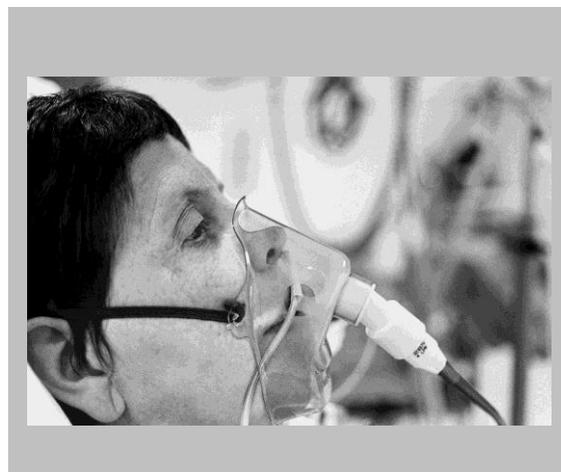
Compassion Fatigue: A physical, emotional and spiritual exhaustion that can affect the ability to feel and care for others.

Moral Distress: Stress, anxiety, apathy and burnout that can often occur from repeated loss and when personal values conflict with the environment.

Brosche, T.A. (2007). A grief team within a healthcare system. *Dimensions of Critical Care Nursing, (26)*1, 21-28.

THE PATIENT

WHEN TO GET HELP

HOW CAN YOU COPE? TRY THESE TECHNIQUES:

- Consider keeping a journal as a way to understand your emotions and process events in your life.

- Purge writing-Set a timer for 5 minutes and write whatever comes to your mind.

- Get physical. Go for a run, take a walk, play tennis, do yoga, just get your body moving.

- Take time to cry.

- Ask for help, especially from colleagues. Don't try to be the "Supernurse".

- Seek professional counseling. Don't be afraid to get expert help to see you through a difficult time.

Consider professional counseling if you're plagued by these symptoms:

- You cry a great deal of the time.

- You find carrying on a normal conversation difficult.

- You're unusually forgetful.

- You're agitated or jumpy most of the time.

- You can't remember the last time you laughed.

- You lose things all the time.

Smith-Stoner, M., & Frost, A.L. (1998). Coping with grief and loss: Bringing your shadow self into the light. *Nursing98, February,* 49-50.

Appendix D

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┌─────────────────────────────────────────────────────────────┐
│                      Overarching Theme                       │
│                                                              │
│   Dynamic Changes: The Continuum from Stable to Unstable     │
│                                                              │
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Theme One	Theme Two	Theme Three
Understanding the Event	Guilt versus Hope	Reaching Out

Subthemes:	Subthemes:	Subthemes:
Fear of the Unknown	Anticipating the Future	Help me
Upheaval and Chaos	Optimism	Aloneness
Swift Change	Self Blame	Grief
Trauma		
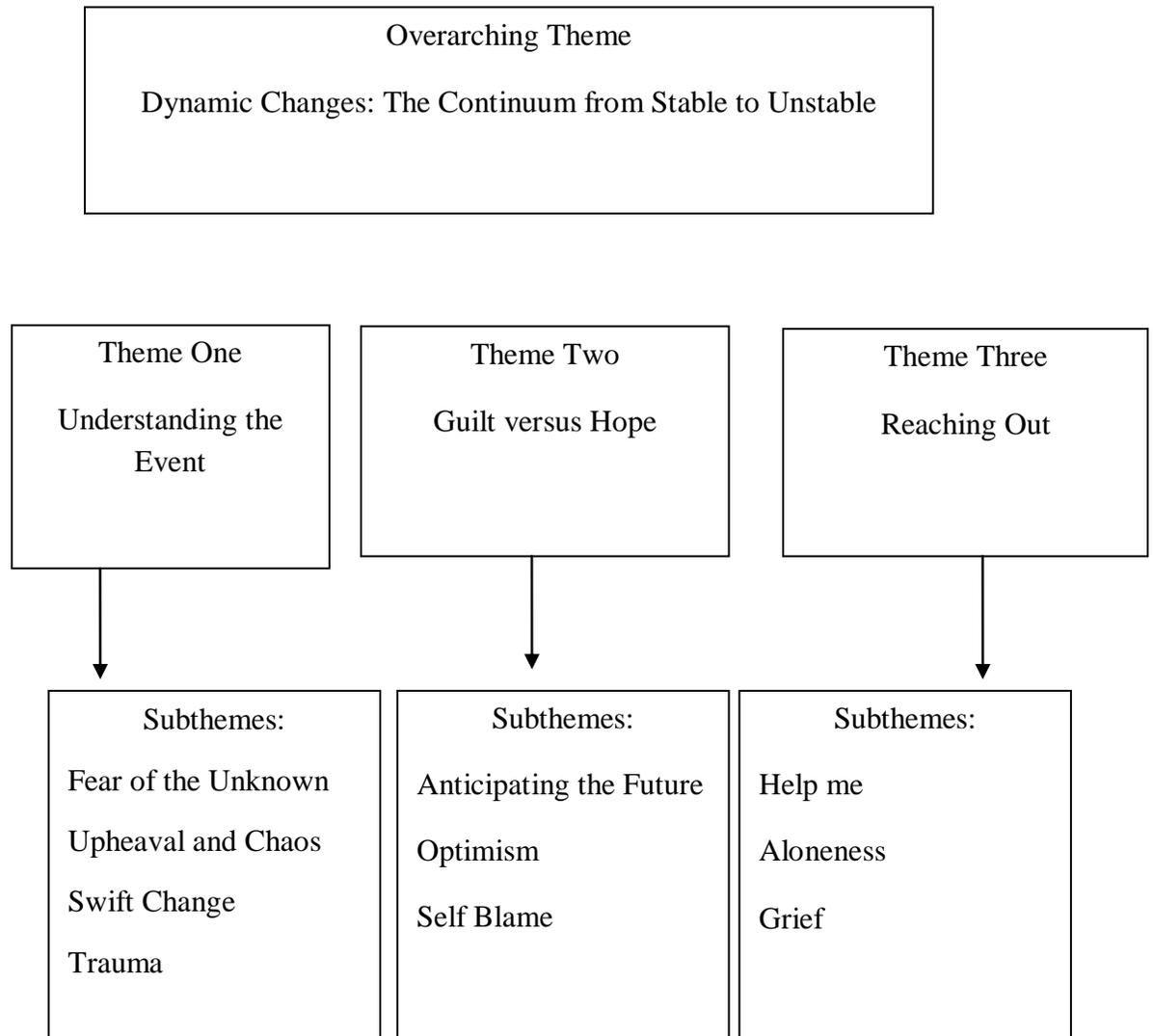
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