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***Experiencing patient death in clinical practice: New Zealand nurses' recollections of their earliest memorable patient death***

**Abstract**

Background: Death and dying are inevitable life encounters, but a nurse's first experience with patient death may pose considerable cognitive, emotional and clinical challenges. This paper reports the findings of the second phase of a study; the first has been reported elsewhere (Kent et al., 2012). This phase explored the earliest memorable patient death experiences of New Zealand registered nurses.

Method: A purposeful, self-selected sub-sample of a larger study of New Zealand registered nurses, took part in individual face-to-face semi-structured interviews. Interpretative Phenomenological Analysis (IPA) was utilised to seek to understand participants' experiences. Thematic analysis was undertaken to identify emerging themes, with participants' own words used as theme headings, where their phrases provided succinct or powerful descriptors.

Results: A diverse participant group of twenty, currently practising, New Zealand registered nurses provided rich and detailed descriptions of their earliest memorable experience with patient death. Participants from a variety of training backgrounds described patient deaths, which occurred in a range of settings – some only a few months prior, others - more than thirty years ago. Seven emergent themes, and features of more positive, or negative experiences were identified: Event Significance; Emotional Challenges; Sharing the Experience; Learning; Feeling Unprepared, Responses to Death and Finding Benefits.

Conclusion: For participants in this study, there was considerable evidence that their earliest memorable patient death was a significant event. Furthermore, although most participants' experiences were characterised by emphatic or poignant description, there was most often a balance of challenges and rewards.

## **Keywords**

Death

Dying

End of life care

Nursing

Nursing education

Qualitative research

## **What is already known about this topic?**

- Research suggests there is significant variability in preparation of undergraduate nursing students for patient death and dying
- Initial encounters with patient death and dying can be highly anticipated events for student nurses

## **What this paper adds**

- Nurses' earliest memorable experiences with patient death can be significant, vividly recalled events, with the potential to exert a lasting impact
- Distressing or negative patient death experiences are often characterised by unexpected elements, lack of acknowledgement and feeling inadequately prepared or helpless
- The most positive patient death experiences are characterised by learning, the supportive influence of a nursing role model and feelings of inclusion and acknowledgement

## Background

Nursing is a stressful job, with high rates of turnover and attrition, which can have serious implications for all health consumers - low nurse-patient ratios are significantly associated with higher rates of patient morbidity and mortality (Aiken et al., 2002, Needleman et al., 2002).

Although empirically far more challenging to measure than deaths and surgical complications, the quality of care provided by nurses adds value to health consumers. Nurses who have the clinical knowledge, coping skills and collegial support (from other well prepared and supported nurses) should be able to provide patient care beyond competent, safe performance of tasks.

This research focuses on one aspect of nursing preparation and support; that of nurses' early experiences with patient death. For decades, researchers have suggested that student nurses' first experiences with patient death can have a significant influence on practice, and attitudes regarding death and dying can be firmly established by the time nurses qualify (Chen et al., 2006, Golub and Reznikoff, 1971, Hurtig and Stewin, 1990, Khader et al., 2010). Nurses who find early encounters with death and dying very difficult can experience feelings of inadequacy, helplessness, defensiveness or distress and coping mechanisms such as suppression, distancing and avoidance may be adopted (Cooper and Barnett, 2005, Kent, 2004, Terry and Carroll, 2008). This can potentially impact on the quality of care delivered, job satisfaction, turnover and attrition.

Quint (1967) highlighted the pivotal role of nurses, in end-of-life care, and advocated for adequate preparation and support for nurses through their early clinical encounters with death and dying.

More recent studies have highlighted that newly qualified nurses can feel anxious, overwhelmed, ill-prepared, inadequate and unskilled when faced with the challenges of caring for dying patients (Allchin, 2006, Beck, 1997, Gillan et al., 2014). Today, there is significant attention on improving the quality of end-of-life care through effective death education for undergraduate nurses (Cavaye and Watts, 2014) and particular focus on offering placements that enable students to be exposed to developments in palliative care and hospice settings (Allchin, 2006, Gillan et al., 2014, Mallory, 2003).

Experiential learning, role play and simulation are also more widely used, which appear to be effective ways of teaching nurses about caring for dying patients and their families (Hurtig and Stewin, 1990, Khader et al., 2010, Kopp and Hanson, 2012).

Despite these changes, little is known about the impact of nurses' early experiences with patient death. Thus a two-phase study was undertaken to address this in New Zealand. It began with an online survey of 174 New Zealand registered nurses (Kent et al., 2012) which was followed by the interview phase of the study. This applied the principles of interpretative phenomenological research to answer a number of key questions, namely:

1. What is the nature of nurses' earliest memorable experiences with patient death?
2. Do nurses' earliest memorable patient deaths have an impact on them, personally or professionally?
3. What cognitive, emotional and clinical challenges do nurses face when they experience patient death for the first time? How do nurses cope with these demands?
4. Do nurses recall positive, rewarding and satisfying aspects to their earliest memorable patient death experiences? What factors are associated with such aspects?
5. Do nurses' feel that they were adequately prepared for early nursing encounters with death and dying?

## **Methodology**

Interpretative Phenomenological Analysis (IPA), an explicitly interpretative approach to analysis of identified descriptive themes and engagement with existing theory, was used for this phase of the study. IPA has been widely applied in health research, including explorations of patient and family experiences of health events, and experiences of health professionals (Smith, 2011). IPA has roots in psychology, and draws from phenomenology, hermeneutics and ideography (Brocki and Wearden, 2006). IPA is regarded as an accessible, user-friendly approach to understanding human experiences

(Pringle et al., 2011). The researcher attempts to move beyond a third person, descriptive, account of participants' experiences, interpreting the meaning of the cognitive, behavioural and emotional components that have been described (Larkin et al., 2006, Smith, 1996). This has been described as a double hermeneutic, with both researcher and participant working in partnership, to make sense of experiences (Smith, 2011).

### Sampling

Participants were recruited from a sample of registered nurses, all of whom were currently practicing in a major metropolitan region in New Zealand and enrolled in postgraduate nursing papers at the University of Auckland. This convenience sample included a number of recently-graduated nurses as well as more experienced nurses undertaking advanced nursing qualifications. All had volunteered to take part in this interview phase of the study after completing an online survey, the details of which are described elsewhere (Kent et al, 2012).

### Data collection

The volunteers were sent a participant information sheet via email, consent was sought and subsequently, an interview time was scheduled. The first author (NA), who was a Registered Nurse with experience of conducting sensitive interviews, undertook one face-to-face interview with each participant, in a mutually agreed, private setting. All interviews were conducted between July and September, 2008. The researcher began each interview with a statement to the effect of "Tell me everything you can remember about your earliest memorable patient death." A semi-structured interview approach, which is considered the ideal data collection method for IPA, allowed participants to tell their story whilst still giving the researcher flexibility to build rapport and use probes in a way which is sensitive to participants' responses, concerns and interests (Smith and Osborn, 2003).

### Data analysis

Each interview was digitally recorded and transcribed in full, inclusive of written indicators of pauses, emphases and emotional expression. IPA acknowledges that the account provided by participants is a reflection of the way they have made sense of that experience. The initial part of each interview, where participants would 'tell the story' of their earliest memorable patient death without interruption, was therefore considered to be particularly meaningful, signalling themes which the participants considered most salient or noteworthy.

When analysing the transcripts, the researcher attempted genuinely to represent the participants' experiences, whilst also acknowledging the limitations and complexities of the conversations and the interplay between participant and researcher. Coding was performed manually, with ideas from previous transcripts 'bracketed' and each transcript initially considered by itself. Consideration was then given to both convergent and divergent emergent themes. Generous verbatim excerpts from transcripts accompany interpretative analysis to provide "grounding in examples" (Elliott et al., 1999), allowing the reader to make their own judgements regarding the interpretation of accounts.

Throughout the design, recruitment, collection and analysis phases, the researcher was aware of the need to acknowledge and incorporate her own nursing experience, with her appreciation of the principles of scientific research. As the researcher was an experienced nurse she had come to trust her own instincts and be guided by 'intuitive' decision making which merges her clinical knowledge with her experience. The sometimes subconscious nature of intuitive decision making, which is part of her clinical role as a nurse, is almost in direct opposition to this deconstruction and questioning of her way of seeing the world.

## Ethics

Death and dying are sensitive topics, and the researcher was mindful that conducting qualitative research can pose risks to both participants and researcher (Dickson-Swift et al., 2008). All interview participants signed a comprehensive consent form and gave permission for interviews to

be digitally recorded. Ethics approval was granted by the University of Auckland Human Participants Ethics Committee. Furthermore, all participants had access to professional counselling services and one of the research team was a clinical psychologist. Researcher supervision included frequent opportunities for reflection and debriefing

## Results

Over fifty of the survey participants volunteered to be interviewed to explore further their earliest memorable patient death. After 20 participants were interviewed, data saturation was reached, and consequently, no further interviews were undertaken.

**Table 1: Participant demographics**

<b>Variable</b>	<b><i>n</i></b>
<b>Age</b>	
21-30	8
31-40	9
41-50	3
<b>Ethnicity</b>	
NZ European	11
Other European	4
NZ Maori	2
Other	3
<b>Gender</b>	
Female	17
Male	3
<b>Training institution</b>	
NZ Tertiary	13
NZ Hospital	2
Other Tertiary	2
Other Hospital	3

As can be seen in Table 1, a large proportion of newly graduated and senior nurses were included in the sample, which appeared to reflect the groups who were most likely to embark on postgraduate study at the time the research was being undertaken. Excerpts from the transcripts are presented here to illustrate the themes, along with pseudonyms, the training level of the participant at the time of the patient death, and the number of years elapsed since the patient death.

## Accounts of the earliest memorable patient death

The interview duration ranged from 20-50 minutes, with most lasting around 40 minutes. Although probes were prepared, they were rarely needed, as the nurses typically provided a rich and detailed narrative, which spontaneously addressed many of the key research questions without further prompting. The clinical circumstances of patient deaths varied widely and included sudden unexpected deaths of young people, neonatal deaths and expected deaths following long or critical illness. Most (n = 17) nurses revealed that the experience described was their very first encounter with patient death. Three nurses alluded to earlier encounters with patient death, but did not choose them to speak about since they had very little or no nursing involvement. At the time of these, many had had no prior exposure to death or dying in their family lives. Most participants experienced this death during their nursing training (n = 14) or as newly-graduated registered nurses (n = 5). The deaths most commonly took place in medical wards (n = 12) or other specialised acute settings (n = 7), which included emergency departments and intensive care units. Only one death occurred in a specialised palliative care setting. The time that had elapsed since this memorable event varied from only a few weeks to over 35 years.

The nature and extent of the participants' nursing care given during the death experience varied. Seven participants were involved with post mortem care, and for three nurses, this was their only contact with the patient. Other reported nursing care included attempting resuscitation, providing symptom-relieving medication, explaining brain-death testing to family members, notifying family members of a patient death and facilitating a family gathering complete with beer, food and guitars, the night before a patient died. Many of the accounts were extremely poignant, and recall of the experience was often so vivid that participants appeared to be re-living the encounter, complete with the emotions they experienced at the time.

## Themes

Seven key themes emerged from the interview data: Event Significance; Emotional Challenges; Sharing the Experience; Learning; Feeling Unprepared, Responses to Death and Finding Benefits.

These are discussed, with illustrative interview extracts, below:

### Event Significance

One of the key aims of this research was to determine if nurses' early experiences with patient death were salient events that had the potential to have an impact on their professional and personal lives. For these participants, there was considerable evidence that their earliest memorable death was a significant event. A challenging combination of clinical and personal factors appeared to have contributed to particularly demanding or distressing experiences for a few participants.

One of the most striking features of these accounts was the vivid recall of details provided by participants. In addition to readily providing details of their own thoughts, actions and feelings at the time, most participants spontaneously recalled the name and age of the patient who had died, pertinent information about family members and, in some cases, highly specific clinical details. Many reported that they had thought about the experience numerous times since it had occurred. Yasmin and Olivia's accounts reflect this:

*Yeah, well I can remember it vividly. . . . I can remember the people that were around that we were trying to get rid of, as well. And the doctors and everything. . . I can just sort of play through it in my mind. (Yasmin, student nurse at time of patient death, 12 years earlier)*

*I brushed her hair, very, very gently, and I took my time. I made sure I rolled a towel and put it underneath her neck. . . . And I laid her flat, making sure that her feet touched. . . . For me, looking at her hands when I was massaging them with hand lotion, [re-enacting holding patient's hand in hers] I kept thinking I wonder what these hands have done. She had lovely knobs on the tips of her fingers. And she had long fingers, and they were delicate and lovely nails that were manicured. (Olivia, student nurse at time of patient death, 30 years ago)*

The impact of patient death experiences was sometimes positive, sometimes negative, and sometimes mixed. Some nurses had subsequently avoided contact with death and dying, particularly clinical situations that reminded them of their experience. For others, an admired role-model, or rewarding experience, stirred interest in care of the dying, which they developed further. Sarah and Tracey capture the expressed polarised responses:

*I certainly don't ever want to work in medical - adults. People gasping for breath just doesn't work for me at all [laughing]. So, yeah. It is - not right at the top of my list when I'm making job decisions - about new careers, new pathways. But that whole breathing thing. Adult medical. Men, particularly. They cough and splutter and spit and - [voice trailing off] it's yucky. (Sarah, student nurse at time of patient death, 29 years ago)*

*So that was my first experience. And I think that's why, ever since that time - so I was eighteen and a half - I said, I think I want to be like [senior nurse working with participant], I think I want to look after cancer patients. If that's what - if that's the sort of experience I can get out of it. And what the patient can get out of it. You know, he died very peacefully. . . . And I thought, you know, this sounds a really nice way of being able to care for people. So after my training, that's what I wanted to do. (Tracey, student nurse at time of patient death, 16 years ago)*

Although many nurses became emotional during interviews, a few nurses described more severe ongoing distress following this experience of death, including disruptive or intrusive thoughts, feelings and behaviours. Negative responses included sleeplessness, re-experiencing the event through dreams, and avoidance of similar clinical situations, with some expressing serious concerns about the ongoing impact of their death experience on future nursing practice. Several nurses took time off work after the event, two took extended leave and one never returned to the clinical setting where the death took place. Mark's recollections capture this:

*Actually, I couldn't sleep for two days. At all. And my [partner] was very worried about me. I couldn't come back the next day, because I was - sort of - traumatised, myself. And that was my first day, and I thought I might not be able to go back. . . . I do have a lot of memories about the first patient. And it just keeps coming back to me. And as a registered nurse, now, I've seen some [other patients with the same diagnosis]. And every time I see those patients, I don't feel good, because I know the patient might die. And - just memories just keep coming back, and I have to work and I go home and go to sleep - and in my dreams, it keeps coming back. . . . (Mark, student nurse at time of patient death, 1 year ago)*

### Emotional Challenges

On reflection, a number of nurses felt that there were things that they would do or have done differently in subsequent encounters with patient death and dying. Whilst most viewed this positively, a few nurses found themselves burdened with ongoing guilt and regrets about their experiences. Sarah experienced repulsion and anxiety when witnessing a patient taking his last breaths, and expressed guilt about her reactions, and her subsequent avoidance of clinical areas where expected patient deaths occur.

*I think the whole experience took me by surprise. . . . I knew the theory but I certainly wasn't prepared for - they weren't big on buddy systems. There wasn't somebody I could really speak to, about it. And then the kind of guilt that I felt. That I should have done something different, or better. . (Sarah, student nurse at time of patient death, 29 years ago)*

Participants were thinking not only about their patient, but also recognising broader implications that death could have on others. A, now senior, nurse reported finding dealing with families and relatives to be the most challenging part of her experience, and thought that family-centred end-of-life care should have been given more attention in nursing training:

*I really don't recall when we had our training, when we talked about people dying, we talked about the person themselves dying maybe - or maybe we talked about death in a medical sense, in that kind of sense, but we never really - in terms of the impact on the people they leave behind and things. . . . when you're nursing a patient who's dying, you're not just nursing that person. You are looking after their whole family and everything. (Anna, student nurse at time of patient death, 17 years ago)*

### Sharing the Experience

This was the most frequently occurring key theme. Those who felt that they were part of a team at the time of the event, or confided in empathetic friends, family or colleagues afterwards, appeared to benefit from these sharing actions. Nurses who felt unable to share their experience, or when the emotional impact of the death was not acknowledged by others, appeared to experience more ongoing emotional distress. Informal debriefing with colleagues were often highlighted as important sharing opportunities .

*Debriefing after the death has always been a good thing. Everybody talks openly, it's nobody's fault. It's – these things happen. Those kind-of talks afterwards, I've always found to be a good thing. (Janelle, student nurse at time of patient death, 2 years ago)*

Facing their experience as novice health professionals, keen to be socialised into their new professional and social role, the theme of inclusion and acknowledgement emerged. Nurses appeared to cope most easily when they felt that they had been part of a team, or other colleagues acknowledged their emotional responses, effectively normalising them, as captured by Rose.

*Because the team support was there, and everyone was feeling it and they were quite open about it. . . I think the team helped and. . . afterwards we all sort of came to a halt, and went into the tea room and sat around a table. If they wanted to say 'oh it's really sad' or they wanted to swear, that*

*was all alright. But it was just the fact, you know, all experiencing something together, individually, if you like. (Rose, student nurse at time of patient death, 10 years ago)*

Conversely, some nurses felt their more experienced colleagues failed to acknowledge the emotional impact early experiences with death can have. Patricia was involved in the care of a patient who died suddenly, and felt pressured to carry on with her work afterwards, but would have appreciated an opportunity to talk about her feelings:

*So it was hard, because no-one actually asked after that 'are you alright' or 'how do you feel?'*  
*(Patricia, new graduate nurse at time of patient death, a few months ago)*

## Learning

Participants frequently identified learning opportunities provided by their death experience, and regarded it as a hurdle or even a rite of passage as a nurse. Nurses encountering death for the first time clearly benefited from working alongside a more experienced nurse. As simple as this may sound, not all of the nurses interviewed had this fundamental support. Nurses who were very new students often had particularly positive experiences, as they felt that the responsibility for nursing care lay primarily with their preceptor, at the time. When the first patient death experience occurred after graduation, there was often less supervision and support given. However, some nurses provided glowing accounts of the practical and emotional support provided by mentor nurses.

*It made me feel, not scared of it anymore. Not worried. Because, as a student nurse and as a nurse I was always worried about that first death. Worried how I was going to react and whether I'd know what to do and things. But when it came time, I was very calm . . . . It was actually extremely rewarding to sort of - conclude that. (Debbie, new graduate nurse at time of patient death, one year ago)*

*I was put with a fantastic nurse. . . everything that he did that day was just fantastic. . . . He made sure – first and foremost – that I was fine with what was going, he was aware that he had a student*

*nurse with him and it could have been something that was a real shock for me. (Janelle, student nurse at time of patient death, 2 years ago)*

### Feeling Unprepared

The majority of participants (n = 16) felt they had been inadequately prepared for their death experience, and all participants offered suggestions to improve preparation for novice nurses encountering death and dying. Many expressed feelings of frustration at a lack of death and dying related skills and knowledge, and a lack of confidence in their professional role:

*I'll never forget that – you know - the blue colour – because his lips and tongue were hanging out, and I never expected it to look like that. . . . Touching him was weird because I felt -I don't know - When I was alone with him, I felt very strange. . . . I didn't feel like it's allowed, to touch him.. (Debbie, new graduate nurse at time of patient death, one year ago)*

*And that was obviously the first time I'd ever seen a dead person. . . . I wasn't quite prepared for, sort of, a few things that happened. Like, when we rolled her over all the [laughs] gas came out of her body. Which is a bit shocking for a young student nurse! (Natasha, student nurse at time of patient death, 11 years ago)*

Participants who voiced feelings of helplessness and chaos at the time of the event often also described ongoing symptoms of distress associated with exposure to a traumatic event. This provides a contrast to the apparent protective function of focussing on nursing tasks and the satisfaction gained from confidence in the nursing role, which feature in later themes.

*I didn't know how to put together a Graesby, I'd never done that before, and I felt if I was there then I was going to lose my composure, and I didn't want to do that. . . . I really felt quite helpless, and unable to do anything, unable to help because of that. . . . I felt unable to give this patient and their family the kind of care and attention that they probably needed at the time. (Tony, new graduate nurse at time of patient death, a few months ago)*

## Responses to Death

Although participants had typically anticipated that they would encounter death and dying in their nursing role, many came away from their experience with an increased awareness of mortality. This event prompted thoughts or anxieties around their own mortality, or the mortality of their loved ones. Immediately following her experience, one nurse scheduled a medical check-up for a parent, another wrote a will and a third nurse reported discussing advanced directives with family members. Patricia found herself thinking about her parents' mortality, after the sudden unexpected death of her patient.

*I was shocked. Again, I think it was mostly because he was so close to my Mum's age, and so close to my Dad's age. And it really gets you thinking about a lot of things. (Patricia, new graduate nurse at time of patient death, a few months ago)*

Nurses sometimes shifted uneasily between descriptions of task-orientated nursing care and more emotionally-laden aspects of their death experience. Focussing on tasks – the technical aspects of their nursing care - seemed to have a protective function, both at the time of the event, and during the interview. Focus on the 'ritual' provision of post-mortem care was described by several participants:

*Almost a bit like a dance going on, with how you washed him, and how you laid him out - very specifically, how you wrapped the body and that sort of thing. And it did seem like a real - yeah, a ritual. (Brenda, student nurse at time of patient death, 9 years ago)*

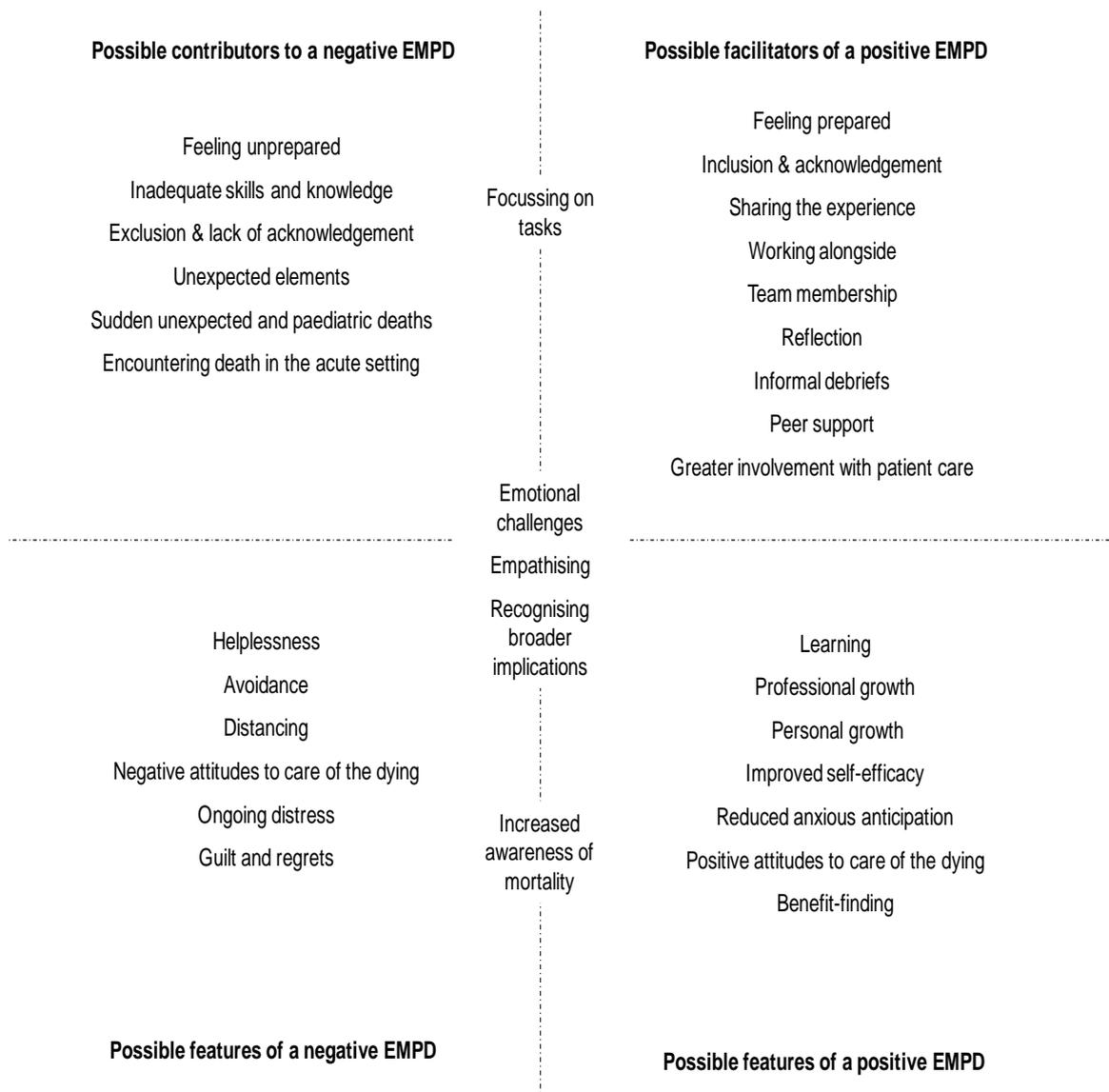
*I was wondering 'where on earth is this enrolled nurse that was meant to be helping me?' And I thought I've got to keep those thoughts at the back on my head. And I just sort of went into automatic overdrive and I knew - fold up her gear, have it ready in the bag. place the seat - there were two seats there - close to her. (Olivia, student nurse at time of patient death, 30 years ago)*

## Finding Benefits

Although participants' death experiences typically presented numerous challenges, several nurses were also keen to point out that they had benefited from the experience. Several of the positive aspects described by participants have been covered in previous themes, including the conquering of a 'first death hurdle', reduced death anxiety and increased self-efficacy, an opportunity for learning, mentorship and role-modelling, feeling included in a team and being well supported.

Rewarding aspects centred around facilitating peaceful death, giving good care to patients and family members, and showing respect for the deceased. Some nurses also described a sense of personal pride, satisfaction, or pleasure when others expressed approval or gratitude. An extremely rewarding aspect of this study was the spontaneous, heart-felt reporting of positive aspects of study participation, from many participants. As well as being generous with their time, participants were also very generous with their accounts, providing richly detailed recall and insightful reflections. Several participants, who were in their first year of nursing, appeared self-conscious or initially unsure, sometimes describing very 'fresh' experiences which had occurred only weeks or months prior. Even for those who had first encountered patient death some decades ago, some appeared to vividly re-live the experience as they described it, and strong emotional responses were often evident. Despite these apparent challenges, all interviews were completed in full, no-one withdrew from the study, and a majority of participants described their participation in the interview study as a positive, beneficial, or even therapeutic experience:

*I feel a bit less emotion in there [gestures pressing down on stomach]. Like there was a pressure, like - pressing me. . . but now I spoke it out so I feel less pressure in there. Probably to keep doing this – a regular, like, debriefing sort of session – would be very beneficial I think. . . . Hopefully it can just help others as well. (Mark, student nurse at time of patient death, 1 year ago)*



**Figure 1: Influential factors in participants' earliest memorable patient death (EMPD)**

### Discussion

The earliest memorable patient death experiences reported by participants in this research were very diverse. Just as there is no typical patient death or family grief experience, there appears to be no universal nurse response. Figure 1 presents the, apparently influential factors in participants' earliest memorable patient death experiences.

The enthusiastic responses, detailed accounts, and vivid recall of information, suggest that earliest memorable patient deaths were salient events for most participants. It is acknowledged that, by asking participants to report on the earliest memorable occasion when a patient died, participants may have been influenced to select a noteworthy early patient death, rather than reporting on the earliest one that they could remember. It should be noted, however, that 17 of the 20 interview participants reported that their earliest memorable patient death was also their first ever patient death.

Previous research indicated that nurses' early encounters with patient death can be highly anticipated, stressful or dreaded events (Cooper and Barnett, 2005, Delaney, 2003). Most interview participants predicted some contact with death and dying as an inevitable part of their job, and although they sometimes responded with shock at the physical aspects of death, or reported an increased awareness of their own mortality, there were few reports of high death anxiety. Anxious anticipation of patient deaths seemed to be focussed around the desire to meet perceived professional expectations – particularly to remain competent and composed. What appeared to be most distressing to nurses was: the unexpected elements of death, feeling helpless during or after the experience and feeling inadequately prepared. Information gained from the interviews indicated that participants often felt unsure of their role as nurses and had few practical skills and little knowledge about death and dying. Changes made to the content of the undergraduate curriculum in New Zealand and to placement locations may have helped to support some participants but these results reinforce those of earlier studies that suggest novice nurses are most anxious about the performance of their caring role as nurses, rather than being fearful of death itself (Beck, 1997, Cavaye and Watts, 2014, Cooper and Barnett, 2005).

Specific areas where participants expressed frustration with a lack of nursing knowledge and skills included: awareness of bodily changes after death; recognising signs of imminent death; the role of the nurse when a patient is dying; the role of the nurse when a patient is found deceased; the role of

the nurse after a patient has died; resuscitation survival rates; causes of sudden death; awareness of neonatal death and miscarriage; and the limitations of responsibility for student nurses in care of the dying patient and family. Increased use of role plays and simulation of peri and post-mortem care may assist students to address these practical knowledge and skill deficits (Hamilton, 2010).

Uncontrollable events, dealing with the unexpected and feelings of helplessness have been associated with the experience of stress (Taylor, 2012). Research suggests that hospital-based nurses feel a need to exert control over the trajectory of a patient's death, and that a well-controlled death is a 'good' death (Costello, 2006). This underlying desire for control was also evident in the interview data gathered in this study, as participants reported frustration with failing to anticipate events, being caught off-guard by their own, and others' emotional responses, and feeling unable to act due to a lack of skills and knowledge. Although control is not necessarily desirable or achievable, preparing nurses to cope with uncontrollable aspects of death and dying may, in itself, be a worthwhile goal.

Although this was not explored due to being beyond the scope of this research, it is plausible that care of the dying may be a more positive experience for a student nurse where palliative expertise and resources are readily to hand, and death is somewhat anticipated. Palliative care has rapidly evolved over recent decades, and the experience of caring for those with life-limiting illness, in settings such as hospice, may have more positive features (King-Okoye and Arber, 2014). Where attention can be focussed on patient and family, comfort and symptom management, there is likely to be opportunity for satisfaction and valuable learning, for student nurses.

## Limitations

Interview data were analysed using Interpretative Phenomenological Analysis (IPA), an iterative approach, outlined in the method. One of IPA's assumptions is that the participant is competent to

accurately and fully articulate the nature of their own experiences. As this study aimed to explore the cognitive, emotional and behavioural aspects of nurses' early experiences with patient death, this was quite a high expectation. This was a convenience sample of volunteers. Participants were all currently-employed nurses who were undertaking professional development through university education. Nurses who were not enrolled in postgraduate education, those who had left nursing, and those not inclined to volunteer for interview studies were not represented. Furthermore, the interview sample was made up of nurses aware that they would need to articulate their earliest memorable experience with patient death. Although the inevitable influence of 'volunteer bias' on this sample is acknowledged, the self-selection of nurses who felt able to communicate their experiences was necessary to meet the study aims. Logistical restraints, including time, may have precluded a more in-depth analysis and integrated presentation of the large amount of data collected for this study.

#### Researcher reflexivity

These studies were designed in consultation with members of the population of interest, under the supervision of experienced researchers (who in addition were a clinical psychologist and a registered nurse), and with ethics approval from the appropriate ethics committee. Participation in this study appeared to facilitate reflection and emotional expression, the benefits of which are supported by research and the anecdotal reports of participants themselves. Although a few participants showed signs of some mild distress during their interviews, every attempt was made to be sensitive to these responses. It was made clear that participants could stop the interview or withdraw from the study, and contact details for professional counselling support were made available. The primary researcher had training, and significant experience, in the use of therapeutic and assessment interview techniques, which may have influenced the style of interviewing used. The primary researcher's dual background in psychology and nursing influenced all aspects of this study, from inception, to design, data collection and analysis. It is possible that preconceptions and biases

influenced the way data were collected and analysed, particularly during interviews. Participants would sometimes explicitly appeal to the researcher's own nursing background, apparently seeking evidence of empathy or understanding, and when participants finished statements with ". . . you know?" it was sometimes challenging finding a balance between facilitating rapport by acknowledging camaraderie and probing for more detail. The assumption of a shared understanding between researcher and participant, as nursing peers, may, at times, have restricted the explicit revelation of the true nature of experiences. On the other hand, results from this research and numerous other studies suggest that nurses prefer to talk about sensitive work-related issues with other nurses, so it is likely that the researcher's nursing background facilitated participation, rapport and the candid, detailed and apparently uncensored nature of accounts provided.

## **Conclusion**

Relatively little has previously been published about nurses' early experiences with patient death, and the exploratory, inductive methodology underlying this research allowed the nature of these experiences to emerge. Results suggest that earliest memorable patient deaths are often salient events, which can have a significant impact on novice nurses. Interview participants had generally thought about death and dying in advance, but few had given consideration to challenging situations such as sudden, unexpected deaths. Where patient deaths were characterised by unexpected elements, lack of preparation and helplessness, participants were more likely to report distress both at the time of the event, and ongoing negative emotions, such as guilt and regrets, during the interview.

Sharing the experience with others was important to participants. Working alongside a more experienced nurse appeared to provide emotional and practical support, and the apparent reduction in responsibility helped to allay fears of inadequacy. The most positive patient death experiences were characterised by the supportive influence of a positive nursing role model, and opportunities for reflection with peers.

Little can be done to control the clinical circumstances of nurses' early death encounters – novice nurses may face extremely challenging situations, including sudden unexpected deaths. However, by better preparing and supporting novice nurses it may be possible to minimise more negative factors, including feelings of inadequacy, exclusion and role conflicts; and facilitate positive outcomes including coping, sharing the experience, personal and professional growth. Nurses supported this project enthusiastically, and many of those who shared their patient death experiences reported that their participation was, in itself, a beneficial experience. The potential benefits of facilitated reflective practice following early encounters with death merit further investigation.

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