

St. Catherine University

SOPHIA

Master of Social Work Clinical Research Papers

School of Social Work

5-2014

Hospital Staff and Bereavement Services: Examining Compassion Fatigue in Nurses

Kelly McManimon
St. Catherine University

Follow this and additional works at: https://sophia.stkate.edu/msw_papers



Part of the [Social Work Commons](#)

Recommended Citation

McManimon, Kelly. (2014). Hospital Staff and Bereavement Services: Examining Compassion Fatigue in Nurses. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/362

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact amshaw@stkate.edu.

Hospital Staff and Bereavement Services: Examining Compassion Fatigue in Nurses

Submitted by Kelly McManimon
May 2014

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work
St. Catherine University/University of St. Thomas
St. Paul, Minnesota

Committee Members:

Lance A. Peterson, PhD, St. Catherine University/University of St. Thomas
Theresa Huntley, LICSW Children's Hospital & Clinics of Minnesota Pediatric Cancer and
Blood Disorders Program
Bridget Chastain, RN Children's Hospital & Clinics of Minnesota Cardiovascular Critical Care
Unit

Table of Contents

Table of Contents.....	ii
List of Tables.....	iii
Abstract.....	iv
Acknowledgments.....	vi
Hospital Staff and Bereavement Services: Examining Compassion Fatigue in Nurses.....	1
Literature Review.....	5
Conceptual Framework.....	20
Research Design.....	23
Sample.....	24
Protection of Human Subjects.....	26
Data Collection and Data Analysis.....	28
Quantitative Findings.....	29
Qualitative Findings.....	36
Discussion.....	54
Implications for Future Research.....	60
References.....	63
Appendix A: Agency Consent Form.....	70
Appendix B: Informed Consent Form for Survey.....	73
Appendix C: Consent Form for Face-To-Face Interview.....	76
Appendix D: Professional Quality of Life Scale (ProQOL).....	78
Appendix E: Face-To-Face Interview Questions.....	81
Appendix F: UST Review Board Approval.....	82
Appendix G: Children’s Hospital and Clinics of Minnesota Internal Review Board Approval.....	83

List of Figures and Tables

<i>Number</i>	<i>Page</i>
Figure 1: Gender Distribution	30
Figure 2: Age Distribution	31
Figure 3: Years of Experience	32
Table 1: Compassion Fatigue, Burnout, and Secondary Trauma	33
Table 2: Descriptives for Years of Experience and Compassion Satisfaction	34
Table 3: ANOVA for Years of Experience and Compassion Satisfaction	34
Table 4: Descriptives for Years of Experience and Burnout	35
Table 5: ANOVA for Years of Experience and Burnout	35
Table 6: Tukey Post Hoc	35
Table 7: Descriptives for Years of Experience and Secondary Trauma	36
Table 8: ANOVA for Years of Experience and Secondary Trauma	36

Hospital Staff and Bereavement Services: Examining Compassion Fatigue in Nurses

By: Kelly McManimon

Research Committee:	Chair:	Lance Peterson, Ph.D.
	Members:	Theresa Huntley, LICSW Bridget Chastain, RN

Abstract

Disenfranchised grief, often experienced by nurses, can then lead to compassion fatigue if left unattended. The prevalence of this concern is rising and the literature shows that this issue clearly needs to become more centralized in the hospitals in which these nurses work. Social workers hold an important role in recognizing the needs of hospital staff and helping to address the issues of grief and loss with those who care for patients. In order to address these concerns a quantitative survey was conducted in one area pediatric hospital to address the effects of this phenomenon. The sample consisted of . . . The correlation between years of experience and the level of compassion satisfaction, burnout, and secondary trauma showed no statistical significance; however, the rate of burnout in nurses who have the most years of experience showed that the statistical significance is approaching relevance, and with a larger sample size may demonstrate a correlation. Following the survey a qualitative face-to-face interview took place with a random selection of volunteer participants, the results of which were analyzed and coded for themes. The findings suggested that grief supports and managing the grief symptoms

helped to eliminate some of the immediate symptoms of grief. The nurses' concerns over what services were offered and what services were useful were also major themes in the research. What was found suggested that many of the nurses have alternate ideas of which bereavement services would be more beneficial to their disenfranchised grief to help eliminate the risk of compassion fatigue. Further research is needed to determine the best ways to alleviate the bereavement that nurses feel following the death of a patient, while still following policy and agency protocol in a hospital setting.

Acknowledgments

I would like to begin by thanking the participants of this study for allowing me to conduct this research. To all of the RN's who work there tirelessly caring for the most important patients, I extend my most heartfelt thank you for doing what you do, and for also making extra time to assist me in this research. My thanks also to the University of St. Thomas and its Institutional Review Board for allowing me to complete this research. Thank you to Dr. Lance Peterson for your continued support, encouragement and confidence this project would get completed.

Without your help it never would have been done. Thank you, Theresa Huntley and Bridget Chastain for your willingness to be on my committee and assisting in this project. With your insight and assistance you have both made this project better. I could not have made it through this program or this research without the support of my husband Ryan and my daughter Elliott, I love you both to the moon and back! To the rest of my family and friends who jumped in and helped with childcare, cleaning and feeding my family while I was in school, thank you, thank you, thank you! Last, but certainly not least to Charlotte "Charlie Girl" my angel baby; you are the reason I went to graduate school. I chose social work in order that I may give back to others what we were given: love, support and care. By doing this research in the very place you lived and died I feel this program has brought me full circle in accomplishing my goal. I hope this project will in some small way honor the nurses who focused their attention and care on you, and recognize that they too need our attention and care. Now I look forward to giving back in your honor and in Elliott's by caring for others each and every day. Your beautiful life has inspired so many, it was brief yet powerful and I owe this accomplishment to you,

charlie girl

Hospital Staff and Bereavement Services: Examining Compassion Fatigue in Nurses

Problem

Grief is an emotional affliction that we feel after a loss. It affects everyone at some point in his or her life. For many individuals grief is the result of a death of a loved one, a family member or friend, and occasionally it is after the loss of a pet, or a job, or termination of a relationship. Grief is an experience that all of us will encounter and processing that grief can be very trying. For those whose grief is considered disenfranchised it can prove to be even more difficult.

Disenfranchised grief is an unrecognized right to grieve (Doka, 1989). Doka (1989) explains that disenfranchised grief is considered insignificant because the bereaved does not have a socially accepted relationship to the person who has passed. This is true of nurses and other healthcare professionals. Critically ill patients are in the care of nurses and often times die in their care; however, the nurse is not considered to have an established, acceptable relationship to the patient and so does not receive the recognition or the right to grieve. This is disenfranchised grief. Disenfranchised grief can cause a host of problems if left unattended and in many instances for nurses can lead to what is known as compassion fatigue. Compassion fatigue is when a nurse has extended himself or herself beyond the ability to emotionally care and be empathetic with patients due to the constant caring and compassionate care for others. "Compassion fatigue, a stress response that is sudden and acute has been defined as a physical, emotional and spiritual fatigue or exhaustion that takes over a person and causes a decline in his/her ability to experience joy or care for others" (McMullen, 2007, p. 491-492).

Scope

The prevalence of this problem is becoming more and more recognized in recent years. Joinson, a nurse, coined the term compassion fatigue in the 90's. Two decades later, according to Coetzee & Klopper, the phenomenon of nurses being unable to nurture their patients is extensive in nursing practice (Coetzee & Klopper, 2010). Nurses are more involved in end of life care of patients, and because of advances in modern medicine people's lives are prolonged. This means that healthcare professionals are often more involved when death does occur because the patients are suffering from chronic or intensive medical maladies and are in intensive care units (Shorter & Stayt, 2009). Nurses are responsible for caring for the sick, wounded, and traumatized; their empathetic care in the presence of pain, trauma and suffering makes them infinitely more susceptible to the feelings of sadness and loss after the death of a patient (Coetzee & Klopper, 2010). Nurses continuing to care for many patients that are critically ill can develop cumulative grief, and because nurses' grief is disenfranchised, this grief remains unresolved. Over time, this cumulative grief may lead to compassion fatigue (Marino, 1998 & Hopkinson, et al, 2004 - as cited in Shorter & Stayt, 2009).

With the number of nurses registered in the US at 3.1 million they are considered the largest group of healthcare providers. With compassion fatigue being a very real and present risk for nursing staff, it is imperative that countering the effects of disenfranchised grief is a priority. Melvin (2012) discussed the need for more research to be done to understand the true scope of nurses who experience compassion fatigue and to what extent.

What Nurses Are Experiencing

In order to address the problem, there needs to be a clear identifiable point of intersection for the social worker to implement change. The disenfranchised grief of nurses is clearly an issue and its prevalence in healthcare settings can cause harm not only for the nurses who are at risk for compassion fatigue but also for their patients' quality of care and the healthcare facilities by the inability to retain nurses because of job dissatisfaction. If the grief is left unattended and compassion fatigue follows, many nurses become so burned out that they care poorly for their patients and some ultimately quit their jobs. Joinson described the phenomenon of unidentified stress due to caring for critically ill and dying patients as detrimental to the nurses' ability to continue effective care, a sense of emotional exhaustion (Coetzze & Klopper, 2010). Joinson continued to explain that compassion fatigue can be invasive and dominating, and if unaddressed, can limit nurses' ability to function. However, Joinson did recognize that if nurses' grief and stress are recognized and signs of compassion fatigue are heeded and appropriately addressed nurses could continue effectively in their role with self-care and supportive services in place (Joinson, 1992).

Significance To Social Work

Social workers will be confronted with grief and loss throughout their professional careers. If this grief is left unattended it will result in many other complex problems for those who are suffering. It is the job of the social worker to assume the responsibility of using the skills and knowledge that they possess in helping to care for those that are grieving (Pomeroy, 2011). Competence in grief work is essential since all social workers will be confronted with grief work. It is important for those in the

profession of social work to be mindful of this reality and to be prepared to not only care for those individuals who can openly express and identify with their grief but also for those whose grief is disenfranchised or kept quiet. Attig (2004) attends to this idea when he explains that for a bereaved individual grief is a right to mourn when and how he/she chooses without restriction from others. Consequently, disenfranchised grief then is a violation of a bereaved individual's right to mourn.

Attig (2004) continues to express the seriousness of unattended disenfranchised grief when he explains that, "Disenfranchisement of grief is a political failure involving both abuse of power and serious neglect. And it is an ethical failure to respect the bereaved both in their suffering and in their efforts to overcome it and live meaningfully again in the aftermath of loss" (Attig, 2004, p. 200-201). As social workers it is our ethical prerogative to care for those who are suffering and provide them with the justice they deserve. In the NASW Code of Ethics, social justice is one of our ethical mandates as social workers. We are to provide social justice on behalf of vulnerable and oppressed individuals providing them with the resources and services they are in need of in order to ensure they are provided with the care they need (NASW, 1999).

Purpose Of The Research

This leaves a substantial gap in care; what bereavement services are being provided and do they attend to the nurses' grief? If this is not understood how can the hospital implement appropriate bereavement services? Are the services provided addressing the specific concerns of the grieving nurses? It is ideal to have bereavement services in place; however, if they are ineffective at supplying the nurses with coping skills and bereavement care, are they even beneficial? By understanding the needs and

desires of the nursing staff in their grief, the bereavement services and social workers at the facility will be able to meet the clients (i.e. nurses) where they are at. This will allow the nurses to take care of their emotions in a healthy manner and be able to recognize the signs and symptoms of compassion fatigue in time to address them and eliminate job dissatisfaction and burnout. This is where social workers can play a big role--by providing understanding of what kind of care will effectively help nurses in their grief they can implement appropriate bereavement services.

This research project consists of a twofold purpose: (1) to understand the relationship between years of experience in the nursing field and burnout, as well as compassion satisfaction; (2) to understand what healthcare facilities offer for nurses' disenfranchised grief and whether that addresses the compassion fatigue many nurses experience.

Literature Review

Grief

Grief impacts all individuals. It can be disruptive and life altering for many. For many people they experience the bereavement in a series of stages known as the five stages of grief: denial, anger, bargaining, depression, and acceptance. Denial is a defensive reaction, a way to ignore the reality, or deny that it has occurred. Anger is the expression of the deep pain a person feels in their grief, a way to express the overwhelming emotions. Bargaining is when a person tries to placate their emotions by imagining or wishing they had done or acted differently before the death occurred and assuming that would have altered the outcome. Depression is the emotional sadness associated with the loss, which can be related to the loss, the stress of the reality of

funeral arrangements, or the need to recoil and mourn separately. Lastly, acceptance is recognition of being in the stage of mourning and working through the process of healing. Some people experience the stages in order while others may experience only a few stages; many people experience the stages over and over again (Axelrod, 2006). Grief is a loss that affects all facets of a person's life: emotional, physical, social and spiritual. It affects all people and discriminates against no one. Grief is different for everyone that experiences the loss of someone or something genuinely significant (Pomeroy & Garcia, 2011).

Disenfranchised Grief

In situations where the bereavement is for a family member or a loved one, it is readily accepted as normal and appropriate to grieve. However, in some instances an individual's grief is considered disenfranchised. Disenfranchised grief occurs when "a person experiences a sense of loss but does not have a socially recognized right, role, or capacity to grieve" (Doka, 1989, p. 3). Doka (1989) explains disenfranchised grief as the loss of an individual to whom one does not have a socially understood relationship. It is considered insignificant; consequently, one's emotions should not be expressed concerning the loss (Kaplan, 2000). Disenfranchised grief often occurs for individuals working in the healthcare field, where patients may die in professionals' care, but no specific relationship is formed. These individuals suffer two losses: the loss of the patient and the loss of recognition for their suffering. This can cause great disparity in their lives and in their work, particularly if the patient death is that of a child. Baverstock and Finley explain that when the death of a patient is a child the grief can overwhelm not only the

parents but the caregivers as well (Baverstock & Finley, 2008 & Meador, Lamson, Swanson, White & Sira, 2009).

An example of the death of a child illustrates the experience of nurses suffering from disenfranchised grief. The death of a child is unnatural and uncommon due to the medical advances in healthcare. In the past, the death of a child was not seen as abnormal. There were many more diseases and illnesses that were untreated or had undiscovered cures leading to outcomes that were not as favorable for children as they are now. Children now are expected to live into adulthood, and when they do not it is an untimely and unnatural death (Kaplan, 2000). As opposed to the early 1900's when patients died at home being cared for by their families, today patients frequently die in the care of doctors and nurses (Kaplan, 2000). This results in more nurses experiencing the death of a child in their care. These deaths cause turmoil and disruption for nursing staff; they can be traumatic and have an extensive emotional impact on the nurses. Lenhardt (1997) explains that because these losses are not acknowledged or considered significant then the grief is not legitimate or anticipated. This causes the individuals who are called disenfranchised grievers the inability to accept and recognize the symptoms of grief they are feeling. By denying the symptoms of anger, denial, sadness, depression, loneliness, guilt, hopelessness and numbness of grief, the symptoms intensify and can certainly lead to compassion fatigue (Lenhardt, 1997).

Compassion Fatigue

If left unattended disenfranchised grief can evolve into compassion fatigue for nurses and cause many more issues for the nurses, the patients, and the hospitals if unresolved.

In the literature, loss has been typically explained through psychodynamic means, positing that when ‘normal resolution’ is somehow interrupted and the necessary ‘grief work’ is left undone (i.e. avoided), grief will become ‘chronic, enduring, and disabling’ (Cacciatore & Flint, 2012, p.62).

Cacciatore and Flint also say that, “Human suffering, particularly when it includes traumatic bereavement, ignites an existential crisis from which a wellspring of concerns emerge” (Cacciatore & Flint, 2012, p.76).

These emotions and reactions, if unattended or ignored, can lead to what is referred to as compassion fatigue. “Unlike garden variety fatigue, which is a common result of overwork, compassion fatigue results from caring to the point that you’re drained of empathy” (Ostrowski, M., 2003). Without the knowledge of what compassion fatigue looks like, nurses will be unarmed in dealing with the aftermath of its symptoms. It is essential that nurses and other staff learn what compassion fatigue looks like and what the symptoms are. Research indicates that the symptoms can be very intrusive into all areas of person’s life.

Compassion fatigue is a state where the compassionate energy that is expended by nurses has surpassed their restorative processes, with recovery power being lost. All these states manifest with marked physical, social, emotional, spiritual, and intellectual changes that increase in intensity with each progressive state (Coetzee & Klopper, 2010).

The systems of compassion fatigue are described by Newell & McNeil (2010) as a joining of symptoms from both secondary traumatic stress and posttraumatic stress (PTSD) symptoms. These symptoms can be intrusive thoughts, traumatic memories, nightmares, insomnia, irritability, angry outbursts, fatigue, difficulty concentrating, avoidance of clients and client situations, and hypervigilant or startle reactions toward stimuli or reminders of client trauma (Newell & McNeil, 2010).

To some people compassion fatigue may seem like burnout. However, burnout is used more often in recent literature as the precursor to compassion fatigue (Sabo, 2011). In this study I will refer to compassion fatigue in regards to nurses reaching a level of exhaustion and emotional depletion that affects their ability to care for their patients, and understand that burnout can lead to compassion fatigue. “Burnout is related to chronic tedium in the workplace rather than exposure to specific kinds of client problems such as trauma (Schauben & Frazier, 1995, as cited in Jenkins & Baird, 2002). Burnout can be caused by caring for others over and over from the everyday tasks required as a caregiver, whereas compassion fatigue is more often a result of caring for traumatic events and situations as a caregiver. According to Figley, compassion fatigue differs from burnout. “Specifically, compassion fatigue is defined as a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, persistent arousal (e.g., anxiety) associated with the patient. It is a function of bearing witness to the suffering of others” (Figley, 2002, p.1435). Burnout is the exhaustion from emotional demands and of caring for others while compassion fatigue is the exposure and care of a victim of trauma or of supplying care during a traumatic event (Figley, 2002). Compassion fatigue was once referred to as Secondary Trauma and the

symptoms were linked to those of PTSD; however, Figley thought it would be less stigmatizing to call it compassion fatigue (Figley, 1995, as cited in Jenkins and Baird, 2002).

Compassion fatigue goes through a series of stages, and if the stress from unaddressed grief and the pressures of caring for the critically ill and dying continue to compound on the nurse, compassion fatigue will set in, which is hard to reverse. In a concept analysis, a study that explains the order or framework of a relationship, Coetzee and Klopper (2010) indicate that compassion fatigue is the last stage in a series of indicators that a nurse or practitioner is finding it difficult to maintain equilibrium while caring for intense and stressful situations. They explain that compassion fatigue begins with compassion discomfort, goes into compassion stress and then finally to compassion fatigue; and once compassion fatigue is reached it is difficult to recover the ability to care in the same manner prior to the compassion fatigue. Ultimately, if compassion fatigue is reached and unaddressed nurses will be unable to care for their patients in the way that they did before (Coetzee & Klopper, 2010).

Result Of Unaddressed Compassion Fatigue

The quality of care the nurse is able to provide after experiencing the loss of a patient or when experiencing compassion fatigue could become an issue and needs to be carefully considered. According to Kaplan (2000) and Sack, Fritz, Krener, and Sprunger (1984) many providers who know that their pediatric patients are going to die express the experience as “relentless prolonged horrors” (p. 189) and feel uneducated in how to handle the experience. This causes them intense stress. Nurses who are not given the ability to manage their grief or to process the compassion fatigue they may be

experiencing could eventually struggle with strained relationships at home as well as work stress or mismanaged care of patients (Clements & Bradley, 2005).

The effect of compassion fatigue resulting from the loss of a patient takes its toll on nurses. “Some evidence shows that when nurses do not receive situational support after experiencing distress in the work setting, they are not able to easily process the experience. This lack of processing can have both professional and personal implications” (Maloney, 2012, p.110). As noted in this literature, it can cause them great amounts of anxiety and it can cause upheaval both at home and also at work, and in some cases, it can even cause them to question their ability to keep nursing (Hinds, Milligan & Puckett, 1996). With the current way the health care system is, acute care hospitals are reimbursed based on performance, so a nurse that is performing well and maintaining his or her position for a longer period of time is worth more financially to the institution over a nurse who works less effectively, or quits abruptly. In addition, “Hospitals rely on premium contract labor or paying overtime rates to current employees to compensate for high turnover and vacancy rates” (Trepanier, Early, Ulrich, & Cherry, 2012). However, by doing this the nurses become burned out and potentially will resign their positions. These facts should imply that hospitals assess the extent to which they burnout their nurses simply for the sake of financial responsibility, not to mention the mental health of their staff.

It is essential that nurses find ways in which to share and express the stress and emotional turmoil they feel from the work they do for critically ill and dying patients.

Learning to manage grief responses to patient deaths is a crucial yet under emphasized skill for health care professionals. Without the ability to

manage one's grief in healthy ways, a health care professional may find his or her personal and professional life affected, resulting in less-than-optimal care for patients and families (Keene, Hutton, Hall & Rushton, 2010, p. 188).

This phenomenon of unaddressed grief resulting in compassion fatigue is of particular concern for nurses, because the compassionate service that nurses render is frequently bombarded with others' pain and suffering (Melvin, 2002).

Why Nurses Feel They Cannot Share Their Grief

Nurses' grief is often unrecognized and leaves them experiencing the death of a patient on their own. They do not feel that they can share their grief with their families or at the healthcare facility they work for fear of being misunderstood, unprofessional, or considered weak (Brown & Wood, 2009). It is also clearly identified that there is not a universal or consistent manner in which nurses are afforded to express their grief in a way that will help them prevent experiencing compassion fatigue. The research shows that in order to avoid compassion fatigue, grief must be identified and addressed in nurses. If the nurses' grief is cared for then that will ensure better care for their patients' health and well being (McMullen, 2007). However, many nurses find it difficult to express this grief and manage these emotions, particularly when they are still at work. Some nurses reported feeling uncomfortable showing emotions, choosing instead to present their emotions as a cold indifference towards their patients in order to protect themselves from breaking down at work (Mak, Chiang, & Chui, 2013). Shorter and Stayt (2009) conducted qualitative interviews with nurses about how they manage their grief after a patient death; for many nurses in the study informal supports were sought out

more readily than formal supports when they were provided. Nurses found that with informal supports, like talking with co-workers, they were able to feel understood, as well as feel a sense of camaraderie. Their peers had experienced similar losses and could relate, whereas in formal bereavement settings that were provided with supervisors or other staff, the nurses did not attend for fear of being misunderstood or for fear of not knowing how to communicate their loss (Shorter & Stayt, 2009). For nurses, being seen as professional and competent is also very important in their work and many nurses keep their distance when dealing with very ill and dying patients in order to present themselves as professional and remove some of the intimacy they may feel towards sick patients. Emotionally distancing themselves from their patients and from the losses helps nurses to cope, and thus, continue working in the field (Hopkinson et al, 2003; Shorter & Stayt, 2009).

Opportunity To Grieve/Bereavement Services

The ideas above express and identify that the real need is the opportunity to grieve. Many healthcare facilities are lacking bereavement services for nurses, and need to address the nurses' well being in order to provide excellent care for their patients. This may be because not only is the nurses' grief disenfranchised, but also it seems that grief itself is considered a typical response and not unusual enough to be addressed in research studies (Pomeroy, 2011). Considering grief as a normal reaction is often the case for families and loved ones who are bereaved, but this is also true of nurses who grieve and it appears that understanding and addressing their grief is even more removed because it is also disenfranchised. Bereavement services would assist them in handling the emotional upheaval that the death of a patient causes and would help prevent the compassion fatigue

that could impact their ability to practice ethically and professionally (Keene et al, 2010). In anticipation of the nurses' grief following a patient death a healthcare facility has an ethical responsibility to address what the best and most worthy type of services are for their nurses: providing them with bereavement or debriefing services would assist them in managing the effects of grief. Without addressing the needs of nurses the resulting outcome will become nurses who are experiencing compassion fatigue and unable to manage their jobs. According to The Journal of the American Medical Association (AMA) states are beginning to pass mandates in regards to protecting nurses from this very idea; however, they are responding to the issues they see in the statistical evidence as opposed to the obvious emotional strain of the nurses. The AMA understands that the more patients a nurse is responsible for the more likely the nurse will become overwhelmed at the caregiving and lack the adequate skills to provide competent care. This is because the result of too many patients per nurse affects not only the patient care but also the rate of burnout and job dissatisfaction for the nurse. "After adjusting for nurse and hospital characteristics, each additional patient per nurse was associated with a 23% (OR, 1.23; 95% CI, 1.13-1.34) increase in the odds of burnout and a 15% (OR, 1.15; 95% IC, 1.07-1.25) increase in the odds of job dissatisfaction" (Aiken, Clarke, Sloane, Sochalski, & Sibling, 2002). Although this is a step in the right direction, just limiting the exposure of patients to nurses will not alleviate the symptoms of disenfranchised grief and compassion fatigue. Without support for healthcare professionals after exposure to traumatic events damaging outcomes can occur. There are a variety of options for follow up care for healthcare professionals and it is essential that these facilities agree to start

caring for their staff in the same manner in which they do their patients (Maloney, C., 2012).

This type of care will provide nurses with a forum to discuss their emotional responses to the death of patients. It will also provide them with a safe place in which to express and explore the emotional responses in hopes to alleviate the natural stress and distress of grief. Allowing them to debrief and respond to their grief will lessen the occasions of compassion fatigue. Nurses' attempts to find meaning after the death of a pediatric patient and to allow the story and experience to radiate their lives helps nurses to be more capable and competent in the future because it makes them more thoughtful and attentive in their nursing care. (Rashotte, 2004).

Healthcare Facilities Practicing Bereavement Services

In researching this phenomenon of nurse bereavement care it should be noted that some healthcare facilities are implementing bereavement and debriefing services for their staff (nurses included). Healthcare facilities that have established services for their staff in the event of a patient's death report its usefulness and provide us with the knowledge that this type of service is essential and effective in helping care for the nursing staff of pediatric patients who die. In a study done of pediatric consultants who dealt with resuscitation and end of life decisions it was reported that the support of the healthcare facility was found to be useful by 85% of the staff when they debriefed after a patient's death. Asked if they could opt to debrief after every patient death, 72% of hospital staff said that they would like to. (Baverstock, A., & Finlay, F., 2008, p. 736). At John Hopkins Children's Hospital, the pediatric palliative care team recognized the need for debriefing with staff after a patient's death and implemented bereavement debriefings to

assist the staff in handling their grief: high percentages of staff, 98.4%, reported that debriefings were helpful, with another 97.8% reporting “it helped them find meaning” (Maloney, C., 2012, p. 113). Lancaster General Medical, another healthcare facility that decided to intervene on behalf of their nurses, implemented bereavement services for the nurses battling compassion fatigue because of patient deaths. The nurses found the services to not only assist in managing their grief but also to bring a greater unity to the floor and team of nurses as well as assist them in recognizing the components and warning signs of compassion fatigue which enabled them to be proactive at self care (Fetter, K. 2012). Another intervention technique, Schwartz rounds, is another example of ways in which healthcare facilities are implementing support for their grieving staff.

Schwartz rounds are not ‘problem solving’ in that they are not designed to establish what can be learned clinically about patient outcomes.

Instead, the focus is on the emotional experiences of staff caring for patients and they allow staff to explore, in an environment that is safe and confidential, situations that confront them (Thompson, 2013).

When Grief Is Properly Recognized

If individuals who are experiencing grief are given the opportunity in a safe and comfortable space to express their reactions of loss and make sense of the grief, the symptoms of grief should lessen. “Recovery hinges on their ability to incorporate their loss into a positive view of self and life and to continue (or restore) activities that are satisfying and meaningful” (Boelen, 2011). For some people, what is needed is a way to make sense of the loss, find a meaning behind it, look to what it has taught them, or a way in which to express what the person meant to them. This can be done through

memorials, rituals, letters to the patient or their family, journaling, and narrating about the person, the loss, or the experience. (Clements & Bradley, 2005; Hinds, Milligan & Puckett, 1996, & Macpherson, 2008). For nurses and other healthcare providers, learning to recognize their grief as a typical response to death will assist them in understanding that they need to express their emotions, find ways to record the experience and make a memory or tribute to the patient and thereby enable them to properly take care of their reaction to the death and to their needs in handling the grief that follows. (Kaplan, 2000). Allowing themselves to experience the grief, and make sense of it will provide the nurses who are bereaved with a way to combat losing sight of what is important in their field: compassionate care. Nurses are there to care for individuals in need with empathy and compassion; if they lose sight of that they will be ineffective at their jobs. When someone they care for dies, that upsets their caregiving role and can cause them to become burned out, or to begin experiencing compassion fatigue. By making meaning of the death and finding purpose out of the patient's life and death experience they will be better able to handle that grief and move forward to caring for other individuals.

Indeed, sense-making in particular moderated the effect of continuing attachment on grief, suggesting that it is those bereaved persons who remain closely bonded to their loved ones but who are unable to integrate the loss into a more ample system of personal meaning who are at greatest risk for bereavement complications (Neimeyer, Baldwin & Gillies, 2006, p.733).

This can also be true for nurses. If they are able to make sense of the loss they will be better apt to care for themselves in the future losses of patients, and in managing their own grief. If they are able to find bereavement services, and avenues of sharing the grief,

ways in which to memorialize the patient that was lost, they could lessen the likelihood of compassion fatigue as well.

Addressing Disenfranchised Grief In Infancy

Addressing disenfranchised grief in infancy is an essential part of caring for the nurses. If nurses who are experiencing disenfranchised grief are provided with services that attend to their bereavement then compassion fatigue has a better chance of being avoided. However, if it is unattended the outcomes for nurses could include compassion fatigue, burnout, or even secondary trauma. It is essential then to also consider the correlation between the nurses' years of experience and how they are identifying their emotions. Looking at their ability to continue working, to carry out daily tasks of living, to discuss their emotions will help to indicate if they are experiencing signs or symptoms of compassion fatigue or burnout. Correlating that to the years of experience they have as a nurse may indicate whether there is a link between nurses who have worked longer and their ability to be resilient in the face of life and death for many years. This needs to be considered and researched in order to understand the implications of more years worked, and compassion fatigue. If the correlation suggests that more years equals higher rates of compassion fatigue than more resources need to be provided early in the careers of nursing staffs.

Where Do Social Workers Fit In?

The knowledge that compassion fatigue could alter the effectiveness of a nurse's ability to care for their patients in the same manner of competent care is concerning and clearly an area that needs to be further researched and addressed. With disenfranchised grief being ignored by the nurses and facilities they work in compassion fatigue is a very

real and possible dilemma for many healthcare facilities. With that in mind, researching ways in which nurses' grief can be adequately addressed will help agencies find appropriate services to help alleviate the symptoms and risk of compassion fatigue in nurses. Social workers may prove valuable to hospital staff in addressing compassion fatigue and managing the disenfranchised grief of nurses before they reach a point of being unable to care for their patients. Nurses' ability to practice their compassionate and empathetic skills is essential in caring for their patients. The need is great to provide bereavement services for nursing staff. Recognizing that they do grieve their patients' passing, that their grief needs to be addressed, and services need to be ample and available for them to process, emote and find meaning in the loss, is critical to their ability to avoid compassion fatigue. This type of support will ensure that they can continue to care and provide services to their patients. Social workers should be utilized in healthcare settings to provide supportive services to the staff that are struggling with compassion fatigue and disenfranchised grief. The talents and training that social workers possess place them in a unique position within healthcare facilities to implement these supports. Social workers could provide support groups, therapy, and debriefing services within healthcare settings. Utilization of these services should be implemented and established to carry out the compassionate care of staff as well as patients.

Research Question

Healthcare facilities need to provide their nursing staff with adequate bereavement services following the death of a patient in order to prevent compassion fatigue. By recognizing the grief that nurses feel following a patient's death a healthcare facility can help provide bereavement services. The purpose of this research is to address the

following question. What types of bereavement services are currently in place that help nurses with the emotional recognition of their disenfranchised grief and effectively reduce the risks of developing compassion fatigue?

Conceptual Framework

Critical Theory

Critical theory is the mixture of modern empowerment theories and classic Marxist methods (Forte, 2007). According to Burr, “Critical theory is also known as an emancipatory theory, a broad category of inquiry intended to raise the consciousness of people about oppression and to help them become emancipated from their subjugation” (Burr, 1995, p. 86). Critical theory is a way to view systems of power. These systems produce broad parameters that over time become patterns, which begin to be perceived as reality. Ultimately, these patterns begin to dictate how individuals view themselves and their role in an organization. Karl Marx inspired the theorists who developed critical theory out of the University of Frankfurt: Theodor Adorno, Max Horkheimer, Herbert Marcuse; Jurgen Habermas developed their ideas in part on the Marxist approach (Forte, 2007). The critical theorists approach their theory in a way that can explain the relationships of power, history, politics, and interactions within relationships while also realizing one’s self-identity and position (Forte, 2007; Denzin, 1992). A manifestation of critical theory is how power within an establishment controls behavior and does not allow for easy change within that system. “Critical theorists, look to a society’s institutions and other large-scale structures like the economy, the political order, and the social welfare system to find the sources of dysfunctional group processes, troubled relationships, and identity disorders” (Mullahy, 1997 & Reisch & Andres, 2001 – as cited in Forte, 2007).

Through The Lens

The relationship between disenfranchised grief and compassion fatigue in nurses who do not receive bereavement support from the healthcare facility needs to be understood. The conceptual framework behind the disenfranchised grief needs to be reevaluated. In this case looking through the lens of why the grief is disenfranchised will help us to understand how the grief can become more recognized in the future. It will also lend to more appropriate care of the nurses whose grief is unrecognized in order to prevent the compassion fatigue that too often follows. The critical theory lens is an appropriate fit to consider explaining how to change what is occurring among grieving nursing staff in healthcare. Bohman considers Horkheimer's definition of critical theory only helpful if it looks at critical theory in 3 ways: explanatory, practical, and normative. This way it can explain what is wrong with the situation, identify who needs to change it, and give rise to what areas need to be reconsidered and altered in order to provide social change (Bohman, 2013).

Relationship To Nursing

In a hospital setting where there is a sense of hierarchy among the staff there are also many other layers of practiced norms that play out. Behaviors that are continued throughout generations of staff, based simply on their patterned and expected existence, are considered the cultural norms of that setting. These behaviors are considered to be the normal approach to a task, and variations from that typical response are seen as departing from the protocol, even if formalized regulations are not in place. When looking back at the three criteria from Horkheimer, it is clear in the nursing setting that nurses' grief is disenfranchised. The actors who can change this are the hospital administration, nurses,

coworkers, and social workers and support staff. The goal for social transformation would be to assess what appropriate bereavement services will adequately support the grief of the nurses in order to prevent compassion fatigue. Critical theory provides a way to identify a problem in the power structure, thus helping people to remove the parameters and circumstances that are enslaving them (Bohman, 2013). Nurses' inability to project their emotions at work causes compassion fatigue and will eventually infringe on their ability to maintain good care for their patients. "A hospital is a particular social reality that nurses and patients enter into; the parameters of behavior, social cues, and so on defined by the existing members of that collective" (Ball, 2011). Healthcare professionals care for their patients in a professional and formal manner. Nurses can provide compassionate care and relationships can be built but the emotional responses that may follow the stress or death of caring for critically ill patients begins to interfere with the care to new patients and families, if unattended. It can be common practice for nurses to contain and ignore the grief and stress they feel at the loss of a patient for fear of being unprofessional (Reese, 1996). Theoretically, when the moral burden of negotiating between the roles constructed in professional workplaces by the policies and professional norms established there is in direct opposition to the emotions and ethical concerns we have as individuals, confusion and instability will occur (Cribb, 2011). Nurses may find themselves controlled by the hospitals' policies and social norms of caring for patients in a timely and professional manner, yet at the same time feel emotionally torn from the relationship that has been built with a patient and experience the emotional exhaustion that follows. Critical theory applied to this problem suggests that nurses require advocacy on their behalf to change hospital norms. It could be the role

of a social worker to advocate on behalf of the nurses' social rights in the hospital. Discrimination against nurses as persons who grieve and have the right to voice their pain and suffering, to seek out help and to process the loss of patients should be advocated for and brought to the attention of the agency in which they work. As social workers it is our ethical responsibility to fight for social justice for all disenfranchised people (NASW, 1999). Though hospitals may address the social norms in their institutions as a base on which to provide professional care, the nurses' grief and compassion fatigue also need to be addressed in a manner that will eliminate job dissatisfaction and potential health concerns, or even job termination; this could be a role the social worker takes on. "There is a strong relationship between the wellbeing of staff and that of their patients . . . Therefore, if staff are stressed and burned out, they can struggle to provide good care" (Thompson, 2013). Healthcare facilities need to respond to nurses' disenfranchised grief. Resources need to be made available, and advocates need to come forward, to allow nurses to emote on the job, and express the stress and frustrations of patient loss. This will help nurses avoid the compassion fatigue that often follow; by breaking down the barriers raised by years of cultural stereotypes depicting nurses as silent observers of intense patient care.

Methods

Research Design

This research looked at discovering what type of bereavement services are provided to nurses and whether they address the disenfranchised grief of nurses' in a way that reduces the risks of compassion fatigue. The researcher's hypotheses are: (1) there is a relationship between years of experience in the nursing field and burnout, as well as

compassion fatigue; (2) bereavement services are in place at the hospital in both formal and informal capacities, but are not often utilized by the nursing staff to allow for resolution of their grief symptoms; (3) nurses who do utilize bereavement services that are provided find their disenfranchised grief reduced in intensity and length of their symptoms related to their loss, thus lessening the risk of compassion fatigue.

A mixed method design was employed in order to assess these hypotheses the researcher was looking at. First, a survey was distributed (see Appendix C) with questions that were quantitative allowing for statistical analysis of their responses (Monette, Sullivan, & DeJong, 2011). Once the survey was completed a random selection of respondents were chosen to participate in a follow up mini-survey and face-to-face interview with qualitative questions (see Appendix E). This provided the researcher with responses that clarified what the nurses' opinions on disenfranchised grief was as well as their views on bereavement services that are provided, and which supports are most utilized and whether that delays or eliminates the onset of compassion fatigue.

Sample

Respondents were selected using purposive sampling. Purposive sampling is a nonprobability sampling that researchers use outside knowledge and judgment to choose people for the sample that will best serve their studies purposes (Monette, Sullivan, & DeJong, 2011). A pediatric healthcare facility in the Twin Cities Metro area was selected as the chosen place of recruitment. The head of the Institutional Review Board (IRB), the executive nursing director, and the nursing union at the facility were notified of the request to perform research at the facility. The permission was requested to send a survey and have it distributed to the facility's nurses through an email correspondence. The

survey was sent via a distribution list to 804 nurses at a local hospital in the Twin Cities. Of the 804 participants, 121 responded to the survey. From the 121 respondents, 99 completed the survey completely and will be used in this research. The information from the remaining 22 was eliminated from the research based on the criteria placed in the respondents' informed consent, which stated any survey not completed 100%, would be considered a denial of consent to be in the study. The survey went to specific units at the agency: Cardiovascular Care Center (CVCC), Neonatal Intensive Care Unit (NICU), Pediatric Intensive Care Unit (PICU), Oncology, and Emergency Department (ED) at this healthcare facility via a distribution list sent out by the hospital's IRB office. The nurses that participated were predominantly female, though there were some male respondents as well. The respondents also varied in age, ethnicity, years worked, and in length since the death of a patient.

In addition to the survey a random selection of nurses were chosen to participate in face-to-face interviews. The nurses were contacted through email correspondence and asked to participate in face-to-face interviews at their place of work. Once participation was verified, the researcher and participants scheduled a meeting time for the interview. Of the 121 potential respondents sixty-five replied that they were willing to participate in the face-to-face interviews. Each respondent was assigned a number from 1-65 that associated him or her with his or her email. From the sixty-five respondents twelve were randomly selected using a computerized program that selected a series of numbers ranging from 1-65 and were emailed to schedule a time to meet for the face-to-face interview. From the twelve respondents only five interviews were scheduled. After one of the interviews was scheduled an additional nurse came to participate in the interview that

had completed the survey but failed to give her email to participate in the face-to-face interview. She was also interviewed and made for a sixth respondent. All respondents were given time to read and sign the informed consent. The interviews were all done in the same conference room, at the hospital in which they all worked. The interviews varied in length from 12-55 minutes. There were five females and one male respondent.

Protection Of Human Subjects

The healthcare facility was provided with an agency letter sent directly to the IRB administrator, requesting admission to facilitate research at their agency (Appendix A). The IRB administrator requested the formal protocol, prior to application to the IRB at the healthcare agency. In addition, the executive nursing director and nursing union were both presented with the research study's protocol and survey questions as well as the consent form for the participants prior to obtaining approval to begin research. Once the protocols were received and approved the agency signed off and the researcher was allowed to begin. Each participant was provided with a consent form developed in part by the researcher and the University of St. Thomas IRB, as well as the healthcare agencies IRB (see Appendix B). Each participant was provided with an informed consent that explained the nature and purpose of the study as well as educated the participants that it was their right to leave blank any questions they did not feel comfortable to answer as well as the option to discontinue with the study at any time without consequence.

With the study being mixed methods and using a random selection of respondents for the face-to-face interview, anonymity was not promised. However, confidentiality was maintained throughout the research. Qualtrics was used for the survey, and it consists of capabilities that hide the email address and names of the respondents who participated

in the survey. Although the respondents who participated only in the surveys were unidentifiable, those who volunteered to participate in the face-to-face did provide their email addresses in order to be contacted and as such eliminated the possibility of anonymity, so it was not guaranteed to any participant. No names were used during the survey and when names were exchanged during the face-to-face interview they were replaced with aliases during the analysis to comply with keeping the respondents' identities confidential.

The researcher ensured that the information received was locked in a drawer with a key, and by password code on the computer. The researcher also audio recorded the face-to-face interviews and transcribed this information. The digital recordings were kept protected by password code and will be destroyed three months after the completed research. These steps are taken to help provide the respondents confidentiality.

The survey included a small paragraph explaining that by completing the survey the participants had consented to participate, by not completing the survey the respondents had denied participation. There was also an informed consent form (Appendix D) given to participants prior to the start of the face-to-face interview. Participants were given the option to either agree or deny participation. The consent was also in place to notify the participants that if at any point they desired to withdraw from the study they could do so without any consequence.

Both the University of St. Thomas and the healthcare facility of choice used their Institutional Review Boards to assess and monitor the research that was done. The researcher also acknowledged and disclosed to the participants the benefits and risks of participating in the study, sharing with the participants that the questions being asked

could be sensitive in nature. The researcher provided the respondent with the names of services that they could use to debrief following the research if they so desired. In one instance a participant requested more services in different locales and the researcher followed up by emailing and providing more resources to the participant.

Data Collection

Research was conducted via email correspondence based on the approval of the executive nursing director of the healthcare facility on specific nursing floors: CVCC, NICU, PICU, Oncology, and ED. Nurses that were willing to participate were able to take the survey on Qualtrics following an email distributed through the Agency's IRB office providing them with a link. The participants had three weeks to complete the survey. The survey was 30-questions scored by a 5-point Likert scale developed by B. Hudnall Stamm, called the Professional Quality of Life Scale (Stamm, 2009-2012).

Those that were randomly selected to complete the face-to-face interview were contacted via email correspondence and were provided the opportunity to consent or deny participation in the interview. The interview took place in a conference room at the agency in which the respondents work. The face-to-face interview was approximately 10-15 questions and took between 11-55 minutes to complete. Both the survey and the face-to-face interview were voluntary for the participants, and were clearly depicted as such in the informed consent (see Appendix B and D).

Data Analysis

The data collected from the Qualtrics survey was deciphered using descriptive statistics (procedures that assist in organizing, summarizing, and interpreting the sample data on hand) and inferential statistics (procedures that allow for generalizations from

sample data to the populations from which the samples were drawn – Monette, Sullivan, & DeJong, 2011).

The demographic information given by respondents was analyzed using frequency distributions and measures of central tendency to determine the delineation of gender, age, and years of experience. It also assessed the differences between their scores on the ProQOL scale of compassion satisfaction, burnout, and secondary trauma. The descriptive statistics were used to examine who my respondents were: what age and gender they were, how long they had been in practice, and how they scored on the compassion satisfaction, burnout, and secondary trauma scale.

In addition, correlations were run to assess if there is a correlation between nurses who identify as compassion fatigued on the Professional Quality of Life Scale (ProQOL) with how many years of experience they have.

The data collected from the face-to-face interviews were analyzed using content analysis. The face-to-face interviews were audio recorded in addition to the researcher taking notations. The notations and the audio-recorded transcriptions were analyzed looking for common themes. Using content analysis is a way in which to code the data that is received in the interview into a number of observable categories (Monette, Sullivan, & DeJong, 2011). These categories were analyzed and subthemes were also taken into consideration.

Results

Quantitative Findings

Descriptive Statistics. In Figure 1 the data being considered is operationalized with the item: gender, which is a nominal variable that measures the participants' gender.

Each participant had one of three choices, male (1), female (2), or transgender (3) when asked this question on the study: What is your gender? The findings shown in Figure 1 show that 5 respondents (5%) are male, and 94 respondents (94%) are female, and 0 respondents (0%) are transgendered. These findings display the majority of the respondents are female.

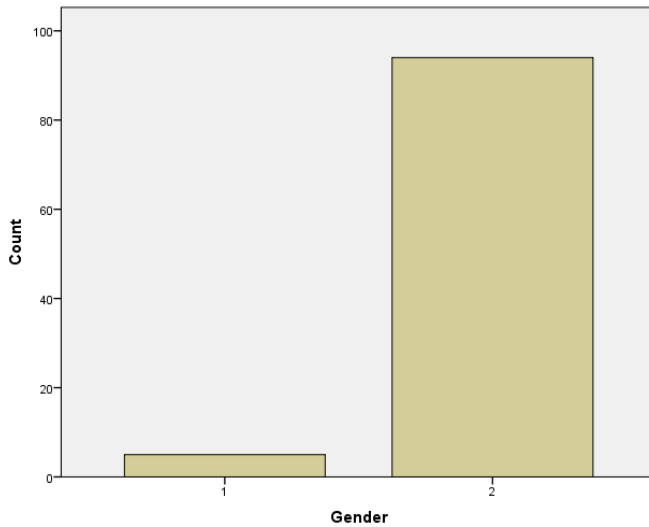


Figure 1: Gender Distribution
1 = Male, 2=Female, 3 = Transgender

In Figure 2 the demographics collected display a ratio variable that demonstrates the age of the nurses who responded to the survey question: What is your age? Each participant was able to answer by selecting one of four categories: 21-35(1), 36-50(2), 51-65(3), or 66+(4). The findings displayed in Figure 2 show that 29 nurses were 21-35 (29.29%), 38 nurses were 36-50 (38.38%) 31 nurses were 51-65 (31.31%), and 1 nurses were 66+ (1.01%). These findings show that the largest quantity of responses were from nurses who were 36-50 years old, and the least amount of respondents were from the group of respondents aged 66+.

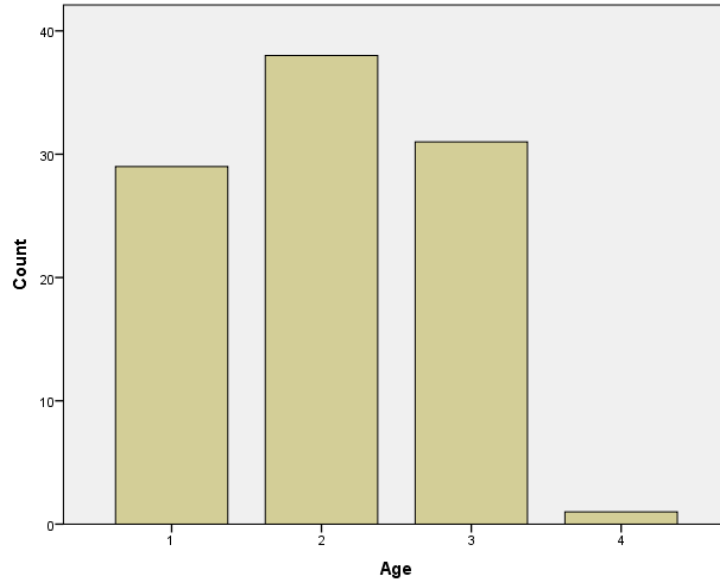


Figure 2: Age Distribution
 1 = 21-35, 2 = 36-50, 3 = 51-65, 4 = 66+

In Figure 3 the data is displaying the experience level of the nurses who responded to the survey question: How many years of nursing experience do you have? The data collected is a ratio variable and the respondents had seven options to choose from: 1-5 years (1), 6-10 years (2), 11-15 years (3), 16-20 years (4), 21-25 years (5), 26-30 years (6), or 30+ years (7). Of the respondents 12 nurses had 1-5 years experience (12.12%), 19 nurses had 5-10 years experience (19.19%), 19 nurses had 11-15 years experience (19.19%), and 9 nurses had 16-20 years experience (9.09%), 9 nurses responded that they had 21-25 years of experience (9.09%), 16 nurses had 26-30 years of experience (16.16%), and 15 nurses had 30+ years of nursing experience (15.15%).

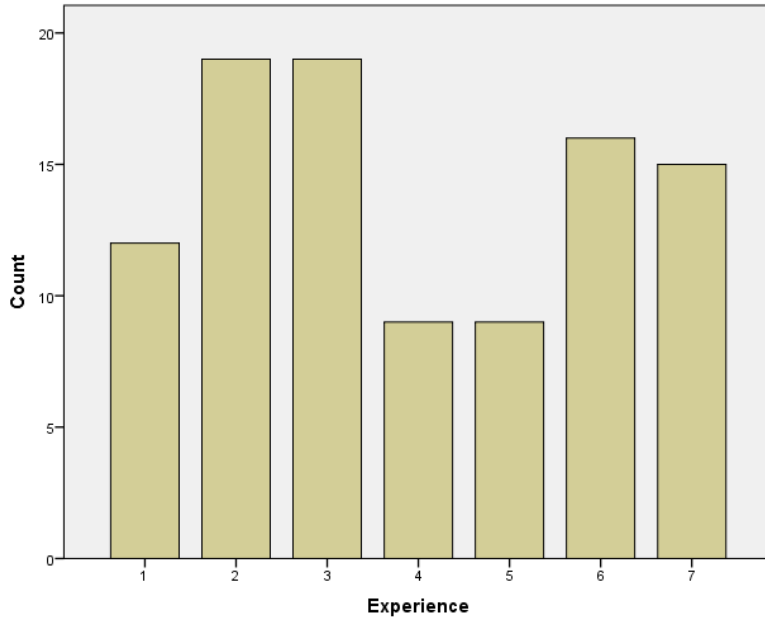


Figure 3: Years of experience

1 = 1-5, 2 = 6-10, 3 = 11-15, 4 = 16-20, 5 = 21-25, 6 = 26-30, and 7 = 30+

Measures of Central Tendency/Dispersion

The measures of central tendency were used to summarize the nurses' responses on three scales: compassion satisfaction, burnout, and secondary trauma. Measures of dispersion were used to calculate the variability for each scale. In Table 1 the analysis shows that the number of participants in compassion satisfaction was 99, the mean was 40.31 and the standard deviation was 4.68. The analysis in Table 1 shows that the number of participants on the burnout scale was also 99, the mean was 21.07, and the standard deviation was 5.57. Lastly, in Table 1 the analysis shows that the number of participants on the secondary trauma scale was 99, the mean was 21.80, and the standard deviation was 5.64.

Descriptives

Table 1: Compassion Fatigue Scale, Burnout Scale, and Secondary Trauma Scale

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
Compassion Satisfaction Scale	99	22	27	49	40.31	4.683	-.672	.243
Burnout Scale	99	27	10	37	21.07	5.574	.540	.243
Secondary Trauma Scale	99	28	12	40	21.80	5.639	.670	.243
Valid N (listwise)	99							

Inferential Statistics

One-Way ANOVA –

In Table 2 this one-way ANOVA shows the findings between participants’ years of experience with their level of compassion satisfaction. The survey given to each participant had a series of questions on the survey that assessed the nurses’ level of compassion satisfaction at their place of employment; this was compared to their number of years working as a nurse. In the descriptive statistics box the means have been averaged for 1-10 years of nursing experience and resulted in 39.95, the mean for 11-25 years of nursing experience is 41.43, and the mean for 26- 30+ years of nursing experience is 39.48. Results of the ANOVA indicate that the independent variable years of experience has no statistical significance on the outcome of the nurses’ compassion satisfaction. This can be seen in Table 3 by looking at the significance value on the top row, which is .203 (>.05) and shows that there is no statistical significance between years of nursing experience and compassion satisfaction.

Descriptives

Table 2: Descriptives for Years of Experience and Compassion Satisfaction Scale

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
					1.00	19		
2.00	37	41.43	4.343	.714	39.98	42.88	30	49
3.00	31	39.48	5.026	.903	37.64	41.33	27	46
Total	87	40.41	4.654	.499	39.42	41.41	27	49

One-Way ANOVA

Table 3: ANOVA for Years of Experience and Compassion Satisfaction Scale

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	69.333	2	34.667	1.623	.203
Within Groups	1793.770	84	21.354		
Total	1863.103	86			

In Table 4 the one-way ANOVA shows that the mean of nurses who have 1-10 years of experience is 20.95, nurses who have worked 11-25 years have a mean of 19.08, and the mean for nurses who have 26-30+ years of experience was 22.84. The ANOVA shows that the independent variable of how many years of experience each nurse has shows statistical significance. The significance value on the top row of Table 5 is .018, which indicates that it is ($<.05$) and is statistically significant. When you compare 11-25 years against 1-10 years, or 26-30+ years it can be seen that nurses in the middle bracket nurses who have 11-25 years of experience rate lowest on the burnout scale than the other two groups. The post hoc analysis (Table 6) shows the clear distinction in statistical significance falls between the number of years nursing 11-25 years and between 26-30+ years of experience with those nurses who have been nursing 11-25 years has lower rates of burnout than those with more years of experience.

Descriptives

Table 4: Descriptives Statistics for Years of Experience and Burnout Scale

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
					1.00	19		
2.00	37	19.08	5.262	.865	17.33	20.84	10	31
3.00	31	22.84	5.797	1.041	20.71	24.97	12	36
Total	87	20.83	5.499	.590	19.66	22.00	10	36

One-Way ANOVA

Table 5: ANOVA for Years of Experience and Burnout Scale

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	238.516	2	119.258	4.241	.018
Within Groups	2361.898	84	28.118		
Total	2600.414	86			

Table 6: Tukey HSD

RecodedYearsExperience	N	Subset for alpha = 0.05
		1
2.00	37	20.22
1.00	19	22.37
3.00	31	22.55
Sig.		.254

In Table 7 the descriptive statistics showed that the nurses who have 1-10 years of experience showed a mean of 22.37, the mean of nurses who have 11-25 years of nursing experience have a mean of 20.22, and the mean of nurses with 26-30+ years of experience have a mean of 22.55. The ANOVA shows that the independent variable of the amount of years of experience each nurse has is not statistically significant in the correlation between how long they worked and to the level of secondary trauma they felt.

Referencing the significance on the top row of Table 8, which shows the significance value was .156, can reveal this. The value of .156 is ($>.05$) which is not statistically significant.

Descriptives

Table 7: Descriptives for Years of Experience and Secondary Trauma Scale

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
					1.00	19		
2.00	37	20.22	5.548	.912	18.37	22.07	12	37
3.00	31	22.55	5.549	.997	20.51	24.58	12	34
Total	87	21.52	5.417	.581	20.36	22.67	12	37

One-Way ANOVA

Table 8: ANOVA for Years of Experience and Secondary Trauma Scale

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	109.355	2	54.678	1.902	.156
Within Groups	2414.369	84	28.742		
Total	2523.724	86			

Qualitative Findings

In the qualitative portion of this research project, I was looking to identify what type of bereavement services are provided to nurses and whether they address the disenfranchised grief of nurses' in a way that reduces the risks of compassion fatigue. After transcribing and coding the data collected from the face-to-face interviews two themes emerged from the responses: grief and agency services. From those two themes, six subthemes emerged: who the participants share their grief with, how they manage grief, compartmentalizing, what resources are available at the hospital, which resources

are utilized, and what could be improved by the hospital to assist nurses in their grief following the loss of a patient.

Grief

Grief was an obvious theme in this research study as nurses shared with the writer the loss of a patient that was in their care. Each nurse expressed those with whom they shared their grief, and how they manage their grief. A few of the nurses shared how compartmentalizing can be a useful tool to making work and home separate entities.

Supports/Sharing

The first subtheme parsed out from the theme of grief was with whom do nurses share their grief and find support? The following quotes were received in response to the question: “Who do you share your grief with?”

My wife.

My coworkers and family.

I totally think the best way to handle it is to talk to your coworkers, I really do; that gives you the most satisfaction.

I have a cousin that also works at _____ so she and I will share our stories a little bit too.

Some of the support is nurse to nurse more than anything else.

My dad's a family physician, ever since I was little I would ask him what is the most interesting thing you saw today? He would share some of his stories and then when I have a hard time I go over things with him. He always has a good perspective to be like, you're working with a very small percentage of the population and you need to know this doesn't always happen and it's not normal and so well I think it helps to kind of ground me.

This quote reveals that an individual's cognitions can become distorted or interrupted differently based on the environment they become enmeshed in. This nurse has worked in the same environment for 5 years, with the same client population, a population who has congenital heart defects and often poor prognosis, her expectation of children's development and life expectancy has been altered by her experiences. Having her father be able to remind her, this is not typical, it is not even as prevalent as it may feel provides her with helpful feedback to counter the feelings of grief associated with the belief that children's lives can be fleeting and lost easily. Having your perceptions challenged can be difficult to handle, but because it came from her father it indicates that he is someone she reveres and trusts and the information then is processed as helpful, accurate and useful to counter the grief felt by such a difficult occupation. This demonstrates that nurses may be more apt to receive support and assistance from

someone they trust, and having that supportive soundboard can provide them with reality checking.

My husband and I are pretty close, and then my mom who I'm really close with, and then I've got some really good friends, and I'm pretty spiritual in that way too, so that helps a lot too.

Yeah, I get a lot of support; I'm very active in the church and stay active in the church.

Yes, definitely (in response to if she shares her grief with nurses) and that's probably the most satisfying because they get where you are coming from, do you know what I mean? Where as other people have no idea, you can say to someone "oh my patient died today" and then you would want to share something, or how sad it was, but they don't get the impact of it.

The responses shared by the nurses clearly were felt by many and were identified as a theme. The responses showed that the nurses felt relief by being supported by others. Having the ability to share their stories was useful particularly with other medically minded individuals. The nurses were able to identify more deeply and have their emotions understood by other nurses that had experienced similar situations.

Managing

The qualitative data also revealed how the respondents managed their grief. The theme of grief management was alluded to in all of the respondent's answers following their response to how they handled grief following the death of a patient. These following quotes express the many ways they handle grief.

Probably detachment mostly.

I would say more tearful, and probably get a little more quiet, and internalize things more, I don't know why I do that.

I get quiet, and then when I get home alone, I mean I'll cry.

These nurses indicate that the way they “manage” their grief is by detaching, internalizing and getting quiet. This suggests that though it may feel like they are addressing or “managing” their grief they are in fact isolating themselves. By isolating from the grief and from others their form of managing actually limits their ability to process and work through the grief. It appears to be more of a way to deny the emotions instead of processing the emotions.

I cry, I cry with the parents. I try to make it as if it was my friend or part of my family, I can tell you I am as professional as I can possibly be, but at that time, just being real, just being who you are.

The word professional stands out in this quote, as she shares that she grieves alongside the family. She was careful to point out that she does it professionally, as if crying is unprofessional; grieving alongside the family is not expected and can seem as unprofessional or substandard behavior. This idea correlates with the conceptual framework indicated earlier in the paper that suggests that in a hospital setting there are practiced norms and how nurses respond to death is one of them. They are expected to understand and anticipate death and dying as part of their profession and the way in which they manage that experience correlates to their professional abilities on the job.

Umm, I think spiritually. I have come to a point where I have a belief in my own spirituality, and that helps.

Really you would be surprised, well maybe you wouldn't be, how many times we go out after work to do just that, debrief ourselves.

This quote indicates again that nurses lean on one another when they need to express the emotions they feel after the loss of the patient. It also suggests that if the formal supports the hospital provides are not addressing the nurses' needs, they find ways to create informal supports by debriefing with one another after work.

The quotes above display the respondents' pattern of revealing that being able to manage their grief after a patient's loss is essential. Many of the respondents manage their grief differently, but by having a method of maintaining that grief they find the ability to keep working and avoid compassion fatigue. This speaks to grief being different for everyone, it is a very personal and intimate expression and can be done in a variety of ways, some that may enhance their ability to work in a setting like the hospital and for some it appears to be a way to more compartmentalize the loss to be a component of their work.

Compartmentalizing

Transcribing the data for the qualitative findings revealed another subtheme of grief from the participants' responses. Many of the nurses try to compartmentalize their work and their home lives by trying to establish boundaries; the following quotes reveal these ideas:

*I ended up walking around the Mall of America for about three hours,
'cause my wife was working, and no one was at home.*

I'm not as much an emotional person, as some other people are.

I compartmentalize, I work through things.

*So my deal is I can cry all the way till I get to my driveway but when I hit
my driveway then I'm done.... cause you have to have real strong
boundaries, strong enough to say this is compartmentalized this is my job,*

this is what I do, and I love what I do, and then this is my home and this is my family.

The theme of compartmentalizing relates to the first two themes of managing grief and with whom they share their grief. The data reflected that the respondents had many similar stances on what was useful and how they were able to manage their grief without becoming compassion fatigued.

Agency Services

The second major theme uncovered when analyzing the qualitative data from the respondents' interviews showed that the agency services in which they work were an important consideration. The data revealed three subthemes when looking at the agency services: available bereavement resources, utilized bereavement resources, and suggested hospital improvements.

Available Bereavement Resources

While analyzing data a subtheme emerged showing that what resources the hospital provides was a large topic of concern for the respondents. When asked the following question: "Are there services that are available at the hospital for you to utilize?" the following quotes were shared.

I know there, there is a grief counselor here; again, I've never met with them.

I know we got something going on now, I don't know if it's some kind of counseling you can have, I don't know if it's health based or whatever.

There's this box or basket that comes around.

I remember when I first started they had like six patients pass away in a period of like two months, in the PICU so they had a grief counselor come in and debrief the staff and check in on how people were doing.

Well I guess, the other thing that they do, the chaplain, I believe she is the one that sends up the basket so there is always like a grief basket on the unit and then they have a card for all the staff to sign. Then they just kind of have these little stones, some people will take one (home) for each patient that they have taken care of as a reminder of how precious life is.

I know they just recently started another program related to that; I don't find there is much satisfaction in that.

Years and years ago we use to have a psychologist who came and talked to us, and we sat around a table and discussed; that was helpful when it's still fairly fresh from losing that patient; I think that was very helpful and it wouldn't have to be a psychologist; it could just be a discussion where

you talk about it, a more, I guess a formal matter, you know not necessarily formal, but someone sets it up is all I'm saying.

Well, I'm gonna be mean here; they bring a little set up that has brochures, and candy and they put that in our lounge; it's like nothing, that is like the dumbest thing ever, you want to help me? Let's set up a meeting and talk about what a cool kid that was, you know.

I know they just started it; I can't think of what it's called, they just started counseling employees, it just started this year?

Well we are supposed to have um, a debriefing, which never happens.

Typically on the floors especially on PICU, K. (the doctor) and some of the other intensivists will get people together within an hour or two and sometimes within a day to debrief everyone, get everyone on the same page, what did you see, what did we see, down in the emergency room we, since we have gone to a level one trauma we are too full on our deaths [implying the hospital is over the expected death amounts for this quarter] and we do not ever have any type of debriefing. We talk about it, there is a lot of talk and even our manager, but there is no action taken.

Yeah they have the basket; they bring in the cart with incense and food, and tea; they are very intuitive when it comes to this, that's all I know of.

The pattern in responses was discovered while coding the data. The responses suggested that there are bereavement resources being provided by the agency in which the nurses worked; however, the nurses are not finding the services overly beneficial. They seem to know very little about their options and what the services can be used for. It is clear they all recognize that after a patient dies then a basket is brought up to the unit for the nurses. It traditionally includes some kind of sweets, either cookies or candies, some incense and small stones, and resource brochures. These baskets seem to be viewed more as a symbol of the death than as a symbol of relief or comfort after a loss. As the nurses shared in the interview process they seem to be aware that there is a new program aimed at allowing the nurses free counseling but they do not see this as a bereavement service but more as a health benefit. A few of the nurses shared that in the past there were debriefings after the loss of a patient, which allowed for nurses and physicians to talk together following the death. It was received well because it was with other individuals who understood the circumstances surrounding the loss; it was with other people who experienced the same type of loss and it occurred shortly after the loss allowing the nurses to grieve and mourn together in a safe and familiar space. The need for this is clear, and the lack of recognition that this need is still prevalent is also clear, as one nurse indicates in her quote, it is readily talked about that more debriefing needs to be done, but no action is taken.

Utilized Bereavement Resources

Another theme was uncovered when analyzing the qualitative data and that was what bereavement services were being utilized at the agency. The respondents shared the following quotes about utilization of services:

I think over the years I have known a few that have, and apparently it has helped them remain nurses, so that's a positive.

That's one thing _____ has done really poorly they just don't, they don't look to see who's been on, and who really needs it, it's kinda funny.

*Umm, the truth, I haven't really attended them because I haven't had too.
– [in reference to debriefings.]*

I think if it's somebody that really needs it, they can, they really do, seek it out; I know with the tractor there was a bunch of them that went to Dr. _____ and said we need to go over this.

I think the basket is nice and everyone appreciates it; it's a good kind of thing that they have to put the services out there, but it, thinking about it now, it's kind of like I've seen the basket come however many times, and so you kind of like overlook the materials that are with it, you know what I

mean, so I don't know if maybe it would be useful for them to like switch it up or something or present it in a different manner.

I don't know. Part of me thinks, I know they have services and these things, but it's like I just don't know if anything would ever help.

Identifying that death is hard, watching someone die after trying interventions to save them is very difficult, and although services might be present they still do not remove the difficulty of seeing a life come to an end. Specifically a life that has been short, which is seen as unnatural because the death is that of a child. This quote shows that part of addressing the grief may be accepting that it's present and that is hard.

I don't think so, some of us have been here long enough that we know that sometimes you need to talk to someone, you do need help. So I don't think there is any stigma, I think a lot of us are private people and we don't share.

These responses link the first two sub-themes in agency services together. The respondents first described what bereavement services are provided by the hospital, and in this second sub-theme, which services are utilized by the hospital staff.

Suggested Hospital Improvements

The last sub-theme discovered when analyzing the qualitative data revealed that the respondents had advice for the agency at which they work. The following quotes reveal the suggested improvements the hospital could make in caring for their grieving staff:

It would be nice if they had little bags, you know, nothing in them, just something to say I'm sorry you went through this hard time, or something, to recognize the nurses, the doctors, and include the doctors and the staff, the HUC's include the chaplains, include everybody...not just the one group, include the lab people that happened to be up there, the radiologist that happened to be up there, there are a lot of people that come in that you would not know were affected.

Being included is important in to everyone, we strive to be recognized and credited in our relationships, in our professions, in all aspects of our lives. It is clearly important, too, to recognize that it is not just nurses who interact with these patients as they die, there are doctors, respiratory therapists, technicians, and so many more people that are invested in these kids' lives, and thus are also affected by their deaths.

Just recognition that you've been through a rough time, you know it's hard.

I think, I always know on our unit you can expect one death a month, probably, like they kinda say we have about 12 in a year, but when you have like 4,5,6 that happen in a 2-month time frame instead of one a month it gets really hard on the staff, especially newer staff, so I kind of feel like we're almost at a point right now, that it would be good to have our manager to arrange to have someone to come in and check on people.

The nurses recognize that death will occur at the hospital; it is expected and anticipated to occur at an approximate rate each month. When the actual amount of deaths exceed that the nurses feel the compounded emotion of multiple traumatic events and need the benefits of bereavement services even more. This quote also identifies that acknowledgement of this loss means so much to the nurses. Yes, there is an expectation that their positions will hold with it the likelihood of death but for the nurses acknowledging the impact of what experiencing a death has is essential. Without recognition of the loss, the nurse feels that they cannot process or grieve the loss; this speaks to the idea of disenfranchised grief. No recognition of multiple losses impresses upon the nurses that there is an expectation that there is no need to grieve.

Well, I mean, ugh, I'm gonna be mean here. They bring a little set up that has brochures, and candy and they put that in our lounge, it's like nothing. That is like the dumbest thing ever, you want to help me, let's set up a meeting and talk about what a cool kid that was, you know.

Yeah, if you can have the right person facilitate it in a non-threatening way (in reference to a debriefing), cause I think again we have become so worried about where it's gonna go, and am I gonna lose my job over it. If I can't say to you I called so and so's mom on the phone and talked to them, if I can't say that to you, which I can't then no that's not helpful.

The nurse in this quote has worked at this agency for over 30 years and has witnessed a progression of change in the way hospitals control how patients and those helping care for them interact. She explains that the culture of the hospital now seems to be on guard. It is always anticipating a counter attack by people questioning their intentions, their boundaries, their professionalism, and with that the hospital has lost its ability to care attentively to their staff and recognize that they become invested in these patients and families lives. It is difficult, maybe impossible, to care well for an individual and feel no regard for them after they have passed on, and yet the hospital expects that there be no affiliation between these caretakers and the families of the deceased. Yet, looking at what the nurse is frustrated with, just wanting to check in on the family, relate to them that she too is saddened by the loss, that she also misses the deceased seems like a reasonable and useful way to mourn. There is a discrepancy here, that shows an agency claiming they believe in caring for the patient and the whole family, and who wants to provide bereavement services to their staff, yet is so fearful of crossing boundaries and possibly facing ramifications that it limits their

staff from interacting in beneficial ways to the families who have lost a child in their care.

If you could give families the option to coming in and invite the nurses that wanted to and just socialize, not like, you know it's like a follow up [reference a specific get together with patients' families who have passed and the unit nurses that cared for them].

I know in the past they had debriefing and stuff, like I said I don't know if that would help; I don't know; maybe some people it would, some people like to talk, some people don't; for some people they keep it real personal, I don't know.

The implications from this quote suggest that although there may be trends or preferred methods of handling grief, it is clearly a very individualized process. A bereavement service that allows the nurses to experience and process grief in their own way might be very useful for nurses at the hospital.

A ___ is our chaplain and is in charge of the emergency room and her and I are starting up a program for staff to come and listen to parents who have lost children. She brings in this group of families that have, obviously she has screened, and they come in and talk to staff about what is important to them, what worked and what didn't work and how it's affected their lives to this day. So were in the works of doing that, and it helps staff understand that what they do is really, really important.

This quote identifies that nurses recognize not only their own grief but that of the families. Sharing ways in which they felt the hospital could improve the grief process for the families was important to them. It is part of the process to call in social workers and chaplains to meet with the families but beyond that protocol each unit has a different method of handling the death. This nurse shares that families are not finding all of the methods helpful, and that in the ED they are looking at ways to improve the system. To her when asked about her grief, sharing ways that the hospital should be addressing the families grief is as important as addressing her own grief.

Well obviously they need to follow through with the debriefing, and immediately after a patient dies we need to call extra staff immediately and cover the nurses that were involved cause sometimes after the death it takes 3 or 4 hours.... for the family to grieve and get through the process and say goodbye.

We have always done something, but never recognized for it, there is no scholarship program for us to develop, any type of grief program which we really need, cause were not as nurses were not going to be able to compassionately give.

The responses formulated in these quotes identify what the nurses voiced after they were asked, “What services would be better utilized or more beneficial to nurses; what should the hospital be doing?” The themes uncovered show that the respondents feel strongly that more can be done. They identify that there are services provided, like the basket and the option to use “some new service” provided by the chaplains, however, their lack of understanding of what the service entails, and their disregard for the basket identify that more is definitely needed. All six nurses interviewed had no difficulty in sharing ways the hospital could improve upon their services to better equip the nursing staff to handle their grief. One of the strong themes suggested by the nurses interviewed suggests that part of the process for the nurses who have helped a child and their family through a death is recognition for their services. Acknowledgment that they were present and helpful during the death process seems to give the nurses a sense of importance. Knowing that by being present and helping the child or the family during that time helps in the grieving process. On the flip side, if that is not recognized, it eliminates the importance of not only their job but also the importance of the child. One nurse in particular pointed out that all she wants after a child dies is a chance to talk about that she was lucky to have known the child and about how great the child was.

Discussion

Summary of Findings

The intention of this research was to uncover whether or not nurses’ disenfranchised grief is addressed at the hospital where they work. It was also to look at the relationship between their years of experience and compassion satisfaction versus burnout or secondary trauma. In addition, it was also intended to consider if services were

provided for the nurses grieving the death of a patient, if nurses utilized the services, and if services addressed the risks of compassion fatigue.

Survey results indicated a relationship only between the number of years of nursing experience and with burnout, there was no relationship found between years of experience and compassion satisfaction or secondary trauma. The survey scale for compassion satisfaction indicated that the nurses who responded show a sense of resilience and enjoyment in their positions for caring for critically ill pediatric patients. The burnout scale showed that nurses who were working for over 26 years were more burned out than those in the middle group who had 11-25 years of experience. This is an interesting finding suggesting that in the beginning years of experience, nurses seem to still feel compassion and resilience in their work, as do the nurses with many more years of experience; however, nurses in the middle stage feel the effects of burnout on the job.

When looking at the qualitative data, themes were discovered when analyzing the respondents' answers, and determined that the nurses who participated felt strongly that they did grieve their patients, and that their grief was not being addressed in a manner at the hospital that alleviated their disenfranchised grief. Most interesting was how many nurses responded to participate in the face-to-face interview portion. The invitation to participate in the interview was attached to the survey and identified to the respondents that the interview would take place at their agency after or before a shift they worked on, and would take up to 45 minutes. Of the 121 respondents who participated 65 were willing to participate in the interview process. For over half of the respondents to be willing to participate suggests that they were interested and motivated to share their point of view on the hospitals ability to address their grief.

Another interesting finding shows the relationship between the nurses and the families of the patients that have died. Many of the respondents shared a dual loss, the loss of the child and the loss of the relationship between themselves and the family. The emotion they felt for both losses was significant and multiple respondents shared that they desired to communicate after the loss of the child with the family to share in their grief, and to provide support to the family. The nurses throughout the interview process spoke not only to their own grief but also to the families grief, without any questions directly addressing the grief of the families, multiple respondents talked about ways in which the care of the families should be improved and enhanced to mitigate the deep emotions the families experience by leaving a hospital empty handed.

Fit of Findings

The research on this topic defined disenfranchised grief as the loss of someone with whom you have no recognized relationship; it is considered insignificant and thus the individual grieving should not express emotions associated with grief (Doka, 1989 & Kaplan, 2000). This idea was touched upon when talking to the nurses about their grief. Some of the respondents shared ways in which they feel their voices are not being heard. They feel that their contributions in working with patients and their families as they pass away are not being recognized. There is a sense of finality after the patient dies that their care for that patient and family has ended and their responsibility is to move on to the next patient and continue moving forward. The hospitals services that were mentioned by the nursing staff include a basket brought to the floor after a child has died for the nurses and other staff members to share. Many of the nurses found this insignificant and take little notice of it after so many losses experienced on the units each year. Debriefings

seem to be something of the past according to the nurses, or only in very traumatic cases and are still desired by many of the workers, again the impact of not having this service was voiced by a few of the nurses as a lack of recognition that these deaths are very impactful on the staff.

Truly impressive was the fact that though the nurses do not find the basket useful, and have very little knowledge of alternative services provided by the hospital the nurses are very capable at utilizing and creating informal supports for themselves in their grief. It was a common theme shared by the nurses interviewed that talking to other people was beneficial in their grieving process, specifically talking with other nurses and coworkers who understood the significance of the illness, or procedures, and life saving measures tried before the child died. Having an individual to share with who has gone through similar instances provided a useful sounding board, as opposed to someone who did not understand all the nuances of the patients life, illness, trauma and death. The nurse showed remarkable resilience in taking care of themselves in light of feeling uncared for by the agency in which they work.

One of the most powerful indications that the nurses feel that their grief is disenfranchised was in the response rate of participants who were willing to share in the interview process. After the survey was complete 65 participants volunteered to discuss the bereavement services being provided at their agency. The number of respondents speaks to the importance of the topic and the feeling that the nurses wanted their voices heard. From the interview process many of the nurses were able to share specifically in what ways they felt the hospital could improve their bereavement services for staff. The disconnect felt by the nurses and the patients family after the passed was significant.

Multiple times the respondents shared that they lost not only the patient but the family as well, and they desired a way to reach out and communicate following the loss. Many felt that the note cards left in the basket to send from the unit was not adequate and they wished for a more personal option. One nurse suggested setting up a meeting time at the hospital to recognize the child, a time for the unit staff and the family to meet together. Not as a large group gathering, but a small and intimate time between the caretakers and the family. Others shared that they really felt the need for more closure between the staff that worked with the child, as they died, a debriefing of what occurred, what was done well, what could have been different, and a time to discuss and grieve together. There was a consensus between the respondents' answers that suggested a sense of closure was missing for the nurses. The nursing staffs desire more bereavement services than are currently available, or than are currently utilized.

Making sense of the patients' loss is crucial; as individuals grieve they desire to find a way to make the loss have meaning. As the respondents were asked questions in regards to their grief they often talked about the families grief as well. There was a sense of loyalty felt for the patient and their family, and their needs even after the death were considered first and foremost. The importance of the child's life in being remembered and the child's family being honored and well cared for was much more of high importance than the nurses own needs. The respondents shared ways in which they believed the hospital could improve their care of families at the time of death, and they spoke to the importance of showing the family that the child mattered and would be missed by the staff as well. Showing that the life lost had value, meaning and importance seemed to be one way in which the nurses could make sense of their role in the child's

life? Honoring them, talking about the benefits and best ways to care for the family they left behind was vastly more important than attending or even discussing their own grief.

Limitations

When creating the survey for the participants to respond to there was a variable created to identify how long each nurse had been working it was identified as years of experience and had seven options to choose from: 1-5 years, 6-10 years, 11-15 years, 16-20 years, 21-25 years, and 26-30 years and 30+ years. When trying to correlate this data to the scale results for compassion satisfaction, burnout and secondary trauma that each nurse demonstrated, it was difficult to determine significance with so many variables, thus it was determined to combine years of experience into three smaller more manageable variables and recode the data to be: 1-10 years, 11-25 years, and 26-30+ years of experience. This allowed for better findings between the correlation of scales and years of experience as well as a more homogenous number of respondents in each variable of years of experience.

If additional questions had been addressed in the quantitative survey more significant findings may have been produced. The survey lacked questions identifying the number of deaths the nurses had experienced. Without this data it was difficult to identify how much disenfranchised grief they were dealing with compared to the level of compassion satisfaction, burnout, or secondary trauma they were experiencing. It would also have been beneficial to have a question identifying if the nurses utilized bereavement services at the agency they worked. Without this identifiable data it was impossible to correlate the compassion satisfaction, burnout, and secondary trauma results they showed

on the various scales compared to the bereavement services offered at the hospital. These missteps in the research show the implications of more research to be done in this field.

A final limitation uncovered revealed that more information could be gleaned from defining the number of years a nurse worked in a specific role, for instance, if a nurse working multiple years in home care versus a nurse working multiple years in intensive care; their perspective and their likelihood of experience loss would be very different. Having a question on the survey, or during the face-to-face process could reveal a discrepancy in the nurses' perspective based on the number of years they worked in intensive care.

Research Implications

The implications from this study show that more research done addressing the correlation between what services are utilized and how well the nurses identify with compassion satisfaction, burnout, and secondary trauma from the ProQOL scale would be useful. By asking one or two additional questions on the survey of this study addressing what services are provided at the hospital and what services do you utilize a clearer understanding of whether those services are addressing the risk of compassion fatigue could have been better addressed.

Another implication in the research after reviewing and analyzing the qualitative data from the respondents shows that although services are provided for these nurses, they do not address or relate to what the nurses are needing in terms of support following a patient's death. Many of the nurses addressed a need to communicate with the families after the loss of a patient, and being unable to add to their feelings of grief and loss. The nurses and families become bonded, particularly if the child has a long illness prior to

their passing, and after the child dies the nurse and family not only lose the relationship of the child but also that of one another. More research needs to be done to understand these relationships and how services can be provided at the agency level in order to remedy these emotional scars carried by the nurses and families.

Within this study a final implication that could have been addressed and would improve the study if done in the future would be to define the current services provided by the agency in which the nurses work, and compare that to what the nurses express to be useful in managing their grief. If what is offered does not adequately address the needs, how could the agency then engage the nurses in appropriate bereavement services?

Practice Implications

There are a few strong implications uncovered when looking at the data from this research. First, nurses are resilient and strong individuals that are often capable of creating informal supports when formal supports are lacking. Still, these nurses desire the agency in which they work to recognize their contributions of caring for sick and dying children and acknowledge that they do grieve the losses of every life. In response to the question: “Have you experienced grief over the death of a patient?” One of the nurses responded, “every one... It brings every one of us (nurses) to our knees.” Recognizing the strengths and abilities of other helping professionals is important and assisting them in finding resources, and informal supports to help them in their disenfranchised grief is essential when benefits are not in place that help prevent limitations of compassion fatigue from unaddressed grief.

Another implication for our practice understands our role as social workers in this field. Working in a hospital setting often allows social workers to provide care and

support for patients and their families, but this research indicates an understanding they are not the only individuals in a medical setting that are in need of social work services. It is time that social workers advocate for the mental health of other helping professionals, and work alongside these large agencies to provide bereavement services that will be useful and beneficial for the staffs that care for the sick and dying populations.

When researching the needs of nurses who are experiencing disenfranchised grief after the loss of a patient it became very evident that this is a current issue. Having nearly half of the participants who took the survey be willing participants for the face-to-face interview shows a clear desire for these nurses' voices to be heard on this subject. Both of these factors display that future research needs to be done like this in other agencies and other healthcare facilities in order to broaden our understanding of the prevalence and scope of these discrepancies in caring for nurses' grief.

References:

- Aiken, L.H., Clarke, S.P., Sloane, D.M., Sochalski, J., & Sibley, J.H. (2002). Hospital nurse staffing and patient mortality, nurse burnout and job dissatisfaction. *JAMA*, *288*(16), 1987- 1993. Doi:10.1001/jama.288.16.1987.
- Attig, T. (2004). Disenfranchised grief revisited: Discounting hope and love. *OMEGA*, *49*(3), 197-215.
- Axelrod, J. (2006). The 5 stages of loss and grief. *Psych Central*. Retrieved on October 26, 2013, from <http://psychcentral.com/lib/the-5-stages-of-loss-and-grief/00617>
- Aycock, N. & Boyle, D. (2008). Interventions to manage compassion fatigue in oncology nursing. *Clinical Journal of Oncology Nursing*, *13*(2), 183-191.
- Ball, E. (2011). A social purpose model for nursing. *Nursing Forum*, *46*(3), 152-156.
- Baverstock, A. & Finlay, F. (2008). What can we learn from the experiences of consultants around the time of a child's death? *Child: care, health and development*, *34*(6), 732-739.
- Boelen, P. (2011). Personal goals and prolonged grief disorder symptoms. *Clinical Psychology and Psychotherapy* *18*, 439-444.

Bohman, J., "Critical Theory", *The Stanford Encyclopedia of Philosophy* (Spring 2013

Edition), Edward N. Zalta (ed.), URL =

<http://plato.stanford.edu/archives/spr2013/entries/critical-theory/>.

Brown, C. & Wood, A. (2009). Oncology nurses' grief: A literature review. *Clinical Journal of Oncology Nursing*. 13(6), 625-627.

Burr, W.R. (1995). Using theories in family science. In R.D. Day, K.R. Gilbert, B.H. Settles, & W. R. Burr (Eds.), *Research and theory in family science* (pp. 73-90). Pacific Grove, CA: Brooks/Cole.

Cacciatore, J. & Flint, M. (2012). Attend: Toward a mindfulness-based bereavement care model. *Death Studies*. 36, 61-82.

Clements, P.T. & Bradley, J. (2005). When a young patient dies. *RN*, 68(4), 40-43.

Coetzee, S. K. & Klopper, H.C. (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing and Health Sciences* 12, 235-243.

Cribb, A. (2011). Integrity at work: Managing routine moral stress in professional roles. *Nursing Philosophy*, 12, 119-127.

Denzin, N. K. (1992). *Symbolic interactionism and cultural studies*. Cambridge, MA: Blackwell.

Doka, K. (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington, MA: Lexington Books.

Fetter, K. (2012). We grieve too: One inpatient oncology unit's interventions for recognizing and combating compassion fatigue. *Clinical Journal of Oncology Nursing*, *16*(6), 559-561.

Figley, C.R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Psychotherapy in Practice* *58*(11), 1433-1441.

Forte, J.A., (2007). *Human behavior and the social environment: Methods, metaphors, and maps for applying theoretical perspectives to practice*. Belmont, CA: Brooks/Cole.

Hinds, P.S., Milligan, M., & Puckett, P.J. (1996). Who supports you when your patient dies? *RN*, *59*(10), 48-51.

Jenkins, S.R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *International Society for Traumatic Stress Studies*, *15*(5), 423-432.

- Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22(4), 116-121.
- Kaplan, L.J. (2000). Toward a model of caregiver grief: nurses' experiences of treating dying children. *OMEGA*, 41(3), 187-206.
- Keene, E.A., Hutton, N., Hall, B., & Rushton, C. (2010). Bereavement debriefing sessions: an intervention to support health care professionals in managing their grief after the death of a patient. *Pediatric Nursing*, 36(4), 185-190.
- Lenhardt, A.M.C. (1997). Grieving disenfranchised losses: Background and strategies for counselors. *Journal of Humanistic Education & Development*, 35(4).
- Lombardo, B. & Eyre, C. (2011). Compassion fatigue: A nurse's primer. *Online Journal of Issues in Nursing*, 16(1), 1.
- Maloney, C. (2012). Critical incident stress debriefing and pediatric nurses: an approach to support the work environment and mitigate negative consequences. *Pediatric Nursing*, 38(2), 110-115.
- Mak, Y.W., Chiang, C.L., & Chui, W.T. (2013). Experiences and perceptions of nurses caring for dying patients and families in the acute medical admission setting. *International Journal of Palliative Nursing*. 19(9), 423-431.

McMullen, L. (2007). Oncology nursing and compassion fatigue: Caring until it hurts.

Who is caring for the caregiver? *Oncology Nursing Forum*, 34(2), 491-492.

Meadors, P., Lamson, A., Swanson, M., White, M., & Sira, N. (2009). Secondary traumatization in pediatric healthcare providers: Compassion fatigue, burnout, and secondary traumatic stress. *OMEGA*, 60(2), 103-128.

Melvin, C.S. (2012). Professional compassion fatigue: what is the true cost of nurses caring for the dying? *International Journal of Palliative Nursing*, 18(12), 606-611.

Monette, D.R., Sullivan, T.J., & DeJong, C.R. (2011). *Applied social research: Tool for the human services* (8th Ed.). Belmont, CA: Brooks/Cole.

National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers*. Washington, DC: NASW Press.

Neimeyer, R.A., Baldwin, S.A., & Gillies, J. (2006). Continuing bonds and reconstructing meaning: mitigating complications in bereavement. *Death Studies*, 30. 715-738.

Newell, J.M. & MacNeil, G.A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventative methods for clinicians and researchers. *Best Practice in Mental Health, 6(2)*, 57-68.

Ostrowski, M. (2003). Caring 'til it hurts. *RN 66(7)*, 9.

Papadatou, D. (2000). A proposed model of health professionals' grieving process. *Omega, 41(1)*, 59-77.

Pfifferling, J.H., & Gilley, K. (2000). Overcoming compassion fatigue. *Family Practice Management, 7(4)*, 39-46.

Pomeroy, E. (2011). On Grief and Loss. *Social Work, 56(2)*, 101-105.

Pomeroy, E. C., & Garcia, R. B. (2011). *Theories of grief and loss: An overview*. In E.C. Pomeroy & R.B. Garcia (Eds.), *Children and loss: A practical handbook for professionals* (pp. 1-16). Chicago: Lyceum Books.

Rashotte, J. (2004). Dwelling with stories that haunt us: Building a meaningful nursing practice. *Nursing Inquiry, 12(1)*, 34-42.

Reese, D. (1996). Please cry with me: six ways to grieve. *Nursing, 26(8)*, 55-56.

Sabo, B. (2011). Reflecting on the concept of compassion fatigue. *Online Journal of Issues in Nursing, 16(1)*.

Shorter, M., & Stayt, L.C. (2009). Critical care nurses' experiences of grief in an adult intensive care unit. *Journal of Advanced Nursing 66(1)*, 159-167.

Stamm, B. H. (2009-2012). Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). www.proqol.org

Thompson, A. (2013). How Schwartz rounds can be used to combat compassion fatigue. *Nursing Management, 20(4)*, 16-20.

Trepanier, S., Early, S., Ulrich, B., & Cherry. (2012). New graduate nurse residency program: A cost-benefit analysis based on turnover and contract labor usage. *Nursing Economics, 30(4)*, 207-214.

Appendix A

Agency Consent Form

Research: Please provide your agency with the information about your project and have your agency contact complete this form.

Agency: Please read this form and ask any questions you may have before agreeing to allow this study to take place at your agency. Please keep a copy of this form for your records.

Project Name	Nurses Grief and Compassion Fatigue	IRB Tracking Number	
This is a study to research the disenfranchised grief of nurses and how if left untreated can lead to compassion fatigue.			
Your agency is invited to participate in this research.			
Your agency was selected based on its location, its familiarity to the researcher, and because it has a large number of nurses in a variety of patient units: CVCC, NICU, PICU, ED and Oncology.			
Study is being conducted by:	Kelly McManimon		
Research Advisor (if applicable):	Lance Peterson		
Department Affiliation:	University of St. Thomas – Masters of Social Work		
Background Information			
This is a study to research the bereavement services being provided to nurses who experience grief after the loss of a child at your agency. I am looking to investigate if the nurses' grief is being addressed? Are bereavement services provided? If nurses utilize bereavement services that are provided? And does this help them eliminate the risks of developing compassion fatigue?			
Procedures			
If you agree to be in this study, you would be asked to sign a consent form stating you understand and are voluntary participants in this research study. You would then be asked to fill out an online survey. Included in the study would be your email address. After the survey is complete a random selection of respondents would be emailed to request that they participate in a short 30-45 minute face-to-face interview, which would be audio recorded and then transcribed. All the information from respondents would be voluntary and kept confidential. If a respondent chose to end their participation at any time, their previous responses would not be used in the research. The findings from the research would be analyzed and presented at the University of St. Thomas on May 19 th , 2014.			

Risks and Benefits of being in the study	
<p>The risks of participating in this research are minimal. The risks include: the sensitive nature of questions may bring up emotional responses in the participants that are unwanted or unexpected. The risk of a breach of confidentiality is also a risk.</p> <p>There are no direct or indirect benefits to participating in this study.</p>	
Compensation	
<p>There will be no compensation for this study.</p>	
Confidentiality	
<p>Every effort will be made to be sure that your participation in this study and all records of your participation will remain confidential. But absolute confidentiality cannot be guaranteed. Due to the review process of my research a few select parties may have the right to review the records of this study. These agencies or members include: the hospital's Institutional Review Board (IRB) and the sponsor, Theresa Huntley (LICSW), as well as the University of St. Thomas review board, and the Chair Lance Peterson, as well as final committee member Bridget Chastain (RN). The purpose of those reviewing my research is to ensure the rights and welfare of the participants are protected and the study is carried out in an ethical manner. If the study is to be published the confidentiality of subjects will be maintained. Audio and digital records will be kept on my personal computer with password protection, any handwritten documentation will be kept locked in a drawer in my personal residence, I will be the only individual with access to these files. All documents both handwritten and digital will be destroyed three months following the completion of my research, which is anticipated June of 2014.</p>	
Voluntary Nature	
<p>Allowing the study to be conducted at your agency is entirely voluntary. By agreeing to allow the study, you confirm that you understand the nature of the study and who the participants will be and their roles. You understand the study methods and that the researcher will not proceed with the study until receiving approval from UST Institutional Review Board. If this study is intended to be published, you agree to that. You understand the risks and benefits to your organization.</p>	
<p>Taking part in this study is completely voluntary. By signing this Consent form, you agree to take part in the research study. You are free to withdraw from this research study at any time with affecting your current or future relationship with the University of St. Thomas or the hospital.</p>	
Contacts and Questions	
Researcher Name:	Kelly McManimon
Research Email:	Mcma4677@stthomas.edu

Researcher Phone:	651.246.8981		
Research Advisor Name:	Lance Peterson		
Research Advisor Email:	Pete2703@stthomas.edu		
Research Advisor Phone:	651.962.5811		
UST IRB Office:	651.962.5341		
Statement of Consent			
I have read the above information. My questions have been answered to my satisfaction and I consent to allow the study to be conducted at the agency I represent. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent.			
Signature of Agency Representative		Date	
Print Name of Agency Representative			
Signature of Researcher			
Print Name of Researcher			

Appendix B:

Nurses' Grief and Compassion Fatigue Informed Consent

This research study involves completion of a survey online. You were selected because you work at the hospital of choice on one of the following units: CVCC, NICU, PICU, ED, or Oncology.

The purpose of the research is to understand what services are provided for nurses at the hospital when they experience the grief from the loss of a patient and if those services are effective in protecting nurses against compassion fatigue.

First Part of this Study- Survey

Your participation in this research study is voluntary. The first part of this study involves completion of a survey which will include about 30 questions and will take approximately 10-15 minutes to complete.

There are minimal risks associated with participating in the survey portion of this research. You may feel that some of the questions asked in the survey are sensitive in nature and you may feel an unwanted or unexpected emotional response to a question. If you begin completing the survey, you will be able to choose to end participation at any point throughout the survey. If you do not complete the survey, your responses up to that point will not be used by the researcher. The researcher will have a list of resources provided at the end of the survey for any participants that feel they may need a referral to speak with someone in regards to the questions that were asked.

All survey responses will be anonymous, unless you provide the researcher with your email address at the end of the survey to indicate that you are willing to be contacted

regarding participation in the second part of this study, which involves a face-to-face interview. (Please see description of 2nd part of this study below.)

All data obtained from the surveys will be kept on the researcher's computer under password protection. All information related to this research study will be destroyed three months following the presentation of findings on May 19th, 2014 at the University of St. Thomas. The researcher will be the only individual with access to the data.

There is no direct benefit to you for participating in this research. Indirect benefits include the potential to contribute to the knowledge of how nurses' grief can be addressed by the provision of care at healthcare facilities in which they are employed. This knowledge may help to further research in providing quality of care to helping professionals in their care of others and of themselves.

If you are not chosen for a face-to-face interview, your email will be deleted from the research data and will not be associated with your responses to the survey questions.

Second Part of this Study- Interviews

Once you have completed the survey you will have an opportunity to volunteer for the second part of this research study, which will involve a face-to-face interview with the researcher. Only 6 volunteers will be chosen for interviews. The interview will take place on the hospital campus, either before or after your work shift and will take approximately 30-45 minutes. If you are willing to participate in the interview, there will be a space at the end of the survey to indicate that you would like to volunteer. You will be asked to provide your work email address so that the researcher can follow up by

email to schedule a time for the interview. A separate paper consent will be provided to you for the interview portion of the study to document your consent to participate.

The interview will include 10-15 questions about your experiences with grief resulting from the loss of patients. This will include questions about how you managed your grief, the bereavement services that were available at the hospital, and other support that you had for your grief.

If you have any questions or concerns or would like to pull out of the study at any time you can contact the researcher by calling: Kelly McManimon 651.246.8981, or Lance Peterson, Associate Professor at St. Thomas University, 651.962.5811.

Thank you in advance for your time and consideration of your participation in this research.

I agree to participate in the first part of this study, which involves an online survey.

Appendix C:

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways.

Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help]*.

14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *[helper]*.
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
24. I am proud of what I can do to *[help]*.
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a *[helper]*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

© B. Hudnall Stamm, 2009. *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*. /www. isu. edu/~bhstamm or www. proqol. org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Appendix D:

Hospital

RESEARCH CONSENT FORM

Nurses Grief and Compassion Fatigue

INTRODUCTION

Before agreeing that you will take part in this research, it is important that you read and understand the following explanation. It describes the purpose, benefit, risks and discomforts of the study, and the safeguards that will be taken. It also describes any other options that are available and the right to withdraw (quit) from the study at any time.

BACKGROUND

You are invited to be in a research study about the disenfranchised grief of nurses and the relationship between unaddressed grief and compassion fatigue. This study is to understand what bereavement services are offered to nurses at the hospital.

RESEARCH PURPOSE

The hope of the research is to understand if nurses who are grieving the loss of a patient are being adequately attended to at their place of employment. Are there services provided for them to express and manage their grief? If there are bereavement services, are they adequate enough to prevent the risks of compassion fatigue? And if there are services, are the nurses utilizing them?

You have already participated in the online survey portion of this study and indicated that you wanted to be contacted to participate in the second part of this study, which involves a face-to-face interview. This consent is for the second part of this research study, which involves a face-to-face interview with you, conducted by the researcher for this study.

RESEARCH PROCEDURES

You will be asked to participate in a 30-45 minute face-to-face interview, which will include 10-15 questions about your experiences with grief resulting from the loss of patients. This will include questions about how you managed your grief, the bereavement services that were available at the hospital, and other support that you had for your grief. The interviews will take place at the hospital either before or after your scheduled shift. Your responses will be audio recorded and transcribed by the researcher. You will be asked not to use your name in the interview and to use pseudonyms (a name different from the person's real name) for any individuals that you discuss in the interview. All information that you provide will be kept confidential. The researcher will also take notes during the interview for later analysis. The findings from the research will be analyzed and presented at the University of St. Thomas on May 19, 2014.

RISKS

The risks of participating in this research are minimal. You may feel that some of the questions asked in the interview are sensitive in nature and you may feel an unwanted or unexpected emotional response to a question. You may end your participation at any time by telling the researcher that you feel uncomfortable or do not want to continue. If you choose to end your participation at any time, your previous responses will not be used by the researcher.

The potential for loss of confidentiality is also a risk of this study. The researcher will protect your confidentiality not using your name in the interview and by storing all electronic recordings on a password protected computer and storing any notes recorded on paper in a locked secure manner. Access to this information will be restricted to the researcher and Theresa Huntley (the researcher's sponsor at the hospital). The hospital (IRB) and the University of St. Thomas IRB may review research records as part of their efforts to protect research subjects.

BENEFITS

There is no direct benefit to you for participating in this study. Indirect benefits include the potential to contribute to the knowledge of how nurses' grief can be addressed by the provision of care at healthcare facilities in which they are employed. This knowledge may help to further research in providing quality of care to helping professionals in their care of others and of themselves.

ALTERNATIVES

You may choose not to participate in this study. As previously discussed, you may choose not to answer some questions and can withdraw from the study at any time without consequence. If you decide not to continue part way through the research, none of their previous responses will be used.

CONFIDENTIALITY

Every effort will be made to be sure that your participation in this study and all records of your participation will remain confidential. But absolute confidentiality cannot be guaranteed. Due to the review process of this research a few select parties may have the right to review the records of this study. These individuals and groups include: The hospital IRB, University of St. Thomas IRB and the sponsor, Theresa Huntley (LICSW), and Lance Peterson, the Research Chair at the University of St., Thomas. The purpose of those reviewing this research is to ensure the rights and welfare of the participants are protected and the study is carried out in an ethical manner. If the study is published the confidentiality of subjects will be maintained. Audio and digital records will be kept on the researcher's computer with password protection, any handwritten documentation will be kept locked in a drawer in the researcher's personal residence. All documents both handwritten and digital will be destroyed three months following the completion of this research, which is anticipated on May 19, of 2014.

FINANCIAL ISSUES

Costs for participation in the study

Appendix E:

Mini-Survey Questions:

1. Gender: _____
2. Age: _____
3. What unit do you work on? _____
4. How many years have you been a nurse? _____
5. Have you ever had a patient die in your care? _____
6. How long has it been since the patients passing? _____
7. Have you ever experienced grief over the death of a patient? _____

INTERVIEW QUESTIONS:

1. When you are grieving for a patient what type of symptoms do you experience?
2. Who do you share your grief with?
3. In what ways do you manage your grief?
4. Are there services that are available at the hospital for you to utilize? If yes, what are they? If no, what do you wish was available?
5. Why do you utilize these specific services?
6. What prevents you from participating in the other services?
7. Are there informal supports at the agency in which you work?
8. What do these supports look like? Are they well utilized?
9. Which supports do you find most beneficial?
10. Please comment on the benefits of informal supports versus formal supports.

Appendix F:

UST Review Board Approval

Institutional Review Board



Institutional Review Board - University of St. Thomas
2115 Summit Ave. - Mail #AQU319
St. Paul, MN 55105-1078
Phone: 651-962-5341 - Email: irb@stthomas.edu

DATE: February 6, 2014

TO: Kelly McManimon, MSW
FROM: University of St. Thomas Institutional Review Board

PROJECT TITLE: [547974-1] Nurses Grief and Compassion Fatigue
REFERENCE #:
SUBMISSION TYPE: New Project

ACTION: APPROVED
APPROVAL DATE: February 6, 2014
EXPIRATION DATE: February 6, 2015
REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # *[enter category, or delete line]*

Thank you for your submission of New Project materials for this project. The University of St. Thomas Institutional Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of February 6, 2015.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Eleni Roulis at 651-962-5341 or e9roulis@stthomas.edu. Please include your project title and reference number in all correspondence with this committee.

Appendix G:

Hospital IRB

Date: February 6, 2014 **To:** Kelly McManimon

From: Subject: IRB# 1401-007 Nurses Grief and Compassion Fatigue

The protocol referenced above was APPROVED (as of the above date) by expedited review (according to federal regulations 46.110, category 7).

The IRB requests progress reports on this protocol every 12 months. The approval for this study will expire **February 5, 2015.**

This approval is contingent on the Institutional Review Board's review of any changes (now or in the future), which other IRBs stipulate.

If I can be of further assistance to you, please do not hesitate to contact me. We wish you success with your research.

CC: Theresa Huntley