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Ward staff experiences of patient death in an acute hospital setting

Wilson JL (2014) Ward staff experiences of patient death in an acute hospital setting.

Abstract

Aim

The aim of this study was to explore specifically how ward staff, including registered nurses and healthcare support workers, experience patient death in an acute medical setting.

Method

A Heideggerian phenomenological approach was used to gather and analyse the data. Thirteen ward staff; eight Registered Nurses and five healthcare support workers were interviewed about their experiences of patient death in this setting, what they perceived as influencing their responses and what support mechanisms were helpful.

Findings

These were grouped into three essential themes; behavioural responses, influences and support. These were further subdivided to reflect the theoretical context of the study from social psychology literature of coping strategies, disenfranchised grief and emotional intelligence and the empirical context which includes the environment of care, the individual's professional status and the wider policy context of healthcare provision in the National Health Service (NHS)

Conclusion

The findings from this study add new knowledge about staff experiences of patient death in the specific setting of an acute medical ward. The findings could have implications for clinical practice, the provision of support for nursing staff and contribute to future policies regarding end of life care and in this healthcare setting.

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Keywords

Nurses grief, staff grief, emotional support, acute setting, bereavement, patient death, disenfranchised grief, emotional labour, emotional intelligence

The death of a patient is an event that most, if not all, ward staff (including registered nurses and healthcare support workers) will encounter as part of their work in a care environment. Ward staff have a key role in caring for patients who die (Dunn *et al* 2005), and this aspect of healthcare has been described as one of the most demanding (Loftus 1998). Parry (2011) found that nursing students' first experience of caring for patients who die could be a

stressful but influential experience, and that ward staff need to be adequately supported when they encounter this aspect of nursing care.

Over 245,000 patients die in acute hospitals each year in England and Wales (Office for National Statistics 2013). Acute hospitals in this context are defined as hospitals intended for short-term medical and surgical treatment and excludes mental health and long-term care facilities. 49% of the total number of deaths recorded in 2012 occurred in hospital compared with 22% of people who died at home, 6% who died in hospices and 21% who died in community establishments such as nursing and care homes (Office for National Statistics 2013). In some areas of acute care in hospital settings, patients might have several hospital admissions or prolonged stays in hospital prior to their death in hospital so both them and their families become known to nursing and other healthcare staff.

Literature review

Theories of loss and death developed throughout the past century have identified a range of responses including physical, cognitive, behavioural and spiritual issues (Wilson and Kirshbaum 2011). A literature search revealed that the focus of most previous research was on the responses of healthcare staff caring for children or those working in palliative and long-term care settings (Rickerson 2005, Meaders and Lamson 2008). There was a lack of studies relating to the experiences of ward staff after patient death in acute adult wards specifically. Rickerson *et al* (2005) conducted a quantitative study of staff working in six long-term care institutions in the United States. Staff who experienced the most grief-related symptoms were those who had worked for the greatest length of time in the institution and had closer and longer-lasting relationships with the patients who had died. Commonly reported responses to patient death were feeling sad, crying, thinking about death and the negative effect that the death had on their relationships and performance both at home and at work. Performance in this context refers to their ability to concentrate and focus on their work. Irvin (2000) found that registered nurses had strong emotions when residents in their care home died and participants expressed difficulty in managing their feelings in this setting.

Meaders and Lamson (2008) studied compassion fatigue in nursing staff in paediatric intensive care units. As children live longer with chronic conditions, nurses and other care givers were at increased risk of developing compassion fatigue, which can be defined as loss of the ability to provide the same level of compassion to patients and their families over time (Figley 2002).

Coping and defence mechanisms

Other literature drawn from the wider area of social psychology included the use of coping and defence mechanisms. Coping mechanisms, such as detachment and social withdrawal, were reported by Sonnentag *et al* (2010) to help employees maintain clear boundaries at work, with a lack of detachment leading to increased risk of burnout and emotional exhaustion. Menzies-Lyth (1960) identified that nurses used a range of defence mechanisms to cope with the anxiety they experienced in their work. Although this study was carried out over 50 years ago, the research was seminal in identifying defence mechanisms used by nursing staff, some of which are still relevant to healthcare today. The mechanisms identified by Menzies-Lyth included task allocation to prevent prolonged contact with individual patients, following set policies and procedures to eliminate individual decisions, Individual decisions means that nurses did not take sole responsibility for a decision related to a patient's care but consulted with other staff so that a joint decision was made. the distribution of responsibility to other levels in the hospital hierarchy and the avoidance of change By avoiding change, nurses avoided the stress of trying new ways of operating and felt comfortable doing tasks in ways that were familiar to them. The issues relevant to current healthcare include the following of set procedures and the distribution of responsibility to other levels of staff in the hospital hierarchy (Krantz 2010).

Emotional labour and emotional intelligence

The recognition of the importance of emotional labour within nursing has led to the development of the related concept of emotional intelligence (Smith 2012). Emotional labour was identified by Hochschild (1983) and is described as the suppression or induction of emotions in order to project the outward appearance that others are being cared for in a safe environment. Although this research was conducted 30 years ago and involved studying the behaviours of cabin crew in aircrafts, it identified emotional labour, which is an important concept for nursing and other healthcare staff today. For nurses, emotional labour can involve smiling and talking in a calming voice even though they may be anxious or worried (Smith 2008). Emotional intelligence involves an individual being self-aware, able to recognise and manage their own emotions and to have insight into how they relate to others (McQueen 2004). Emotional intelligence has been identified as a feature that is essential for nursing work (Freshwater and Stickley 2004).

Disenfranchised grief

In 1987, Doka reported that some people feel unable to or are not allowed to express their grief following a bereavement. Doka called this concept disenfranchised grief and defined it as grief that is not openly acknowledged, socially validated or publicly observed. Disenfranchised grief is an understudied phenomenon in health care (Spidell *et al* 2011).

Although loss and death is a recurrent event in this area of work, it is frequently overlooked and ignored. Romesberg (2004) proposed that disenfranchised grief resulted in an increased risk of healthcare staff developing compassion fatigue and burnout as a result of not having their grief acknowledged and of not being given an opportunity to express their emotions following patient death.

Healthcare policy in the UK Employees in health and social work in the UK have been identified as having some of the highest rates of self-reported stress, anxiety and depression (Health and Safety Executive 2008). Dame Carol Black's review of the health of the UK's working age population (Department of Work and Pensions and Department of Health 2008) identified key issues, including early intervention, prevention and proactive responses, to develop health promotion in workplaces.

Two influential documents were published in 2010; *The Route to Success in End of Life Care—Achieving Quality in Care Homes* (NHS National End of Life Care Programme 2010a) and *The Route to Success in End of Life Care—Achieving Quality in Acute Hospitals* (NHS National End of Life Care Programme 2010b). The former document acknowledges that the death of a care-home resident can remain a lasting memory for staff and that support for them is important. The latter, however, contained no acknowledgement of the potential effect of a patient death on staff or the need for staff to be supported at this time.

Aim

The aim of this study was to explore specifically how ward staff, including registered nurses and healthcare support workers, experience patient death in an acute medical setting. These findings will add to the existing body of knowledge, in terms of the experiences of ward staff relating to patient death in an acute care setting at a personal, professional and organisational level. The findings may also have an effect on the broader context of healthcare policy and practice. The objectives of this study were to:

- Identify staff responses to patient death
- Discover factors that staff perceive influence this response
- Analyse the way the support mechanisms of a hospital ward setting affect the experience of death in personal and professional terms, with reference to the organisational culture
- Compare the experiences of nursing staff with that of healthcare support workers
- Assess the wider implications for healthcare policy and practice

Both registered nurses and healthcare support workers were included in this study as they both work together in the ward setting caring for patients, and it was thought that both groups may form relationships with patients and may therefore be affected if a patient dies.

Method

Heideggerian phenomenology, a qualitative approach used previously by Callaghan (2010) and Standing (2009), was used in this study. The purpose of this method is to fully describe the lived experience of a certain phenomenon as expressed by the people who have experienced it and to achieve a deeper understanding of the nature or meaning of these experiences (Cresswell 2007). This approach asserts that preconceptions, such as existing knowledge and beliefs, are legitimate components of the research and that the experiences of researchers and participants can be combined to create a shared understanding of the phenomena being studied (McConnell-Henry *et al* 2009).

Study participants

The study was carried out from May 2010 to September 2011 and involved ward staff from two acute medical wards caring for patients with respiratory conditions. Participants were selected using a technique known as 'judgement' or 'purposive sampling' (Parahoo 2006), in which participants are selected on the basis that they can inform the research question. Inclusion criteria were that participants: worked as registered nurses or healthcare support workers; worked in the selected wards, in this case an acute adult medical ward; and had cared for patients who had died in this setting. A pilot study with three participants was conducted initially to test the methodology, and confirmed that the objectives could be met by using this method so no changes were made before data collection for the main study. A total of thirteen staff members were recruited (three from the pilot study and ten from the main study). Of these, eight were registered nurses and five were healthcare support workers. One participant was male and 12 were female. The ages of the participants ranged from 22 to 55 years and the range of time they had worked in acute respiratory medical wards varied from two to more than 10 years.

Data collection

Data was collected from individual interviews, which began with an open-ended question to allow participants to describe their experiences of patient death. If participants did not cover all the aspects of the study objectives in response to the first open ended question **then** prompts were used to explore these additional topics. The researcher was not known to the participants; however, the participants did know that the researcher was a nurse, which may have influenced the interview process. For example, knowing that the researcher was also a

nurse might have enabled participants to speak more comfortably about their personal experiences and responses to patient death, without having to explain what their job involved. Also they could use language and abbreviations familiar to healthcare staff, such as COPD (chronic obstructive pulmonary disease), knowing that the researcher would be familiar with these terms. It is also possible that participants might have felt inhibited in sharing their views with the researcher, who they might have viewed as an authority figure, and may have said things that they thought the researcher wanted to hear rather than sharing what they really thought. It was stressed from the outset that the researcher did not work for the hospital trust, and that all information given would be anonymous. The researcher might have made assumptions based on their own experience, which may or may not have been relevant or applicable to the participants in the current study. For example, the researcher might have assumed that the participants definition of words they used was the same as their own, or that the work setting of the participants was the same or similar to that of the researcher. To allow for this, participants were asked for definitions of some words used, and the researcher did not rely on their own interpretation of what was said.

The length of the interviews ranged from 30 to 60 minutes and they were carried out in a private office away from the clinical area where the participants worked. Interviews were recorded and transcribed in full by the researcher. Names and other identifying features mentioned in the interviews were removed to preserve the confidentiality of the participants and patients.

Data analysis

Data analysis was carried out in two stages; following the first interviews, an initial analysis of the transcripts identified pertinent and commonly reported phrases. These phrases were written on cards and the participants were asked at a second interview to identify the phrases that were relevant to them and to sort them into groups, giving each group a title. The next step of the process, referred to as 'phenomenological reflection' (van Manen 1990), was carried out with a thematic analysis. The groups of phrases were further scrutinised by the researcher, along with the interview transcripts, to confirm the groups or preliminary themes. These were further reviewed by the researcher and the essential themes derived.

Ethical issues

The regional NHS ethics committee approved the research proposal. Unit managers were provided with information about the study and their permission was obtained before staff were approached. All 13 participants in the study signed informed consent forms.

Findings

Table 1 shows the preliminary and essential themes derived from the interview data. The participants' quotes from the interviews are identified as being from registered nurses (RN) or healthcare support workers (SW).

Table 1. Preliminary and essential themes

Essential theme	Responses	Influences	Support
Preliminary theme	Behaviour Thoughts	Pressure Life experiences Expectations Type of death	Support (actual) Support (desired)

Responses

From the two preliminary themes of behaviour and thoughts, release of emotions through behaviour and the rationalisation of thoughts were common features reported by participants. *It upset me, I went home and cried.* (Participant 3, RN)

Taking time out away from the patient area, and particularly having a cup of tea, was highlighted by several participants. Several participants mentioned the importance of talking to others

We took time out, we went and had a cup of tea. (Participant 1, RN)

I'm one that likes to debrief and talk about the death. (Participant 6, RN)

Thoughts included rationalising why patients had died; registered nurses in particular related checking through in their minds that everything had been done correctly. The nurse quoted below (Participant 6) explained that, for her, this meant that aspects of physical and emotional care were delivered well, including spending time with the patient, talking to them, the giving of medication, food and drink and of being available to give support.

I can rationalise that people with ill health die. (Participant 1, RN)

I always think was everything done right. (Participant 6, RN)

Influences

There were four preliminary themes in the essential theme of influences: pressure, life experiences, expectations and type of death. Some overlap between these preliminary themes was noted. For example, participants' life experiences influenced their expectations and there were links between the type of death (for example, from a certain type of cancer)

with a participant's experience of a relative with the same condition. Organisational pressures were identified by the registered nurses specifically in terms of the constant demand for available beds and the need to carry out other nursing duties after a patient death.

It's very rushed; we need to get the patient to the mortuary quickly as we need the bed for the next patient. Recently a nurse arrived on the ward with a patient saying they had come as we had a bed free for the new patient. The bed still had the patient who died in it and his relatives were still with him. We had to ask the new patient to wait in the day room, we felt very pressurised. (Participant 5, RN)

After someone dies there is no time to think about what has happened. You've got to get on with the next job, admitting someone, doing the drugs or whatever. (Participant 1, RN)

Although the life experiences of participants were varied, all had some personal experience of loss or death in their own families and talked about how these experiences affected them at work.

It affects me on here, because my [relative] has cancer. (Participant 2, SW)

My [relative] died last year, it made death more difficult on the ward. (Participant 10, RN)

Some participants expressed the view that their life experiences helped them to develop skills in managing their emotions after a patient death. The following quote is from participant who had worked in this area of healthcare for over 30 years.

As the years have gone on it has got easier, I think you perhaps learn to manage your feelings better (Participant 5, RN)

There were a range of expectations expressed by the participants. Some of these were overt, where staff were actually told how they should behave following a death, and some were implicit, where staff knew as a result of professional socialisation what was expected of them.

I knew she [a new support worker] was going to cry, I said, don't you dare. (Participant 12, SW)

If I get upset, my colleague says, 'you must leave it at work' and I try to do that, but sometimes it's difficult. (Participant 7, SW)

I think there is a big expectation that you can cope, because it's an expected part of your role. (Participant 10, RN)

Within the preliminary theme of type of death, issues raised included the manner in which the patient died, the personal circumstances of the patient, and the relationship the

participant had with the patient. If the patient death was unexpected or traumatic, the response from ward staff was greater in terms of shock and feeling upset.

It was very visual [a fatal haemoptysis]. I can still picture it now even though it was when I first started on this ward, so a long time ago. (Participant 1, RN)

Sometimes the reaction of a relative affected the response of the participant.

He died and she [the patient's sister] was still holding on to him, she was devastated, he was her everything. That really played on my mind and I went home and cried. (Participant 5, RN)

Patients who were a similar age to the participant when they died or who were young had a particular effect on the participants.

A patient died who was the same age as me and had children a similar age, I felt acutely aware, that could be me. (Participant 1, RN)

One young woman with two small children died, it was heart-breaking (Participant 6, RN)

Regarding the relationship staff had with patients the following comments were made:

You build up relationships with patients and their families, and then when they die it is quite traumatic (Participant 6, RN)

If you've not really got to know them, it does matter (when they die) but it doesn't affect you as much (Participant 2, SW)

Support

The theme of support included what support was currently available and what support was desired by participants. Many of the participants had people they talked to at work and from whom they received support.

I think you find your own support networks. I've got really good colleagues on here. (Participant 6, RN)

There were occasions when staff felt they did not receive support from others at a time they needed it.

When the patient with the haemoptysis died I think we couldn't have done anything. I can remember sitting with him on the bed. Sitting and talking to him even though I knew he was just dying in front of me, in front of my eyes and glad there was somebody there to do that, that he wasn't on his own and he could hopefully hear me, even though everything wasn't going to be all right he knew someone was there speaking to him. It was over quite quickly for him, it was traumatic all round for everybody. Everybody wanted to talk about what happened, but that day there was no time, we just carried on (Participant 1, RN)

Two participants said they engaged in banter and black humour with colleagues, which helped them to cope with their experiences of patient death.

I think it's perhaps the banter between staff that gets you through it. (Participant 10, RN)

Regarding what support participants would like to have, some felt there was little that could be done in the present climate of healthcare.

I think it is just the acute care setting and the pressure of beds, I don't know how it could be any different. (Participant 5, RN)

Participants recognised that taking even a short time away from the clinical area to have a brief conversation and a drink of tea could be beneficial. Although it would not resolve the emotional response, it could enable them to begin to process what had happened and help them continue to concentrate on their work for the remainder of their shift.

If there was something in place where you could have some time away, I don't mean go off somewhere for a few hours, but within the shift. If you had somewhere to talk about it, even if it was just two people then that would be helpful. (Participant 1, RN)

Two participants said they would like more understanding from managers.

They (managers) don't seem to value or have insight into the stresses at ward level. (Participant 6, RN)

Three participants expressed reluctance to access counselling services as they felt this would be viewed negatively by colleagues.

I can imagine if I said, 'I've accessed this service', it'd be like 'get over it', 'pull yourself together' and I do think that's how it would be (Participant 5, RN)

I think staff maybe wouldn't access it as there may be a fear it would be seen as a weakness. (Participant 8, RN)

Discussion

All of the participants in this study related individual accounts of their own experiences of patient deaths that had had an emotional effect on them. This demonstrates that, as well as caring physically for patients, the ward staff engaged emotionally with those they cared for.

Pressures and coping strategies

The pressure of bed provision elicited emotional responses as participants expressed the conflict they felt of needing to make the bed available to the next patient but also wanting to

allow relatives to spend time with the patient and to perform care after death in a respectful and unhurried manner. Stories involved incidents of a new patient arriving on the ward for a bed that still contained the dead person; phone calls asking when the bed would be available were related by four participants. These accounts were accompanied by expressions of anxiety and concern by the participants. As this study was conducted in an acute hospital setting, this distinguished it from other studies and the issue of pressure appears to be particularly pertinent in this setting.

Another pressure was the workload on the ward. Staff were aware of things they needed to do, for example to admit a patient, give out medications and write up records. Several participants said they did not allow themselves to have time out to reflect on or process what had happened after a patient death because of these pressures. Some participants reported thoughts about a patient death intruding into their mind in the evening at home or at night when they went to bed.

Some staff had developed strategies that helped them personally and had strategies in place to manage their response to patient death. These included having a network of colleagues they felt they could talk to and some described having clear boundaries around work, enabling them to leave work and not allow thoughts to intrude into their personal lives. Two participants who had both worked in an acute ward setting for over 20 years had very clear strategies regarding their support networks and boundaries; both these staff members felt they had developed these skills over time to manage their emotions in the work setting.

Humour between staff was used to relieve the tension on the ward and to help defuse a tense situation. However, the interpretation of humour was recognised as varying from person to person. Sensitivity and intuition were used to judge the appropriateness of humour with specific colleagues and, as identified by Astedt-Kurki and Isola (2001), humour was contextual. These strategies demonstrate the use of emotional intelligence as staff were aware of their own emotional responses, were able to regulate these in the work setting and managed them through coping mechanisms which were effective for them personally. Although several participants exhibited these features, none of them used the term emotional intelligence during the interviews.

Regarding support services provided by the healthcare organisation, most participants expressed the view that they would like some form of support locally on the ward, something more informal than a counselling service, where they could talk about their experiences. This view is in alignment with the research by McCreight (2004), who found that staff did not want

to attend formal counselling as this was viewed as showing a weakness or being unable to cope with your role. Clinical supervision could meet the need for staff to have a local, informal system of support where they could share their experiences in a safe and confidential setting.

Differences between responses from registered nurses and healthcare support workers

There were several areas where the responses of registered nurses differed from those of healthcare support workers. Registered nurses were proactive in seeking out colleagues with whom to talk for support and recognised the importance of taking time out away from the clinical area for a short break. This could indicate that registered nurses had more awareness of the need to manage their emotions and sought to do this. Registered nurses also tried to rationalise their thoughts after a patient death and reported having a checklist in their heads that they used to determine whether everything had been done correctly in caring for the patient. Registered nurses were aware of the organisational issues around patient death and were mindful of their responsibilities regarding management of their work and of supporting more junior staff. This could relate to the issue of professional identity, with registered nurses feeling a responsibility to support more junior colleagues.

Healthcare support workers spoke of the support they received from colleagues and in both groups younger members of staff commented on the encouragement they were given by more senior and experienced members of nursing staff. Some healthcare support workers said they did not talk about their experiences to others and it was a healthcare support worker who became abrupt and snappy at home following a patient's death and was not aware of this until it was pointed out by family members. This could indicate that some healthcare support workers may lack self-awareness of their own emotional responses to situations such as the death of a patient and may need support in both identifying and managing their emotions.

Wider implications

Guidelines published by the National Institute for Health and Clinical Excellence (NICE 2009) relating to staff health in the work environment stress the importance of promoting the mental wellbeing of employees to increase job satisfaction and staff retention, improve productivity and reduce staff absence. The current study found that some participants felt their managers did not appreciate the stress caused by patient death and that facilities were not available that could be accessed easily at ward level. Although there is a counselling service staff can access within the organisation, several participants were reluctant to do so because they thought it would be viewed negatively by colleagues.

This study also showed that nursing staff are affected by patient death in an acute hospital setting, and that there is a need to acknowledge this and to support staff. These findings could provide the National End of Life Care Programme with useful information for their future work regarding guidance for end of life Care in acute hospitals (NHS National End of Life Care Programme 2010b).

Disenfranchised grief, as defined by Doka (2002), was identified in this study. Although no participants mentioned this phrase, many reported that the effect of a patient death on staff was not openly acknowledged or socially validated by managers or by some of their colleagues. Some staff reported not recognising the effects of grief in themselves; it was not until a behaviour change was pointed out to them by colleagues or family members that they realised they were reacting to a patient death at work. Education and skills training could be beneficial in helping staff to increase their emotional self-awareness and to develop constructive coping strategies.

There are certain findings from this study that have not been identified in previous studies. Some of these seem to be particularly relevant to the acute hospital setting:

- The acknowledgement that nursing staff are affected by patient death in this setting.
- The differences between registered nurses and healthcare support workers in relation to identifying and managing their emotional responses to patient death.
- The lack of awareness, knowledge and use of emotional intelligence among some clinical staff in this setting.
- The pressure to make a bed available quickly for a newly admitted patient after a patient has died on the ward.
- The need for staff support available locally to enable staff to have a short break away from the clinical area.

Study limitations

The aim of qualitative research is to open up discussion and debate and to sensitise readers to new ways of thinking (Green and Thorogood 2014). The transferability of the findings to other settings may also be considered. The findings from this study raise some important issues for debate and inform thinking in various areas. In analysing the transcripts from this study, findings were compared with more general social science literature related to this issue. These issues included the level of insight and awareness that ward staff have of

emotional intelligence and their knowledge of bereavement theories, including disenfranchised grief (Doka 2002), and of the culture in which they are working.

The number of participants recruited in this study was determined by examining numbers of participants in similar studies. The clear inclusion criteria for the selection of participants ensured that only ward staff working in the selected area, and with appropriate experience of caring for patients who had died, were included in this study. It may be that some staff, who had experienced the death of a patient they had cared for, declined to be involved in this research. As a result, pertinent information, which may have made a valuable contribution to this research, could have been omitted.

The setting for this study was an acute ward in a large teaching hospital in the north of England that specialised in caring for patients with respiratory conditions. These factors could be pertinent to the findings of this study as this type of ward has patients who have recurrent admissions, over a period of several years. This means that staff become known to the patient and their relatives over a period of time and the staff may have a different response to the deaths of these patients than to patients they have only known for a few days. Future research could involve a similar study conducted in a ward caring for patients with other types of chronic illnesses, for example heart disease, in a smaller hospital, and in another area of the country. This could add useful knowledge by confirming any similarities or identifying differences between ward settings.

Data collection and analysis during the research process was part of the methodology used. In the initial interview, each participant was asked very open questions, and clarification was sought by asking participants what they meant by specific words and phrases they used. The second interviews used words and phrases recorded in the first interviews, and participants were able to confirm that these were significant or otherwise and also to clarify the meaning they gave to these words and phrases. The purpose of this was to guard against anecdotalism, which is described by Green and Thorogood (2014) as the reporting of issues from interview transcripts that have caught the attention of the researcher but are not rigorously supported by a systematic analysis of the interviews. By asking participants to group their responses under headings they chose themselves, the meanings were confirmed and verified by the participants and not by the interpretations of the researcher.

Conclusion

There is little information in the literature concerning the responses of ward staff to patient death in the setting of an acute medical ward. The key findings of this study provide an

opportunity to open up discussion and debate regarding this specific area of care with regard to the responses of nursing staff to patient death. The findings from this small study identified two types of disenfranchised grief; firstly, some participants did not recognise that they were experiencing grief as a result of patient death; and secondly, the effect of a patient death was not recognised or acknowledged by managers and some colleagues.

Other findings from this study related to differences in responses between registered nurses and healthcare support workers, the awareness and use of emotional intelligence, and the effects of professional socialisation. These findings relate to the themes identified from the literature review in terms of the theories of grief and bereavement, grief support and education for staff.

Implications for practice

The following recommendations may inform thinking and stimulate discussions about practice in this area of nursing:

- The need for both individuals and the healthcare organisation to acknowledge and take action to ensure staff grief is recognised and that there are mechanisms in place to provide staff with the necessary support and resources to manage their grief.
- Provision of education and training to increase knowledge and skills in the use of emotional labour and emotional intelligence.
- Raising awareness of the effect of professional socialisation and opportunities to promote cultural changes in this setting.
- The introduction and establishment of regular clinical supervision for staff, to include support in the development of constructive coping mechanisms.

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