DISTRESS IN NURSES FOLLOWING PATIENT DEATH:

A LOCAL RESPONSE TO THE NEED FOR DEBRIEFING

by

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Melanie Ann Bickham

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ABSTRACT

The purpose of this clinical project was to determine if nurses in an acute care setting would report a need for debriefing following a patient death. The review of current literature revealed mixed results regarding the effectiveness of debriefing as an intervention. Literature shows that emotional expression is perceived as cathartic by nurses and is viewed as a positive coping mechanism. However, randomized controlled trials of debriefing models did not demonstrate that participation in debriefing prevented distress symptoms.

A survey was created to assess nurses' views regarding debriefing following a patient's death. Surveys were placed in mailboxes of Registered Nurses and Licensed Practical Nurses in a 220 bed hospital in Montana. There were 55 respondents.

Demographically, the average participant in the survey was 38 years of age, held a bachelors degree, had been a nurse for 9 years, worked in a critical care unit, and had experienced approximately 15 patient deaths over their career. The majority of nurses surveyed felt that an information-sharing and event processing session among peers (debriefing) would be helpful in coping with their emotions after a patient's death. Thirty of those surveyed reported they would be very likely to participate or would definitely participate in a debriefing session if it were available. The overwhelming majority (n=52, 94.3%) reported experiencing one symptom of distress after a patient death. Comments written on the surveys were grouped into themes. These themes included catharsis/sharing, positive coping, past experiences with debriefing, prevention of death, perceived need for formal debriefing, no perceived need for formal debriefing, emotional distancing, and debriefing only for special circumstances.

Surveys revealed that the majority of nurses surveyed felt that debriefing sessions would be helpful in processing their emotions following a patient death. The author wrote a nursing policy regarding the use of debriefing in a hospital setting for nurses following a patient death and made this available to the organization surveyed.

CHAPTER ONE:

INTRODUCTION TO THE PROJECT

Introduction

Working in a profession where the focus is on healing, death can seem like a failure. Nurses often experience sadness and grief when dealing with the deaths of patients, and without any support, can suffer distress (Hanna & Romana, 2007; Cain & Ter-Bagdasarian, 2003). Events that overwhelm a person's usual coping skills can cause distress and evoke a need for intervention (Cain & Ter-Bagdasarian, 2003). Often, nurses only have informal resources available to them when coping with emotions they may experience following a patient death (Cain & Ter-Bagdasarian, 2003; Antai-Otong, 2002). Stress debriefing is a therapeutic intervention designed to help nurses to explore and process their experiences. Debriefing has been described by participants as cathartic. Research has shown that stress debriefing demonstrates a significant reduction in anger levels of participants and a greater use of coping strategies by participants (Irving & Long, 2001).

Nurses are well educated in physiological responses to stress and illness. It is equally important that they recognize the emotional impact of distress and learn techniques to manage it (Cain & Ter-Bagdasarian, 2003). Nurses should be given the opportunity to release any emotional distress they experience when caring for patients. When people are not given the opportunity to process and assimilate their distressful experiences, symptoms including depression, anxiety, depersonalization, and dissociation

can develop (Irving & Long, 2001). Availability of structured debriefing for nurses is limited. There are few debriefing teams at various stages of development in acute-care settings (Laws, 1995). Debriefing is of interest to nursing administration and staff in order to promote nurses' wellbeing.

Problem Identification

Studies suggest that patients "still die in hospitals with poor quality of life" (Granda-Cemeron , Lynch, Mintzer, Counts, Pinto, and Crowley, 2007, p. 772). Many critically ill patients in hospitals undergo prolonged deaths involving the use of invasive procedures (Granda-Cameron et al., 2007). Inadequate relief of pain and other symptoms negatively affect the dying patient and the nurse (Ferrel, Dahlin, Campbell, Paice, Malloy, & Virani, 2007).

Growing concerns regarding health care resources include "social, legal, and ethical issues surrounding medical futility" (Ferrell, 2006, p. 922). Medical futility is life-sustaining care that is most unlikely to result in meaningful survival. However, the impact on nurses who care for patients for whom they believe treatment is futile, has not been given much attention (Ferrell, 2006).

Authors concur that nurses who are impacted by issues concerning medical futility and patient death can suffer from distress. There is a range of cognitive, physical, emotional, and behavioral responses following a stressful event. Cognitive problems associated with distress include confusion, difficulty concentrating, and memory lapses. Physical symptoms include fatigue, difficulty sleeping, gastrointestinal upset, muscle

tension, and heightened autonomic activity. Emotional effects include anxiety, depression, denial, anger, and guilt. Behavioral manifestations include substance abuse, aggressive behaviors, social withdrawal, and listlessness (Caine & Ter-Bagdasarian, 2003). The multiple effects of this distress can lead to nurses being less responsive to each other and to patients (Hanna & Romana, 2007).

Nurses must recognize and confront their own feelings toward death so that they can assist patients and families in end of life issues (Dickinson, 2007). Irving & Long (2001) observed that many individuals are "afraid of their own strong emotions" (p. 311), and the debriefing process helps them understand their feelings and reactions. These debriefing sessions normalize an individual's reactions to distressing events. It may be helpful to nurses if they had the opportunity to explore their emotions in a debriefing session after a patient dies. However, most nurses have received little support in coping with end-of-life issues (Ferrell, et al., 2007). Traditionally, nurses have lacked a formal support structure in which to deal with their reactions to distressing experiences. Informal discussion with peers at meal breaks or social gatherings has shown to be inefficient and ultimately harmful in its approach (Laws, 1995). Comments and comparisons of peers can be judgmental and unhelpful in resolving emotional distress.

The need to find meaning is a profound motivational force that may decrease distress in nurses following a patient death (Desbeins & Fillion, 2007). Debriefing sessions serve to affirm the group members suffering, and help the group cope with their emotions (Hanna & Romana, 2007). Emotional coping strategies of hospice nurses include venting of emotions, emotional processing, and emotional expression. Hospice

nurses, with evolved coping strategies exhibit a positive response to the stress associated in caring for the dying (Desbeiens & Fillion, 2007).

In conclusion, nurses are at the bedside with patients who are dying. At a very human level, these emotionally-intense situations can lead to nurses experiencing distress. Traditionally, nurses have not had an appropriate emotional outlet for this distress. Stress debriefing may help nurses deal with their emotions after a patient has died.

Definitions

For the purposes of this project, the following are the definitions that will be used.

- Nurses are defined as registered nurses and licensed practical nurses from any unit that are either relief, part-time, or full-time employees.
- Debriefing is defined as an information-sharing and event processing session consisting of a conversation between peers (Hanna & Romana, 2007).
- An acute care setting is defined as the hospital setting.
- End of life care is defined as care given to a dying patient. This care includes physical, psychological, and emotional activities that the nurse provides to the patient and family.
- Dying patient is defined as a patient who is in end of life trajectory and meaningful survival is highly unlikely.
- Distress or stress is defined as any reaction to an event which overwhelms ones coping skills (Caine & Ter-Bagdasarian, 2003). It is

manifested as “anger, frustration, guilt, loss of self-worth, depression, nightmares, suffering, resentment, sorrow, anxiety, helplessness, and powerlessness” (Zuzelo, 2007, p. 346).

Purpose of Paper

This paper explores the need for acute care nurses to participate in a stress debriefing session following a patient death. The first aim is to analyze nurses’ responses to a survey about their emotions involving patient death. An additional aim of this paper is to develop an institutional nursing policy regarding debriefing for nurses after a patient death. The policy will be based on the literature and on survey responses.

Assumptions

The following are the assumptions on which this paper is based:

- End of life care is important.
- Nurses in distress are in need of situational support through a formal debriefing session.
- Without stress debriefing, nurses do not feel adequate release for their emotions in caring for a dying patient.
- If nurses adequately process their emotions in caring for a dying patient, patient care and nurses will benefit.
- Leadership initiative is needed to support debriefing.

CHAPTER TWO:

LITERATURE REVIEW

Description of Literature Review

The literature was reviewed relating debriefing, stress responses, and debriefing models. Two electronic databases were selected to search about stress debriefing for nurses: Academic Search Premier and Health Reference Center (CINAHL). The keywords used in the search engines were nursing, distress, and debriefing. Articles were also retrieved from the Inter Library Loan Program through the Montana State University libraries. There was a significant gap in the literature regarding use of debriefing for nurses following a patient death.

Introduction

Discourse in the field of end of life care recognizes the call for attention to meeting the emotional needs of nurses in coping with patient death. Nurses have the unique privilege of working at the bedside and therefore they are at the frontline in patient death. Dickenson (2007) writes “of all health professionals, nurses are in the most immediate position to provide care, comfort, and counsel near the end of life for patients and families”(p. 741). Nurses are looked to for reassurance and are viewed as a human connection in the overwhelming milieu of healthcare (Zuzelo, 2007). The nurse-patient relationship is considered an essential dynamic to care (McVicar, 2003). This can put an emotional strain on nurses.

A study by the Center for Disease Control and Prevention (2005) found that over 50% of critically ill patients in the United States die in an acute care setting where nurses are the primary caregivers. With the aging baby boomer population, there is little argument that end of life care will be a nursing concern (Weigel, Parker, Fanning, Reyna, & Gasbarra, 2007).

The emotional demand of caring is a theme that many nurses have consistently identified. Emotional labor is when nurses have to work at caring. They do this in order to meet the professional demands expected of them. The work of emotional labor can lead to increased frustration. This may cause a nurse to be less personal with patients, which affects quality of care (McVicar, 2003). Emotional labor can also lead to burnout (Huynh, Alderson, & Thompson, 2008).

There is an emotional cost to being in a healing profession. Nurses are expected to be vulnerable and respond to need, but then are expected to turn their empathy off in order to cope with stressful and emotionally draining events like a patient death. The dichotomy between emotional responsiveness and being 'tough' and unaffected by patient suffering can result in overwhelming stress (McEvoy, 2005). Stress responses to an event like a patient death may be severe and debilitating enough to impair daily functioning (Robinson, 2004).

Stress Responses

Stress responses often result from events where one experiences fear, horror, or helplessness (Berman & Davis-Berman, 2000). Post Traumatic Stress Disorder (PTSD) is

a diagnosis where the person experiences symptoms greater than one month following the event. There are four diagnostic criteria. The first involves the presence of a traumatic event where actual or threatened death or serious injury was present. The second criterion is re-experiencing the event through dreams, thoughts, or 'reliving the experience.' The third is the person avoids events, people, or feelings related to the event. Lastly, the individual may experience symptoms of stress such as insomnia, increased physical arousal, irritability, or anger (American Psychological Association, 1994). Acute stress disorder is characterized by symptoms immediately following an event. Emotions such as "helplessness, anger, sadness, and anxiety" (Weigel, et al., 2007, p. 86) are reported by nurses caring for others at the end of life.

Research reveals that exposure to bereavement and patient sufferings are stressors that nurses endure throughout their careers (Desbeins & Fillion, 2007). Dealing with death and dying patients has been identified by McVicar (2003) as workplace stressors that influence nurses. Instances of futile care evoke strong emotional responses from nurses, including that the futile care was violent and cruel (Ferrell, 2006). Distress can adversely affect a nurse's ability to respond adaptively at work and home, and lead to emotional burnout and physiological disturbance (Caine & Ter-Bagdasarian, 2003; McVicar, 2003). Distress in nurses is associated with emotional burnout, frustration, and resignations (Zuzelo, 2007).

Stress responses to an event like a patient death may be severe and debilitating enough to impair daily functioning. Research reveals that exposure to bereavement and patient sufferings are stressors that nurses endure throughout their careers (Desbeins &

Fillion, 2007). Dealing with death and dying patients has been identified by McVicar (2003) as workplace stressors that influence nurses. Distress can adversely affect a nurse's ability to respond adaptively at work and home, and lead to emotional burnout and physiological disturbance (Caine & Ter-Bagdasarian, 2003; McVicar, 2003).

Emotions such as "helplessness, anger, sadness, and anxiety" (Weigel et al., 2007, p. 86) are reported by nurses caring for others at the end of life. Nurses exposed to events like patient death need to be familiar with stress response symptoms and know that their jobs increase the likelihood that they may experience symptoms of distress. It is the prevailing belief in the helping professions that debriefing is an appropriate method for dealing with such reactions (Berman & Davis-Berman, 2000).

Models for Debriefing

Critical Incident Stress Debriefing Model

The most popular and widely accepted model of psychological debriefing is Critical Incident Stress Debriefing (CISD) which involves a facilitator. CISD is viewed as the prevailing efficacious treatment in response to PTSD. Mitchell & Everly (2001) recommend that debriefing should be offered to anyone exposed to a critical incident. The model has seven phases.

1. Introduction: The facilitator begins by explaining that debriefing is a method for alleviating common stress symptoms triggered by a critical incident. It is made clear that it is not psychotherapy. Introductions are made and the purpose and any ground rules are set.

2. Fact Phase: In brief, each participant, in turn, talks about their role in the event, what they saw, and any factual information.
3. Thought Phase: The participants explain what their first thoughts about the incident were as it was happening.
4. Feeling Phase: Each participant reveals what feelings were generated by the incident.
5. Reaction Phase: This is a discussion of immediate and subsequent reactions the participants may be experiencing.
6. Strategy Phase: Facilitators provide education to group regarding common stress reactions and share strategies for coping with stress reactions.
7. Re-Entry Phase: This is a summary of the event and is an opportunity for participants to clear up any misunderstandings. This allows for confirmation of feelings.

Mitchell created this program in the 1980s, and it was designed for groups of people that were similar in nature (i.e. same profession) that had experienced a traumatic event. The program was conducted by trained workplace peers and mental health practitioners. The process is very structured while still allowing participants to discuss their thoughts, feelings, reactions, and strategies for coping.

Psychological First Aid

Psychological First Aid (PFA) is a set of interventions designed for both emergency service personnel and the general public. Like CISD, there is a facilitator, but it is not someone who is trained specifically in debriefing. This process emphasizes completing some main steps including safety, social connections, and efficacy of the individuals involved.

1. Safety: Recreating a sense of safety for the individuals who are experiencing the distress is the first component. This includes meeting immediate physical needs, protecting personnel from onlookers and media, and the facilitator determining if formal help is needed.

2. Social connections: Establishing social connections is the second main component. This includes the facilitator helping the individual connect with family, friends, significant others, children, etc. Providing information regarding normal signs and symptoms of the stress response empowers the individuals while keeping them informed about possible PTSD symptoms they may experience.

3. Efficacy: Reestablishing a sense of efficacy is the third main component. The focus of this is to encourage resumption of normal activities while incorporating stress-reduction activities. A three month follow-up assessment by the facilitator for any needs the person may have is another aspect of this step.

PFA is a method that has little criticism in the literature as a debriefing model. This may be because of the flexible nature of PFA as an intervention for distress. PFA is recommended by the National Institutes of Mental Health (NIMH) and the World Health

Organization (WHO) (McEvoy, 2005). These institutions are defining world policy makers that add weight to the use of PFA as a debriefing model. The WHO states that guidelines suggesting the use of PFA are a significant step in providing better care and support to people suffering from disaster (HealthNetTPO, 2007; Van Ommeren, Saxena, & Saraceno, 2005). Persons who arrive first at a scene of violence may not be trained to provide early mental health interventions, so the NIMH recognizes that early response personnel be trained in PFA in order to help those in distress (NIMH, 2002). These organizations recognize and support access to PFA interventions in order to help those in distress.

Many fire and EMS departments practice PFA (McEvoy, 2005). This is a loosely structured program which highlights three main points of safety, social connections, and efficacy. Supporters tout that this method is just like basic first aid; one need not be a trained professional to do it (Extreme Behavioral Risk Management, 2008) and it is easily applicable to many situations and individuals.

The Value of Debriefing

It is the prevailing belief in the helping professions that debriefing is an appropriate method to alleviate the stress response (Berman & Davis Berman, 2000). However, one should be aware of the controversies in the literature about debriefing. Some studies challenge the basic assumption that debriefing is the primary preventive intervention for emotional distress. Controversy remains whether early interventions like stress debriefing are effective at preventing and/or limiting symptoms of PTSD. Meta-

analysis of the CISD model claims that debriefing may not promote natural recovery from trauma.

In one study, a group of burn victims was randomly divided into treatment and non-treatment groups. The treatment group received single one-on-one debriefing sessions. At a 13 month follow-up, the rate of PTSD was significantly higher in the debriefed group than in the non-treatment group (26% vs. 9% respectively). The questionnaire measured depression, anxiety levels, and symptoms of post traumatic stress. The authors of the study suggested that CISD's routine use be discontinued (Bisson, Jenkins, Alexander, & Bannister, 1997).

The information in the previous study cannot be taken as an adequate representation of debriefing because the sessions were one-on-one with the facilitator. This poses a problem as the CISD model is meant to be used in a group setting. The nature of the debriefing intervention is an issue in this study because it was not a standardized intervention using trained facilitators. Departures from the CISD routine lead the author to question the conclusions of the study.

A randomized controlled trial of early psychological intervention with children involved in motor vehicle accidents found that early psychological intervention did not result in any better outcomes of self-reported PTSD symptoms (Stallard, Velleman, Salter, Howse, Yule, & Taylor, 2006). However, the researchers concluded that the nature of the structured assessment of the children may have been therapeutic in and of itself. Also, the CISD process was used, but modified for use with children. Therefore,

the argument must be proposed that the original CISD model was not being tested and the results from this study cannot be extrapolated.

Randomized, controlled trials regarding debriefing conclude that current evidence shows no propensity toward using psychological debriefing in the prevention of PTSD after critical or traumatic events (Rose, Bisson, & Wessely, 2001). CISD and non-CISD interventions did not lead to greater recovery than no treatment at all for victims of trauma (Berman & Davis-Berman, 2000). However, one should keep in mind that CISD is neither a therapy nor a treatment, but is a formal means of support for staff undergoing stressful events (Robinson, 2004). Many of these studies take the interventions out of context of the original process of CISD. The reasons behind lack of supporting data for debriefing becomes clear when considering the multiple issues affecting the current body of research. Debriefing research is riddled with lack of clarity in reporting and conducting processes. Research in this area has been further hampered by conceptual and methodological shortcomings involving inconsistent use of the debriefing label.

It is imperative to discern if debriefing is an adequate intervention for the prevention of distress because the wellbeing of healthcare workers is at stake (Tuckey, 2007). Most studies that applied CISD to victims did not follow the guidelines set forth by the CISD protocol. There were variations in relation to size of groups, (in some studies, one-on-one counseling was used) as well as differences in the timing and duration of debriefing sessions. Also, many conclusions regarding debriefing are based on individual debriefings, not group debriefings as outlined in the original CISD process.

Despite over two decades of research, the efficacy of group psychological debriefing is not clear. Tuckey (2007) states that lack of empirical rigor in most studies results in little comparative value between debriefing interventions and non-intervention groups. Issues identified include non-random assignment of group members, and unclear baseline measures to evaluate the equivalence of stressful events. As one reviews the literature, one is compelled to consider ethical considerations involved with the assignment of participants to treatment and control groups. The nature of the trauma/debriefing sessions and outcome measures need further refinement. Other limitations to debriefing research are high attrition rates as participants are likely to withdraw from studies, as well as variations in terminology and clarity of reporting (Tuckey, 2007).

Overall, there is a need for reliable, valid, and controlled studies of group debriefing along with careful interpretation of research evidence. There were no studies directly related to debriefing for nurses following a patient death. Also, no randomized controlled trials for the use of other debriefing models were discovered in the review.

Recommendations for improving the methodology and analysis of future research studies are included in the following Table 1 (Tuckey, 2007, p.114):

Table 1. Inconsistencies in Debriefing Research

Issue:	Recommendation:
Allocation of participants to treatment groups	Randomization of participants Replication of studies
Baseline measures	Take baseline measures when possible
Nature of the trauma	Clear definitions and inclusion criteria
Nature of the debriefing intervention	Standardized intervention, trained facilitators
Outcome measures	Clear definitions of the aim of intervention
Response rates and attrition	Take steps to avoid drop-outs
Terminology and clarity of reporting	Nature of event, demographics, how participants were selected, treatment conditions, model used, setting, timing, size, integrity, nature of control

It is difficult to study the effectiveness of stress debriefing for many reasons. The vast array of human reactions and emotions adds even more complexity to researchers' attempts to understand debriefing. The question remains if some type of debriefing is better than no debriefing at all. The author makes a stand that offering a debriefing is important to facilitate nurses in coping with their emotions following a patient death.

Coping and Debriefing

It remains to be seen whether or not debriefing is a true intervention for the prevention of distress symptoms. However, it is a way of coping with emotional reactions resulting from distress. Processing emotional reactions with peers has been and will continue to be a coping strategy used by nurses. An inability to process feelings and reactions to patient death can lead to burnout in caregivers. Emotional coping strategies of hospice nurses include venting of emotions, emotional processing, and emotional expression. Hospice nurses, with evolved coping strategies exhibit a positive response to the stress associated in caring for the dying (Desbeiens & Fillion, 2007).

One study by LeSergent & Hanley (2004) found a positive relationship between stressors that rural nurses encountered and emotion-focused coping strategies. The researchers propose that as stress levels rise, nurses perceive that they cannot alter the situation through problem-focused interventions. They then begin to rely on emotion-focused coping strategies which included nurses discussing the stressful situation (i.e. cardiac arrest) in a reminiscent fashion to let their feelings out. The nurses then turned their attention back to task oriented work.

Stress levels on the job increase for nurses who perceive less support from colleagues (Chapman, 1993). Emotional support for nurses coping with stressful situations like patient death is important. As job stress levels increase, so does caregiver burnout and job turnover. Therefore, the need for support increases and the form of support can be in the form of a structured debriefing session.

Intensive care nurses in a research study involving coping skills reported seeking social support as one of their main coping strategies. Critical and unstable patients, as well as unnecessary prolongation of life were among the top four stressors for nurses in this study. Forty-nine percent of the 135 nurses surveyed reported utilizing social support as a coping strategy for stressful situations in their job (Hays, All, Mannahan, Cuaderes, & Wallace, 2006).

Debriefing sessions are often perceived as an affirmation to the group members suffering and help the group to cope with their emotional reactions (Hanna & Romana, 2007). Debriefing has been described by participants as cathartic. Research has shown that stress debriefing demonstrates a significant reduction in anger levels of participants and a greater use of coping strategies by participants (Irving & Long, 2001). Debriefing can act as an emotional outlet and positive coping mechanisms for nurses in distress.

Summary

In summary, the literature is not consistent regarding the value of debriefing. Debriefing is perceived as cathartic, as well as a positive coping strategy involving peer support with the processing of emotional reactions. Some studies have negative conclusions regarding the effectiveness of the CISD model in the prevention of distress, while other sources discuss the emotional benefits of debriefing and/or psychological intervention.

A limitation of the literature is the use of the CISD model as the major focus. Two major worldwide policymakers support the use of PFA. The models the author

recommends is CISD because of its long-standing use and very structured format fitting for a group environment. It is important that hospitals offer debriefing like the CISD or PFA models to support nurses in coping with their emotions following a patient death.

CHAPTER 3:

PROJECT DESCRIPTION

Introduction

An assessment is paramount in identifying target populations in need of services (Petersen & Alexander, 2001). The assessment tool is a survey developed by the author. For the purposes of this project, the target population is acute care nurses at a Level II Hospital in Billings, MT. A need is defined as "a value judgment that suggest that problems exist for target populations" (Petersen & Alexander, 2001, p.18), and "discrepancies between a target state and an actual state" (Petersen & Alexander, 2001, p.23). The need in this project is the nurses' perceptions of the need for debriefing following a patient death.

Assessments play a fundamental role in program and policy development (Petersen & Alexander, 2001). Evidence-based policy and procedures for hospitals are the backbone of excellence and standardized care. An assessment provides scientifically credible information to policyholders in order to identify existing and emerging needs and advocate for effective policies in order to meet those needs (Petersen & Alexander, 2001). A policy that supports nurses' emotional needs following a patient death would be an acknowledgement that nurses do experience distress in patient death.

There is no nursing policy in the institution surveyed regarding debriefing for nurses. Currently, nurse managers can act as a point of contact for staff suffering from distress following a patient death. Staff nurses on all units do not have availability for

structured debriefing in the event of a patient death. There is no nursing policy at St. Vincent Healthcare addressing emotional needs of staff nurses after an event such as a patient death. Nurse managers may call informal meetings after a particularly disturbing death, but the question is raised if the managers are the appropriate person for identification of such an event. The managers are not trained in stress debriefing, and do not have a formal policy or procedure to go about making a debriefing available to staff.

Project Design

This project employed a descriptive survey with a convenience sample. Surveys included items related to the study purpose and demographic questions. The surveys were placed in employee mailboxes which are located on the unit that they work in.

Tool

The tool used for this project was a survey developed by the author (see Appendix A). The tool consisted of close-ended questions and sections for comments. The purpose of the survey was to ascertain the need for debriefing. Surveys provide several important strengths to an assessment for need including direct feedback, foster public awareness, tailor-made to address specific issues, targeted to specific population, and timely results (Petersen & Alexander, 2001, p. 47).

Implied consent is assumed via the return of the completed questionnaire (Polit & Beck, 2008). This survey has been subject to expert review and has been presented to a sample of nurses for understandability. Validity of this tool was established by evaluation

of a public health nursing expert and another nursing expert in instrument development. A cover letter was stapled to each survey which explained the project and requested participation (see Appendix A). The letter stated the optional, anonymous nature of the project. The survey was estimated to take two minutes to complete and the instructions were for the participant to drop it in a box supplied in the unit break room.

Sample

The nurses surveyed were employees of St. Vincent Healthcare in Billings, Montana. This sample includes nine units of the hospital: Intensive Care Unit, Emergency Department, Telemetry, Oncology, Medical/surgical, Pediatrics, Mother Newborn Care Unit, Labor and Delivery, and Neonatal Intensive Care Unit. The Level II hospital is a 220 bed private Catholic institution. The nurses surveyed could be any employee practicing with a LPN or RN license. There are approximately 450 nurses in the institution including full-time, part-time, and per diem employees.

Data Collection and Analysis

Permission to survey this population was obtained from the Chief Nursing Officer and the Chief Operational Officer at St. Vincent Healthcare. The plan for this project was submitted to the Institutional Review Board (IRB) at Montana State University. An exempt status was granted due to the anonymous survey methodology used. The IRB of Billings, Montana honored the decision of the above mentioned IRB and granted permission after a brief presentation of the project by the author.

The surveys were placed in mailboxes of nurses on the nine units of the hospital on December 11, 2008. The boxes and surveys were made available until January 8, 2008. The completed surveys in the drop boxes were collected over a two week period. One survey reminder was emailed to all LPN and RN employees on the selected units one week after initiation of the survey. All surveys were numbered for reference by the author. All the quantitative data were entered into SPSS 13. The quantitative data were analyzed for frequencies, percentages, means, and standard deviations with SPSS. The median was calculated for the number of patient deaths experienced among nurses. Qualitative data were transcribed into a word document and coded for content themes.

CHAPTER 4:

FINDINGS

Descriptive Statistics

The purpose of this survey was to determine if nurses felt debriefing would be helpful in processing their emotions following a patient death. This chapter provides the results of this survey. Means and ranges were calculated for date of birth and date of licensure. The total number of deaths over career as a nurse was calculated using median. Frequencies and percents were calculated for the following characteristics: level of education and specific unit where employed. A response rate of 27.5% (n= 55) was achieved from the distribution of 200 surveys.

Date of Birth

The average age of those surveyed was 38 years old. The ages ranged from 21 years old to 61 years old.

Level of Education

The majority, 52.7% (n=29) reported having a bachelor degree. One nurse reported having a PhD. See Table 2.

Table 2. Level of Education	n	%
Diploma	1	1.8
Associates Degree	15	27.3
Bachelors Degree	29	52.7
Other	7	12.7
No response	3	5.5
Total	55	100%

Unit

Forty seven percent (*n*=26) of respondents were from critical care areas, including 6 from Emergency Department, 14 from Intensive Care Unit, and 6 from Neonatal Intensive Care Unit. The lowest response rate was from Orthopedic Unit with one respondent. See Table 3.

Table 3. Unit	n	%
ED	6	10.9
Float	3	5.5
ICU	14	25.5
Med/Surg	7	12.7
MNCU	5	9.1
NICU	6	10.9
Onco	3	5.5
Ortho	1	1.8
Peds	5	9.1
Tele	5	9.1
Total	55	100

Length of Career and Number of Deaths

The majority of participants 90% (*n*=50) had experienced a patient death within the last 2 years. One respondent had never experienced a patient death. The average length of career was a mean of 9.2 years (SD 6.7). The median number of deaths experienced per nurse was 15.

Debriefing Helpfulness and Participation

Frequencies and percentages were calculated for whether or not the participants felt that debriefing would be helpful in processing their feelings following a patient death. Table 4 exhibits that a majority 87% (*n*=48) of nurses surveyed felt that an information-sharing and event-processing session among peers (debriefing) would be helpful in coping with their emotions after a patient's death. See Table 4.

Table 4. Helpfulness of Debriefing	n	%
Yes	48	87.3
No	7	12.7
Total	55	100

The question regarding participation in a debriefing session was presented as a Likert scale. See Table 5. Thirty one of those surveyed reported they would be very likely to participate or would definitely participate in a debriefing session if it were available.

Table 5. Participation	n	%
Unlikely	7	12.7
Somewhat unlikely	6	10.9
Neutral	11	20
Very likely	22	40
Definitely	9	16.4
Total	55	100

Reporting Distress Symptoms

Most respondents (*n*=52) reported signs or symptoms of distress following a patient death at some point in their nursing career. Symptoms of distress assessed on the survey included anger, nightmares, sorrow, guilt, anxiety, and depression. These

questions were presented in a yes/no format. The respondent then circled yes or no for each symptom of distress. A majority of respondents reported they felt anger following a patient death. See Table 6.

Table 6. Anger	n	%
Yes	29	52.7
No	24	43.6
No response	2	3.6
Total	55	100

About a quarter of the participants reported experiencing nightmares following a patient death 25.5% (*n*=14). See Table 7.

Table 7. Nightmares	n	%
Yes	14	25.5
No	39	70.9
No response	2	3.6
Total	55	100

The overwhelming majority 94.3% (*n*=50) reported experiencing sorrow. See Table 8.

Table 8. Sorrow	n	%
Yes	50	94.3
No	3	5.5
No response	2	3.6
Total	55	100

There were equal amounts of people who felt guilty following a death vs. those who did not experience guilt (49.1% vs. 50.9%). See Table 9.

Table 9. Guilt	n	%
Yes	27	49.1
No	26	49.1
No response	2	3.6
Total	55	100

Over half of respondents reported experiencing anxiety following a patient death. See Table 10.

Table 10. Anxiety	n	%
Yes	31	56.4
No	22	40.0
No response	2	3.6
Total	55	100

Finally, 30.9% (*n*=17) reported depression following a patient death. See Table 11.

Table 11. Depression	n	%
Yes	17	30.9
No	35	63.6
No response	2	3.6
Total	55	100

Themes

Every survey (*n*=55) had at least a single word comment. Comments written on the surveys were grouped into themes. These themes included catharsis/sharing, positive coping, past experiences with debriefing, prevention of death, perceived need for formal debriefing, no perceived need for formal debriefing, emotional distancing, and debriefing only for special circumstances.

Table 12. Themes	n
Catharsis/Sharing	20
Positive Coping	12
Past experiences with debriefing	4
Prevention of death	5
Perceived need for formal debriefing	5
No perceived need for formal debriefing	5
Emotional distancing	5
Special circumstances	8

*some comments qualified for more than one category

Catharsis/Sharing

Opportunities for debriefing were described as a way to talk about feelings and experiences while gaining input and support from peers. There were 20 comments that were grouped under this theme. Within this theme, many comments cited debriefing sessions as the ability to find common ground, air feelings, and validate memories of the event. One respondent wrote “Talking among other RNs who have experienced the same thing is an excellent outlet. Other people in our lives will not understand as well as our co-workers”. Debriefing would be helpful “because we could get things off our chest and mind and share our experiences” and “…it is always a relief to get it off your chest and hear how others feel about the situation”.

Positive Coping

Coping strategies these respondents described as helpful included venting of emotions, emotional processing and emotional expression. Many of the comments discussed using debriefing as a positive coping mechanism to receive closure from the event of patient death. There were 12 comments in this area. One comment exemplifying

positive coping stated “[debriefing allows one to] receive feedback and communicate negative emotions in order to be able to continue on without extra baggage”. Another comment read “…talking through the process with those involved in the event can bring closure and healing”. Another nurse wrote that “Sharing feelings with others helps coping process”. One respondent wrote “In many cases, those involved put everything they have into saving someone and it doesn’t always work. Being allowed to vent and talk to one another gives us an outlet so we don’t have to deal with the situation alone”.

Past Experiences

There were four responses that fit the category of debriefing used in past experiences. Respondents wrote that “Discussing it [patient death] in a structured environment [would be] helpful” and “I have used debriefing in prior experiences and it really helped me to cope”! These nurses felt that debriefing had been a useful tool for coping with their emotions following a patient death.

Prevention of Death

There were five comments regarding feelings of debriefing helping the nurse to process if anything could have been done differently to prevent the death. “My greatest worry is if there was something more that I could have done to prevent a death”. Another respondent wrote “A limited number of deaths seem to be preventable. It [debriefing] would be a good opportunity to share ideas and improve outcomes”.

Perceived Need for Formal Debriefing

This category involves the theme that nurses' feelings were brushed aside and they were to act like nothing had happened after a patient death. There were five comments in this area. One comment read "I had a very difficult time after my first code that ended in death. It would have been nice to have someone reassure me it wasn't my fault".

Traditionally, nurses have lacked a formal support structure in which to deal with their reactions to distressing experiences. One nurse wrote "There is really no one or no time to talk to anyone about this". Another stated that "[it] is nice to talk to others who have had similar experiences…leave a little more of the emotions at work, START THE HEALING PROCESS there". One nurse wrote "Death is a very difficult thing to deal with. I've been a nurse for over four years and it [patient death] is still difficult and emotional".

No Perceived Need for Formal Debriefing

This category grouped together comments that fit under no perceived need for formal debriefing. Five respondents stated that unstructured debriefing occurs on the unit anyway when needed. One person wrote "…a structured setting might feel awkward". The general theme of these comments was that debriefing was not needed because it already occurs naturally. Comments included "I feel that as peers in most instances we participate in unstructured debriefing amongst ourselves to relieve stress" and "within the unit we talk to each other and unknowingly 'debrief' each other".

Emotional Distancing

Another theme that cropped up among the comments was the nurses feeling emotionally distant from the circumstances of patient death. One nurse commented “It [patient death] doesn’t bother me so much anymore. I have learned to not let it affect me, but at the same time I feel like I have become very hard and cold. Not only at work but in life, and I am becoming burned out”. Personalities of nurses may have some determination on whether or not they react emotionally to a patient death. One respondent commented “[I’m] not the type to talk about things”. Another nurse stated “Not emotionally attached to patients”. Some nurses perceived they were not affected by death and therefore would not find a debriefing session helpful. There were five comments in this area.

Special Circumstances

Eight comments described the need for debriefing with special circumstances like sentinel events, trauma, or pediatric death. These circumstances were described as instances where nurses were affected by the emotional nature of the patient’s early or unexpected demise. Regarding the helpfulness of debriefing, comments included “Much depending on details surrounding death” and “Sometimes depends on the situation of the death if it is an older person that is expected or a tragedy” and “mostly if this is a sudden death especially a young person”.

The comments also bring to surface the thought that certain units may have special needs. For example, a Neonatal Intensive Care Unit nurse wrote that debriefing should be available for all staff following a patient death. One nurse wrote that debriefing would be needed "Depending on the patient and staff involved".

Also, there was one comment regarding the need for debriefing based upon a nurses experience level. This read "…a new grad[uate] would likely benefit from an intervention [of debriefing]…"

Summary

The voices of the nurses came alive as the author began transcribing the qualitative data. One particularly poignant quote from a pediatric nurse touched on some of the motivating factors for this project; "When a patient dies, there seems to be a lack of group/caregiver closure. It's always hard and its part of our jobs, but an awkwardness lingers for a while". The awkwardness the nurse describes may be unspoken emotions that need to be expressed. Debriefing is a positive coping mechanism nurses can use to gain support and reassurance from their peers while expressing their emotions. This expression may help nurses to process their reactions to distressing events like patient death.

With the majority of respondents' reporting signs of distress and feelings that debriefing would help them process their reactions, the logical intervention would be to offer debriefing to nurses to help them cope with their feelings. A majority of nurses also

responded positively to the likelihood of participating in a debriefing session, which supports the implementation of debriefing in the hospital setting.

CHAPTER 5:

OVERALL EVALUATION

Introduction

The purpose of this project was to explore the need for acute care nurses to participate in a stress debriefing session following a patient death. One aim was to analyze nurses' responses to a survey about their experiences involving patient death. The another aim of this paper was to develop an institutional nursing policy regarding debriefing for nurses after a patient death based on the literature and based on survey responses.

The mixed results of the review of literature call for further research, as well as clarification of existing research. Studies have expounded the benefits of emotional catharsis similar to what structured debriefing offers, but randomized controlled trials refuted the use of models like CISD for preventing distress symptoms. Further research on the application of debriefing models to the nursing setting will provide more information on how institutions can best meet a need for processing emotional reactions to patient death.

However, policy in public health often precedes evidence as policy-makers respond to the needs of those around them. Based on this thought, the author recommends using an established debriefing model like CISD or PFA for the sake of congruence. Further research on the application of debriefing to the nursing setting would help clarify the use of debriefing for healthcare providers. Debriefing should be available for nurses

in order to provide a formal mean for nurses to cope and process their reactions following a patient death.

Aim 1: Responses to Survey

The majority of nurses felt that debriefing following a patient death would be helpful in processing their emotions. Thirty of those surveyed reported they would be very likely to participate or would definitely participate in a debriefing session if it were available. The overwhelming majority (n=50, 94.3%) reported experiencing one symptom of distress after a patient death. Demographically, the average participant in the survey was 38 years of age. The average participant had been a nurse for 9 years, had experienced approximately 42 patient deaths over their career, and had a bachelor's degree.

The main theme of the comments written on the surveys (n=20) was that debriefing would be valuable for catharsis and sharing of emotions. Debriefing is also viewed as a positive coping mechanism as evidenced by survey respondents (n=12). Some feedback from the respondents' (n=8) indicated that in special circumstances of patient death (i.e. trauma, pediatric), debriefing may be more relevant. One nurse from the Neonatal Intensive Care Unit wrote that debriefing should be available to all nurses after a patient death, which calls attention to the possibility that different units may have different needs.

Aim 2: Write Nursing Policy

Evidence-based policy and procedures for hospitals are the backbone of excellence and delivery of standardized care. Evidence for the nursing policy written based upon this project was extracted from the literature as well as the surveyed population. The survey was a tool that provided information specific to the population for which the policy was recommended. See Appendix B for Debriefing Policy.

Limitations

As with any study, there are limitations to be considered. The findings cannot be generalized beyond the scope of the study population. The method of surveying is another limitation as it was a convenience sample. By leaving the surveys in the break rooms on various units in the hospital, some nurses may not have the chance to participate. There was a low response rate from oncology unit. The tool used did not undergo rigorous reliability and validity testing. Some surveys did have missing data, but all surveys were numbered, recorded and analyzed. The number of surveys received (n=55) represented only a fraction of all the nurses working at the facility (450), so sample size is a limitation. Further review of models of debriefing is also needed. The applicability of debriefing to clinical nursing is another area for further research.

Another limitation may be the use of the definition of distress. The definition used for the purposes of this paper were emotional reactions like “anger, frustration, guilt, loss of self-worth, depression, nightmares, suffering, resentment, sorrow, anxiety, helplessness, and powerlessness” (Zuzelo, 2007, p. 346). However, one may argue that

some of these reactions (i.e. sorrow) are normal responses to patient death and are not indicative of distress in and of itself. This paper focused on self-reported reactions to patient death, and emotions like sorrow were included in the definition of distress.

Implications for Nursing Practice

The very nature of being in a healing profession exposes nurses to emotional situations with patients. Studies prove that emotionally taxing situations such as patient death can cause distress symptoms in nurses. Literature shows that debriefing sessions are perceived as cathartic by nurses and are viewed as a positive coping mechanism. Debriefing for nurses is important because distress in nurses is associated with emotional burnout, frustration, and resignations (Zuzelo, 2007). It is also important that healthcare organizations acknowledge and offer support in the difficult emotional situations that nurses encounter on a daily basis. Peer support will always be important for nurses, and structured debriefing would be a formal means of support for emotional coping and relieving distress.

Implications for Nursing Research

Debriefing research is riddled with lack of clarity in reporting and conducting processes. Research in this area has been further hampered by conceptual and methodological shortcomings involving inconsistent use of the debriefing label. Current research on debriefing should be weighed against standards of conducting processes as not all studies followed the process of CISD. Further research must streamline specific

issues. These issues include random assignment of participants to treatment groups, baseline measures reported when possible, clear definitions as to the nature of the event, and inclusion criteria. Clarifying these issues will aid in replication of studies. Further recommendations include standardizing the nature of the interventions using trained facilitators, clear definitions of outcome measures, attention to attrition and response rates, and clarity of terminology and reporting.

Further research in the nursing setting will help to establish if debriefing is an appropriate intervention to prevent distress symptoms. There is a lack of data regarding the use of debriefing in the nursing setting. Also, further research needs to be done on the effectiveness of PFA. There is a lack of data regarding the effectiveness of PFA in relieving distress symptoms and preventing PTSD.

Implications for Policy Development

Developing a policy involved pulling data from the literature and input from the surveys was also taken into consideration. Policy in a public health often precedes evidence, as the policy-makers are responding to a perceived need in a population. Data used for this policy included information regarding administrative support, staff leader for debriefing, and length and timing of debriefing.

Leading policy-makers both within the country (NIMH) and world-wide (WHO) advocate for stress debriefing as a valuable practice. The WHO states that guidelines suggesting the use of PFA are a significant step in providing better care and support to people suffering from disaster (HealthNetTPO, 2007; Van Ommeren, Saxena, &

Saraceno, 2005). Persons who arrive first at a scene of violence may not be trained to provide early mental health interventions, so the NIMH recognizes that early response personnel be trained in PFA in order to help those in distress (NIMH, 2002). These organizations recognize and support access to PFA interventions in order to help those in distress.

Policy for debriefing in the hospital setting is a new development for the organization used in this study. Therefore, emulating these leading policy-makers adds support for debriefing for nurses.

Administrative Support

Administrative support is crucial because it encourages participation and supports the nurse. Debriefing for nurses is important because distress in nurses is associated with emotional burnout, frustration, and resignations (Zuzelo, 2007). Investing in debriefing may aid in employee wellbeing and increase performance. Debriefing is a key investment that institutions need to make. Employers must support and encourage nurses to seek help rather than struggle alone (Antai-Otong, 2002). A sound understanding of the stress phenomenon for nurses depends upon the effectiveness of organizational interventions aimed at reducing or eliminating sources of stress (McVicar, 2003). The use of an assessment tool is vital for strategic leadership because without it, focus, effectiveness, and accountability of programs can be threatened (Petersen & Alexander, 2001). The assessment tool used in this project was a survey which captured the thoughts and feelings of nurses regarding debriefing. Comments from the surveys echoed that

administrative support is important in supporting debriefing programs. One comment read “backing and support from administration is vital…”

Staff Leader

Data from the literature indicates it is essential to use trained and experienced staff leading the stress debriefing (Irving & Long, 2001). Feedback from some of the surveys indicated that nurses would like to have the stress debriefing leader involved in the actual event, or as someone in the unit that the nurses are familiar with. One comment read “Not [debriefing] by anyone outside the situation, that can be more traumatic!”

This staff leader may be a nurse on the unit who undergoes additional training in a debriefing model in order to act as a guide through a debriefing session. This would be a nurse who would have an interest in debriefing and volunteer to be in the position of staff leader for debriefing sessions.

Length and Timing of Debriefing

If a debriefing policy was initiated at an organization, administration would need to take into account evidence from the literature regarding the effectiveness of adequate debriefing sessions. For example, the CISD process normally takes 2-3 hours (Antai-Otong, 2002). Stress debriefing provided within 24 hours after the experience has been identified by the literature as the most helpful (Irving & Long, 2001). These time frames would need to be accounted for in staffing matrixes. Scheduling a debriefing session may

complicate adequate staffing on the unit. This responsibility would fall on the managers and staffing support from the unit.

Summary

The literature review has shown how imperative it is that nurses have some outlet for distress experienced following a patient death in order to avoid burnout and poor performance. Acknowledgement from administrative leaders regarding the need to diffuse the emotional stress of nurses may be paramount in the beginning of organizing the availability of a structured debriefing system. Instituting a nursing policy regarding stress debriefing following a patient death involves many complicated processes, including support from administration, staff input, and evidence from the literature. The majority of staff in this survey indicated that of some form of debriefing for nurses following a patient death would be helpful to them. The author supports debriefing for nurses, offers an evidence-based policy (See Appendix B), and encourages institutions to use it.

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APPENDICES

APPENDIX A

SURVEY

YOU ARE INVITED TO PARTICIPATE ~

Caring for the Nurse that Cares for the Dying

Hi. My name is Melanie Bickham. I am a Registered Nurse at St. Vincent Healthcare in the OBS Unit. I am currently seeking my Masters of Nursing through Montana State University. As part of my curriculum, I am completing a professional project which involves a survey requesting input from nursing staff. I am interested if staff would find debriefing sessions helpful in processing their feelings following a patient death. Debriefing is defined as an information-sharing and event-processing session consisting of a conversation among peers.

If you are interested, please read below for further explanation, and fill out the survey on the next page. This will take less than two minutes of your time. Please leave survey in the provided boxes labeled 'stress debriefing surveys.' The results of this survey will be the basis of a written recommendation to administration at St. Vincent Healthcare. If you have any questions or would like to contact me for results of this project, please email me at melwalker01@hotmail.com.

Thank you for participating.

Disclosures

Study Goal: This questionnaire is part of a study to determine whether or not there is a need for structured debriefing sessions for nurses following a patient death.

Benefits: This needs assessment will indicate if nurses feel that intervention is needed because of emotional distress following a patient death. Because distress in nurses can lead to turnover, burnout, and Post Traumatic Stress Disorder (PTSD) symptoms, an opportunity for debriefing could help to prevent these issues. This needs assessment would hopefully also identify sub-populations (i.e. oncology units, new graduates) that may have a greater need for stress debriefing following patient death.

Risks: While limited, there is a slight risk of distress when taking this survey and potentially reliving emotionally charged events in ones nursing career. Psychological services are provided by St. Vincent's to all employees should this risk arise for a participant.

Confidentiality: Participants are assured that anonymity is guaranteed. The data are confidential; only grouped data will be reported.

1. Do you feel that an information-sharing and event processing session among peers (debriefing) would be helpful in coping with your emotions after a patient's death? (please circle)

YES NO

Why? Why not?

_____

_____

2. How likely would you be to participate in a structured debriefing session if it were available? (please circle)

1-unlikely, 2-somewhat likely, 3-neutral, 4-very likely 5-definitely

1 2 3 4 5

3. Have you ever experienced any of the following after a patient has died: (please circle)

- anger YES NO
- nightmares YES NO
- sorrow YES NO
- guilt YES NO
- anxiety YES NO
- depression YES NO

Please add any additional comments below:

_____

_____

_____

4. When was the last time you experienced a patient death?

_____

DATA CODE:

1: less than a month ago
2: 1-7months ago
3: 7-12 months ago
4: 1-2 years ago
5: 2-10 years ago
6: 10+ years ago

5. As a rough estimate, how many patient deaths have you experienced in your career as a RN?

_____

6. What unit do you currently work on?

_____

7. In what year were you born?

_____

8. In what year did you get your RN licensure?

_____

9. What is your highest level of education?

CODE: 1- Associate
2- Bachelor
3-Diploma
4-other

APPENDIX B

DEBRIEFING POLICY

Approval_____ Director Performance Excellence	Title: **Debriefing for nurses following patient death** Section: Staff Effective date: 4/09 Number Last Review Date: new Pages 1 of 1 Next Review Date: Contact person:

DEFINITION: **Debriefing:** Debriefing is defined as an information-sharing and event processing session consisting of a conversation between peers.

POLICY:

1. All nurses will have debriefing available to them following a patient death.
2. The debriefing session occurs within 24 hours of the patient death.

PROCEDURE:

1. A nurse requesting debriefing will put a verbal and/or written request to the manager on his or her unit.
3. The nurse manager will schedule 1-2 hours for the debriefing and coordinate staffing to cover for the debriefing time.
4. There will be debriefing leaders on each unit (who are also staff nurses) available to lead debriefing sessions.
5. Documentation of the debriefing will be provided to Human Resources after the debriefing session.
6. Any staff with follow-up concerns will be referred to the hospital's Employee Assistance Program.
7. Evaluation forms regarding the debriefing will be filled out by staff upon completion of the debriefing session. These evaluations will go to the leaders and manager of the unit.