University of Alberta

Experiences of Novice Nurses with their First Death in Critical Care
by

Gwen Ruth Theresa Thompson

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Master of Nursing

Faculty of Nursing

Edmonton, Alberta
Fall 2007

Your file Votre référence
ISBN: 978-0-494-33184-2
Our file Notre référence
ISBN: 978-0-494-33184-2

Dedication

This thesis is dedicated to

The nurses who so graciously shared their experiences for this study

and my parents

Cecile and (the late) Roland Thompson

Abstract

The curative focus of critical care and the advanced technology may overshadow the fact that critically ill patients die. Research investigating critical care nurses involvement with death has predominately focused on experienced nurses but these findings may not be applicable to novice nurses. Increasingly, novice nurses are beginning their careers in critical care and there is minimal research describing their experiences with death. A qualitative research study was completed to explore the experiences of novice nurses with their first patient death in critical care. Five nurses, employed in a medical-surgical intensive care unit, participated in the study. Data collection involved an unstructured interview with each participant. Analysis of the data revealed five themes: anticipating death, transition from life to death, the moment of death, being with the family, and carrying on. These findings are discussed with implications for academic and clinical settings and suggestions for future nursing research.

Acknowledgement

My sincere appreciation is extended to my thesis committee:

Dr. Joanne Profetto-McGrath (thesis supervisor) for her guidance and support as my thesis supervisor and faculty advisor. Your patience and editing skills were appreciated.

Dr. Wendy Austin (thesis supervisor) for her encouragement and guidance during data analysis. Your patience and sense of humour made the task much easier.

Dr. Barbara Russell for her commitment to this project. Your thoughtful and encouraging email messages were always welcomed.

Chris, your support and understanding made so much of this possible and I am thankful to have you in my life. Missy and Queenie, the border collies and the J-Girl cats I thank you for your steadfast companionship.

I would also like to extend my deepest gratitude to my family, dear friends, and nursing colleagues who were always so accommodating and encouraging throughout my graduate studies.

Table of contents

Chapter One

Introduction

The curative focus of critical care and the available advanced technology and life support measures can overshadow the fact that critically ill patients often die. Critical care education programs emphasize assessment skills, timely interventions, and resuscitation protocols, potentially leading nurses to view death as a failure. The low patient nurse ratio in the critical care setting facilitates interaction with patients and their families and can lead to significant nurse involvement when a patient is dying. Although death and dying is a common occurrence in critical care (12 to 15% mortality rate in one Albertan health region), it often receives little attention in academic or clinical settings (Delaney, 2003; Simpson, 1997).

Increasing numbers of novice nurses are beginning their nursing career in critical care due to the current nursing shortage. In this study, a novice nurse is defined as a registered nurse (RN) who graduated from an accredited and/or approved nursing program, successfully passed the Canadian Nurses Registration Examination and was employed in critical care within 12 months of graduation. In the past, registered nurses hired to critical care areas had approximately two years of acute care experience; however, more recently managers in their attempt to deal with vacancies and limited candidates for these areas are employing novice nurses to maintain staffing levels. Novice nurses with limited practice experience and who have not been exposed to death and dying during their nursing education may find themselves unprepared to deal with this aspect of critical care nursing.

Research studies examining death and dying in the critical care setting have focused on experienced critical care nurses (Badger, 2005; Halcomb, Daly, Jackson, & Davidson, 2004; Isaak & Paterson, 1996; Jones & FitzGerald, 1998; Kirchhoff et al., 2000; McClement & Degner, 1995; Simpson, 1997; Yang & Mcilfatrick, 2001). Davenport (2000) reports new nurses orientating to critical care anticipate emergent situations or the death of a patient. However, novice nurses working in acute care identify being uncomfortable and unprepared to care for dying patients and their families (Amos, 2001; Delaney, 2003; Hopkinson, 2001; Hopkinson, Hallet, & Luker, 2003). The transition from nursing student to graduate nurse is a stressful time (Boychuk Duchscher, 2001; Charnley, 1999; Ross & Clifford, 2002) and novice nurses may experience reality shock when they realize their nursing education program did not adequately prepare them for the clinical setting (Kramer, 1974). Although increasing numbers of novice nurses are employed in critical care, research describing their experiences with the death of their patients is limited.

Critical care nursing has been the predominant focus of my nursing career and I have worked as a bedside nurse, assistant charge nurse (ACN), and clinical nurse educator (CNE). Throughout these past 20 years I have cared for numerous dying patients and their families, been present at many deaths, and assisted colleagues with their dying or deceased patient. The first patient death I experienced in critical care occurred during my initial shift in the intensive care unit (ICU). I had just completed a four week critical care course and was beginning the three week clinical component. Although some of the details have been lost over the years, I still remember seeing the red crash cart and the activity of a code in progress as we approached the bedside. My buddy "Donna" was an

experienced ICU nurse and we had been assigned a young man who had sustained a head injury in a snowmobile accident. I was not expecting or prepared to receive a coding patient that morning. Cardiac arrests generate their own energy and the bedside was a hub of activity and people. The code was called soon after our arrival and we were left standing at the bedside of a recently deceased patient with the curtains drawn around us. I remember Donna saying "Do not leave me alone behind these curtains!" After 20 years, those may not have been her exact words but the intent was clear; she did not want to be alone with the dead body. I do not remember responding to Donna; I was so taken aback by what had transpired that morning, I do not think I could even speak.

I had nursed in orthopaedics for three years before starting in ICU and in that time had only experienced one patient death. One night when I was in charge an elderly patient died. The death was not unexpected and the patient had died quietly in her sleep. One of the nurses, an experienced RN, quickly prepared and transported the body to the morgue later confessing she felt very uncomfortable with a dead body on the ward.

That first morning in ICU, I do not remember preparing the body or going to the morgue; however I do remember being careful to stay within sight of Donna while we did whatever it was we did behind those curtains. My recollection of this event does not include words of wisdom imparted by an experienced ICU nurse. I do not remember talking to Donna or anyone else about the code and subsequent death. The patient was not from the city and his family was not at the hospital when he died. My memory does not register anyone shedding tears at the end of the unsuccessful resuscitation. All I remember is thinking about my four brothers; this could have been one of them, they were the same age and all drove snowmobiles.

The next patient death I encountered involved a young woman who died of meningitis. I was still relatively new in the unit and remember "Greta", the ACN, being with me in the room. The family had left and as Greta started to leave she asked if I was okay by myself. I remember meeting her gaze, as we were wearing masks only our eyes were visible. I nodded that I would be fine. When she left and closed the door behind her the reality of the situation hit me; I was alone with a dead body and I was terrified. I kept telling myself everything was okay and there was nothing to be afraid of when the ventilator arm moved making a high pitched squeak. This unexpected sound scared me so much that I would have run out of the room screaming if the heavy sliding door had not prevented a quick exit. Faced with a closed door and the desire not to lose face with my co-workers, I managed to stay in the room and control my flight response. Although the death of this patient was a significant event, I also realized that it was my responsibility to prepare the body for the morgue. With this in mind I remained alone in the isolation room and continued on with my work. The recognition that there was nothing to fear except for my imagination was an important lesson for me as a novice ICU nurse.

Reflecting on my early experiences with death illustrates how the reactions of other nurses can influence the attitudes and responses of inexperienced nurses. The two nurses present during my first two encounters with death were experienced and clearly demonstrated uneasiness with death; one by actions and the other with words. In retrospect, my response to an unexpected noise while isolated and alone with a dead body is not surprising.

As I continued working in ICU, I repeatedly encountered death and dying and became more comfortable and skilled in dealing with dying patients and their families. It

did not bother me to be alone with the dead behind closed curtains or doors. I would find myself quietly explaining what I was doing while preparing the deceased patient for the morgue. It was not until I was working as a CNE that I started to think about the impact that death could have on nurses, especially the novice nurses working in ICU.

The need to address death and dying with newly hired nurses became apparent after a CNE colleague shared an incident that occurred in her unit. A novice nurse and her preceptor were caring for a patient who unexpectedly arrested. The other nurses and medical team quickly responded to the cardiac arrest but the resuscitation was unsuccessful and the code was terminated. Everyone left as quickly as they had arrived, leaving the novice nurse and her preceptor alone with their deceased patient. The novice nurse was devastated and could not understand how the other nurses could go back to their work seemingly unaffected by what had just happened. To the novice nurse it appeared that she was the only person upset by the patient's death.

This incident provided an opportunity to examine how new hires were prepared to deal with the possibility of caring for a dying or decreased patient. Unit orientation for newly hired staff outlines how to call for the morgue stretcher, where to find shrouds on the supply carts, and the location of the paperwork required after a patient dies. Time is provided during orientation for the Chaplain and Social Worker to explain their roles in the unit. I became more aware of the need to discuss caring for dying or deceased patients with the new hires as it related to their patient assignments and events in the unit.

Completing a practicum with the nurse educators in the regional critical care orientation program offered me an opportunity to develop a presentation on death and dying. Discussion related to death and dying in critical care was not included in the

curriculum and the program educators were supportive of my presentation. Focusing on the critical care setting the presentation addressed the needs of dying patients, their family members, and the nurses involved. I used examples from my nursing practice in ICU to support the information presented. There were novice nurses in the class so I shared my first experiences with death in the ICU setting. Questions and personal anecdotes were encouraged and overall the presentation was well received. Class evaluations provided feedback that validated the importance of a discussion on death and dying in critical care. Nurses in the class thanked me for sharing my personal experiences and acknowledging patients died in critical care.

Purpose of the Study

The purpose of this research study is to explore the experiences of novice nurses with their first death in critical care. Death is defined as the cessation of life. A death could be experienced while the novice nurse was being preceptored or working independently in critical care. The type of death, whether sudden or expected, and the quality of the death, either good or bad, is not the focus of this project.

Significance of the Study

The first death experienced by novice nurses has the potential to affect their future view of death and their response to dying patients in the future. This study has the potential to increase awareness of novice nurses' experience with their first death in critical care and provide nurse educators in the academic and clinical settings with valuable knowledge and direction for initiating discussions about death with nursing students and nursing staff. Additionally, the findings of this study may generate further research relevant to the experiences of nurses with death or dying patients.

Chapter Two

Literature Review

This chapter provides a review of the literature addressing nurses' experiences with death and dying. A comprehensive review of the literature was completed using the keywords death and dying, nurses, novice or graduate nurses, nursing students, critical care or intensive care, terminal care or terminally ill patient, patient death, and attitude to death. The HealthSTAR/OVID, CINAHL, PsychINFO, MEDLINE, and ERIC databases were utilized for the search. For the purposes of this study, the literature review was focused exclusively on the experiences of nurses with the deaths of adults and spanned 1994 to 2006. Research studies identified through the database searches were reviewed for appropriateness based on the title and abstract. The reference lists of the published studies addressing death and dying were also examined for authors not captured in the initial search.

The literature review did not reveal research projects investigating the experiences of novice nurses with death and dying in critical care. Most of the research projects exploring death and dying in critical care focused on participants with several years of experience. Two research studies were found that addressed novice nurses caring for dying patients in acute care. The literature review included studies which focused on nursing students because this group had the potential to be more similar to the novice nurses in terms of exposure to death and dying than nurses with years of experience. Based on the literature review this chapter includes background information on research examining death and dying in a hospital setting, death as a nursing stressor, and the experiences of nurses and student nurses with death and dying.

Background

In the 1960's, sociologists Strauss and Glaser explored how nurses and physicians interacted with dying patients in hospital. This study reflected the increasing trend of Americans dying in a hospital rather than at home. Their classic publication, *Awareness of Dying,* described the types of recurrent interactions that occurred between dying patients and hospital staff, how staff responded to these situations, and the effect this had on those involved (Glaser & Strauss, 1965). Physicians and nurses who frequently encountered death and dying recognized their inclination to stay away from dying patients. In particular, they avoided patients who were unaware death was imminent, had not accepted their death was inevitable, or were experiencing considerable pain. As a result of these avoidance tactics, healthcare workers felt ineffective and uncomfortable caring for dying patients. Involvement with dying patients was a source of emotional distress for nurses. Interviews with nurses who had just graduated from nursing disclosed that their educational programs did not necessarily include instruction on dealing with death and dying. As a result, it was possible for nurses to complete their education with limited exposure to dying patients. This lack of preparation had implications for nurses facing their first death. This led Quint (1967) to investigate how nursing programs prepared student nurses for their involvement with death and dying. Her landmark work, *The Nurse and the Dying Patient*, revealed that student nurses' first encounters with death could influence their response to death and dying over their nursing career. Exposure to their first death can be a significant event for student nurses because they lack nursing experience and caring for a dying patient may require nursing skills they have not yet acquired (Quint).

The importance of preparing student nurses to deal with death and dying through death-related discussions in the classroom and exposure to dying patients in the clinical setting has been identified in the research (Hurtig & Stewin, 1990; Mallory, 2003; Quint, 1967). An examination of the death education provided in Canadian nursing degree programs revealed death education was part of the curriculum in most of the educational institutions (82.9%) responding to the survey (Goodwin, 2005). Death education tended to be integrated throughout the curriculum instead of specific courses devoted to the topic. The opportunity to complete clinical rotations that focused on caring for dying patients was noted to be rarely offered. It was also reported that one-third of the respondents expected that their students would have cared for a dying patient during their nursing program while only one-quarter of the respondents believed their students felt prepared to care for a dying patient when they graduated (Goodwin). These findings suggest it is possible for novice nurses to begin their nursing career lacking experience with death and dying and confidence in their ability to care for dying patients.

Death and Dying as a "Stressor" for Nurses

Recognizing specialized intensive care units with critically ill patients could create a stressful work environment; quantitative research was conducted to study the stressors affecting nursing staff. Huckabay and Jagla (1979) examined stress and critical care nurses and identified four categories of stressors: knowledge base, environment, patient care requirements, and coping mechanisms. Patient care was rated the most stressful of these four categories. The aspects of patient care that critical care nurses considered highly stressful were the death of a patient, workload, and the amount of physical work.

Anderson and Basteyns (1981) also investigated stress and critical care nurses. Similarly to the findings reported by Huckabay and Jagla, nurses in their study identify the death of a patient, staffing and workload problems, and communication difficulties with physicians as stressors. A stress audit of American nurses ranked lack of support in dealing with death and dying as the third cause of stress in nursing (Bailey, Steffen, & Grout, 1980). Involvement with death and dying was identified as a major source of stress for nurses who felt unprepared for the emotional needs of the critically ill patient (Gray-Toft & Anderson, 1981).

These research studies examining the stressors of critical care nurses did not specifically target novice nurses, however Huckabay and Jagla (1979) identified that an inverse relationship existed between critical care experience and stress. A novice nurse or a nurse without critical care experience experienced more stress in the critical care setting because they lacked knowledge or clinical experience. Anderson and Basteyns (1981) included nurses with less than six months experience in their study but only 3% of the participant group met that criterion. The findings they reported were not specific to nurses with minimal critical care experience.

Researchers have compared the stress of critical care nurses with nurses from other specialty areas. Foxall, Zimmerman, Standley, and Captain (1990) examined sources of job stress for intensive care, hospice, and medical-surgical nurses and reported death and dying was more stressful for intensive care and hospice nurses. Inclusion criteria required nurses had been employed in their position for at least one year. Cooper and Mitchell (1990) studied the stressors associated with nursing the critically ill and dying patients and revealed hospital nurses found situations involving death and dying

more stressful than hospice nurses. They also reported that young inexperienced hospice nurses were more affected by death-related stressors than their older experienced colleagues (Cooper & Mitchell).

It is not surprising that death and dying is more stressful for nurses working in intensive care given that the purpose of these specialized units is to sustain and support patients through life-threatening illness or injury. In comparison, nurses employed in a hospice encounter death and dying on a regular basis. Their experience with palliative nursing provides an opportunity to develop the necessary skills to work in this setting. This could explain why inexperienced hospice nurses found death and dying more stressful.

These quantitative studies identified death and dying as a source of stress for critical care nurses but do not describe nurses' experiences caring for dying patients. In order to fully appreciate the challenges nurses face dealing with death and dying in the critical care setting, the circumstances surrounding the death of a patient need to be explained. This information emerged several years later as qualitative researchers began investigating critical care nurses' experiences with death and dying.

Qualitative research allows researchers to study human phenomena such as values, culture, and relationships that can not be described through quantitative research methods (Struebert Speziale & Carpenter, 2007). Several of the research studies cited in the literature review employed phenomenology as the research method. The intent of phenomenology is to describe perceptions of human experience with all types of phenomena (Struebert Speziale & Carpenter). Hermeneutic phenomenology focuses on interpretation of the phenomenon being studied (Struebert Speziale & Carpenter). Other

research studies included in this literature review utilized grounded theory to study nursing and develop theories regarding phenomena relevant to the nursing profession (Struebert Speziale & Carpenter).

Critical Care Nurses' Experiences with Death and Dying

The research studies examining nurses' experiences with death and dying in the critical care setting were found to primarily involve experienced nurses. Studies included in the literature review cited participants with a minimum of one month of critical care nursing experience and a maximum of 35 years (Badger, 2005; Isaak & Paterson, 1996; Jones & FitzGerald, 1998; Kirchhoff et al., 2000; Simpson, 1997; Yang & Mcilfatrick, 2001). The research conducted by Badger was the only study to identify participants with one month of critical care experience whereas the other studies indicated nurses with a minimum of 1.5 years in critical care. Findings specific to inexperienced critical care nurses were not reported by Badger. McClement and Degner (1995) described the sample of nurses in their study with a mean of 9.6 years critical care nursing experience. Research studies that reported the participants' years of practice as registered nurses indicated a range from 1 to 35 years (Badger; Isaak & Paterson; Kirchhoff, et al.; Maeve, 1998; Rittman, Paige, Rivera, Sutphin, & Godown, 1997; Simpson).

McClement and Degner (1995) described expert nursing behaviours in the care of dying adults in ICU utilizing a descriptive exploratory research method. Six critical nursing behaviours were identified: responding after death has occurred, responding to family, responding to anger, responding to colleagues, providing comfort, and enhancing personal growth. Responding after death had occurred involved three themes: creating a peaceful bedside for the family; confirming death had occurred by providing funeral and

bereavement information, and sufficient time with the deceased, and showing respect during post mortem care. Responding to the family entailed two themes: the family's need for information and reducing the potential for regret. Nurses met information needs by explaining the patient's medical treatment and their response to treatment. Reducing the potential for regret involved providing family with unlimited access to their loved one, assisting with care if desired, and letting them know treatment was not working. Responding to anger meant having empathy for patients and family members displaying anger, understanding their anger, and not taking it personally. Timely feedback about nursing care and emotional support for difficult situations were important aspects when responding to colleagues. Providing comfort included decreasing the physical and psychological pain of dying patients. This was accomplished using analgesic, giving skin and mouth care, listening and talking to patients, and honest and non-judgemental communication. Nurses enhanced their personal growth by being involved with and defining their role caring for dying patients.

Isaak and Paterson (1996) described the experiences of critical care nurses involved with an unsuccessful resuscitation through a phenomenological research study. Two categories emerged: knowing what to expect and the aftermath. Nurses used their clinical knowledge and previous experience during a resuscitation to predict patient outcomes as a means to prepare for unsuccessful outcomes. The age of a patient was a significant factor; nurses expected younger patients would survive and if resuscitation was unsuccessful, the death was especially difficult. Involvement with an unexpected death was upsetting for nurses because they had not anticipated the event. A nurse's performance during a resuscitation attempt was important; knowing they responded

appropriately was crucial if the patient died. During the aftermath of an unsuccessful resuscitation, nurses regained control of their environment by preparing the patient for family viewing, spending time with the family, sending the body to the morgue, and reorganizing the room. Feelings of grief, loss, guilt, anger, and regret after an unsuccessful resuscitation were possible but did not occur with every death. Nurses tended to be more affected by a death if they had established a relationship with the patient or could identify with the loss. Not all deaths were viewed negatively, especially if the patient's prognosis was extremely poor.

Simpson (1997) explored the experiences of nurses caring for hopelessly ill patients in ICU using grounded theory. Eleven themes were condensed into three categories: family separation, trust, and family reconnection. Family separation involved the physical ICU environment, patient suffering, and emotional stress of the family. These factors created barriers between patients and their families. The category of trust consisted of team decision-making, communication with the family, and acknowledging medical responsibilities. Nurses needed to trust treatment decisions in order to feel comfortable caring for their patients. Distrust existed with ambiguous decision-making and hidden agendas. Inexperienced nurses were seen as having more difficulty understanding decisions to continue or withdraw treatment compared to their experienced colleagues. Family reconnection was the third category and involved emotional attachments nurses formed with patients and families, coping with the stress this caused, and management of death. When the decision to withdraw treatment was made, nurses focused on the family's needs, providing patient care, and trying to make the situation as normal as possible.

The experiences of critical care nurses caring for patients undergoing withdrawal of life-support treatment were examined by Jones and FitzGerald (1998) employing interpretive phenomenology. Five themes were identified: being there, being comfortable and uncomfortable, being in control and out of control, being in time, and being able to talk. Nurses described the importance of being there with patients and families, whether they felt comfortable or not. Being comfortable and uncomfortable also included the decision-making process and withdrawing life-support. Knowing, understanding, and feeling comfortable with the decision to withdraw treatment were factors of being in control and out of control. The ability to communicate openly with those making the decisions was also identified as an important aspect of withdrawing treatment. Being in time related to the nurses' perception of time surrounding withdrawal of treatment and could be viewed either objectively or subjectively. The length of time involved during withdrawal of treatment was unique to the situation and could contribute to nurses' distress. Being able to talk about their experience caring for a patient undergoing withdrawal of treatment was a crucial coping mechanism for the nurses involved.

Kirchhoff et al., (2000) explored intensive care nurses' experiences with end-of-life care as part of a descriptive study. "Good" end-of-life care involved managing pain symptoms; ensuring comfort, dignity, and family presence, and respecting the wishes of the patient and family. Nurses believed that families and, if possible, patients needed a clear understanding of the prognosis and the quality of life with survival. Continuity of nursing care and demonstrating care and involvement with patients and families were identified as important aspects of end-of-life care. Of the acknowledged obstacles to good end-of-life care nurses identified two that were extremely distressing: prolonging futile

treatment and dissension among family members. Positive features of end-of-life experiences included a cohesive healthcare team working together with patients and family members, satisfaction with the care provided, and appreciation from the families. Nurses identified coping with end-of-life situations by talking to their colleagues.

The experiences of intensive care nurses caring for dying patients were described by Yang and Mcilfatrick (2001) in a phenomenological study. Thirteen themes were categorized into three groups: nurses' attitudes towards caring for dying patients, stressors, and coping strategies. The attitudes of nurses caring for dying patients included fear and guilt, frustration and powerlessness, understanding, compassion and empathy, grief reaction, and an opportunity for growth. Fear and guilt were the feelings most often elicited and this was especially true for nurses with less than two years of experience. Several nurses recounted feelings of sadness and loss when they were newly qualified and caring for dying patients. Nurses identified the doctor-nurse relationship, coping with family relationships, concealment of prognosis, and Do Not Resuscitate (DNR) orders as stressors. Coping strategies involved providing exemplary nursing care, respecting patient wishes, having compassion for patients and families, and the religious beliefs of nurses.

Halcomb et al. (2004) explored nurses' experiences with withdrawal or withholding treatment in ICU utilizing hermeneutic phenomenology. The five themes identified were comfort and care, tension and conflict, do no harm, nurse-family relationship, and invisibility of grief and suffering. Comfort and care involved providing pain relief and comfort measures, treating dying patients with dignity, and addressing the needs of their family members. Nurses experienced tension and conflict when they were not included in the decision-making process but were expected to withdraw treatment and

preside over the patient's death. Do no harm reflected the desire of nurses to ensure patients and their families did not suffer unnecessarily due to prolonged futile treatment. Relationships with families were viewed as both a positive experience and a source of stress for the nurse involved. Invisibility of grief and suffering addressed the emotional impact of withdrawing life support and the lack of support available for nurses. The authors noted that nurses appeared reluctant to seek out professional counselling services. Support from other nurses was identified as a means of coping with withdrawal of treatment.

Coping strategies used by medical ICU nurses during transitions from cure to comfort-orientated care were identified by Badger (2005) in a descriptive qualitative study. Findings revealed that nurses coped with complex patient-care situations through cognitive, affective, and behavioural strategies. Cognitive strategies involved "putting up with it," visualizing, learning from experience, and reminiscing. Affective strategies utilized laughter, externalizing feelings, and emotionally compartmentalization. Behavioural strategies entailed retreating, avoiding, and distancing. Providing futile care and the perception of torturing patients was identified as the two most distressing situations that nurses encountered. Nurses also found facilitating communication between medical staff and families frustrating.

Two of the studies reviewed for this study explored the experiences of registered nurses caring for dying patients outside the critical care setting. A hermeneutic phenomenological study identified the skills oncology nurses used to provide care to dying patients and their families (Rittman et al., 1997). Themes identified were: knowing the patient and stage of illness, preserving hope, easing the struggle, providing for

privacy, and spiritual aspects of living and dying for both the nurse and the patient. Oncology nurses used their knowledge from previous experiences to anticipant patient outcomes and supported the patient and their family accordingly. The process of knowing the patient did not indicate that significant attachments were formed with every patient and family. Preserving hope entailed helping patients face an uncertain future and encouraging them to use their remaining time to achieve meaningful and realistic goals. Easing the struggle addressed the value of a peaceful death through pain control, physical comfort, and presence of loved ones. Providing for privacy reflected the importance of a private room for dying patients and their families. Spiritual aspects of living and dying for both the nurse and the patient were not discussed in the article.

Maeve (1998) examined how experienced nurses deal with patients who were suffering and dying using naturalistic inquiry. The three supporting themes described were tempering involvement, doing the right or the good thing, and cleaning up. Tempering involvement related to the extent nurses became emotionally involved with their patients. Doing the right or the good thing entailed knowing what was right and then acting accordingly. Education and experience influenced how nurses determined what was right. Competency, commitment, and courage influenced being able to do the right thing. Cleaning up represented the physical and psychological aspects of ending the relationship with deceased patients. The time spent cleaning up provided an opportunity for nurses to reflect on their experience with death. Maeve noted that nurses incorporate professional experiences into their personal lives, weaving a fabric of moral meaning.

Novice Nurses Caring for Dying Patients

Two phenomenological studies in the literature review specifically addressed the experiences of novice nurses with death and dying in acute medical settings (Hopkinson, 2001; Hopkinson et al., 2003). Participants had been employed as registered nurses from two months to three years; averaging 12 months of work experience. Hopkinson reported on the self-perceived skill deficits of newly qualified nurses caring for dying people. The novice nurses reported feeling unprepared to interact with dying patients and their families. Knowing what to say or do was especially difficult when the nurse did not know the patient or family. As a result of this self-perceived skill deficit, novice nurses felt inadequate dealing with death and dying. Participants believed the skill of caring for dying people developed with time, experience, and being able to consult with or observe experienced nurses.

Hopkinson et al. (2003) explored caring for dying people in hospital from the perspective of newly qualified staff nurses on medical wards in the United Kingdom. Themes identified were the personal ideal, the actual, the unknown, the alone, tension, and anti-tension. The personal ideal described participants' beliefs about the care dying patients should receive. This view of an ideal death was specific to each nurse and constantly evolved with time and experience. Nurses caring for dying patients were exposed to the actual, an experience of death which could be very different from their personal ideal. The unknown referred to the humanly and personally unknowns. Humanly unknown involved questions the patients or family members asked to which there were no answers. Personally unknown resulted from the nurses' lack of knowledge or experience with death and dying. The alone related to events involving death and dying

that the novice nurses had to navigate on their own or the feeling that others did not understand the significance of the experience. Nurses experienced tension when their personal ideal was not realized during the death of a patient. Tension resulted in feelings of helplessness, guilt, uncertainty, frustration, and anger. Strategies to avoid tension included developing supportive relationships with other staff, making assumptions to guide decision-making, and controlling emotions. These strategies promoted personal comfort for the nurses; a sense of acceptance and satisfaction with their role caring for dying patients. Findings from the study were used to develop a model detailing the experience of caring for dying patients.

Student Nurses' Experiences with Death and Dying

Most of the novice nurses who participated in the current research study had been working in critical care for approximately six months when they experienced their first death. Considering the participants had commenced employment in critical care immediately after their nursing graduation, it is possible that they had more in common with student nurses experiencing death and dying than nurses who had been working for several years.

Kiger (1994) examined student nurses' image of nursing as they entered a nursing program and after they had clinical experience in a qualitative study. Findings revealed entry-level students viewed death as a negative aspect of nursing. However, once students had death-related experiences they recognized the rewarding features of caring for dying patients.

The experiences of student nurses caring for dying patients were explored by Beck (1997) in a phenomenological study. Six themes were identified: gamut of emotions

experienced; contemplation of a patient's life and death; supporting the family; helplessness as a patient advocate; providing patients with physical, emotional, and spiritual comfort, and the learning that occurred. Students caring for dying patients described feelings of fear, sadness, frustration, and anxiety. As students cared for dying patients, they speculated about the patient's life and impending death. Involvement with a dying patient also included addressing the family's needs. The status of student nurses was viewed as a deterrent to their patients' advocacy and caused the students to experience feelings of helplessness. Caring for dying patients involved meeting their physical, emotional, and spiritual needs. These initial experiences with death revealed the nurse's role in caring for dying patients, the need for unconditional care, and provided an opportunity for the students to gain confidence in their nursing skills. Findings from this study suggest that student nurses experience anxiety about death due to feelings of personal inadequacy and lack of experience (Beck).

Loftus (1998) using a phenomenological approach described the experiences of student nurses with the sudden death of their patients. Although six themes were identified in this research, only three are discussed in the published article: sudden death experience, vulnerability in caring, and support. No other published work related to this research could be found. Sudden death experience encompassed dying with dignity, unexpected deterioration, and cardiac arrest. Vulnerability in caring related to the relationship students established with patients and the effect of a patient's death. Students identified receiving emotional support from friends and relatives whereas staff focused on the procedures associated with death.

Kelly (1999) explored the experiences of female student nurses encountering death for the first time in a phenomenological study. The four themes identified were the event of death viewed for the first time, the progression from life to death, sadness, and incorporating death as a part of nursing. The event of death viewed for the first time included sub-themes of helplessness and being afraid. Student nurses experiencing death for the first time felt helpless and afraid because they lacked knowledge about death. Students expressed surprise at how quickly life progressed to death and the awe they experienced during this event. Students described different types of sadness: not knowing the patient as a person, observing the struggle to live, and witnessing the family's sorrow. These first experiences with death forced the student nurses to reconcile their preconceived notions that death would be peaceful with the reality that they encountered.

A phenomenological study by Wong and Lee (2000) examined critical incidents in early nursing experiences. The five main themes identified were facing death, interpersonal relationships, professional development, school life, and dealing with unexpected cases. Facing death was the critical incident most often cited and involved unsuccessful resuscitations, sudden death, death of young patients, and suffering at the end of life. The deaths reported in this study occurred when the participants were student nurses. Although the nurses identified their role as providing psychological support to dying patients and relatives, their involvement with death resulted in feelings of helplessness, frustration, uselessness, and guilt.

The aspects of caring for dying patients that caused anxiety in first-year student nurses were described by Cooper and Barnett (2005) in a qualitative descriptive study. Eight themes emerged from the data: coping with the physical suffering of patients,

severing the relationship with the patient, not knowing what to do or say, type of death, CPR, last offices, coping mechanisms, and helpful interventions. Observing the physical suffering of patients was particularly difficult for the student nurses who identified wanting to ease the patients' distress. When student nurses established strong bonds with patients, they experienced more anxiety and sadness with their death. Talking to dying patients and family members was a major source of anxiety for student nurses because they did not know what to do or say. Sudden death was more disturbing than an expected death because student nurses treated dying patients differently. When a patient died unexpectedly the student nurses did not have an opportunity to provide special care. Caring for young dying patients was also a source of anxiety for the student nurses. Involvement with CPR created feelings of inadequacy related to inexperience and concern their performance could impact the patient's outcome. Student nurses reported not understanding the rationale for DNR orders. Completing last offices (post-mortem care) was anxiety provoking as this was the student nurses' first exposure to a deceased patient and some of the death related tasks were unpleasant. Some students described talking to dead patients during last offices as helpful while others found it uncomfortable. In an attempt to manage their first death, the student nurses identified keeping their emotions under control, distancing themselves from the patient and family, or trying to maintain a normal environment. Despite their method of dealing with a dying patient, reflecting on the death at a later time was upsetting for the student nurses. Students' ability to discuss their patients' death with other students was a valuable coping mechanism. Student nurses found discussions related to the emotional aspects of death and dying, sharing of feelings, and explanations for DNR orders helpful interventions for

their first death experience. Findings from this study suggest that caring for a dying patient, rather than a personal fear of death, was responsible for most of the students' anxiety (Cooper & Barnett).

Summary of the Literature Review

The literature reviewed addressing the experiences of nurses with death and dying clearly reveals the emotional impact experienced by those involved in the care of dying patients and their family members. The inclusion of student nurses' experiences as part of the literature review provides their perspective of seeing death for the first time, which is unique to the uninitiated and may be applicable to novice nurses. Research describing the experiences of nurses who have had repeated exposure to death and dying offers another perspective on this topic.

Novice nurses felt unprepared to deal with dying patients and their families and as a result felt inadequate in these situations. Student nurses also identified similar feelings caring for dying patients. Novice nurses reported learning to care for dying patients through experience and by observing their colleagues dealing with similar situations. Working with dying patients allowed student nurses to experience the rewarding aspects of caring for these patients and an opportunity to increase their nursing knowledge and skills.

The desire to ensure dying patients had a good death was identified by experienced, novice, and student nurses. Student and novice nurses often had to reconcile their image of an ideal death to what they encountered in the clinical setting. The failure to achieve a good or ideal death was a source of distress for nurses. Experienced critical care nurses demonstrated their knowledge of compassionate end-of-life care but

identified struggling with the challenge of futile or prolonged care, family dissension, and lack of involvement in the decision-making process to withdraw or withhold treatment. Students and experienced nurses identified being more affected by the death of a patient when they had established a relationship with the patient and their family members. It was difficult for student and novice nurses to interact with dying patients and families unknown to them.

The focus of this literature review was to establish the backdrop to situate a research study investigating the experiences of novice nurses with death in a critical care setting. A review of the literature revealed minimal research examining novice nurses' experiences with death and dying. Most of the literature addressing experiences with death and dying focused on student nurses or nurses with several years of nursing experience. Although there are similarities between student and novice nurses there are some significant differences. Student nurses, especially first-year students, have less responsibility and a smaller patient assignment than novice nurses in the clinical setting. A nursing instructor is usually available for the students whereas novice nurses rely on their nursing colleagues. The ability to access these resources can be limited on a busy unit. Research studies examining the experiences of critical care nurses tended to involve experienced participants who would have had an opportunity to develop skills and coping methods to deal with death and dying. In contrast, novice nurses encountering their first death in critical care do not always have this level of nursing experience and skill.

It is worth noting that experienced critical care nurses still found certain aspects of caring for dying patients challenging. Knowing experienced critical care nurses struggle with issues related to death and dying has implications for novice nurses beginning their

careers in critical care. As the number of novice nurses working in critical care continues to increase, research that focuses specifically on their experiences is warranted. The need to understand what novice nurses experience indicates that a qualitative, descriptive study would make a contribution. The research question in this study is, therefore, what are the experiences of novice nurses with their first death in a critical care setting?

Chapter Three

Method

This research project is a qualitative investigation of the experiences of novice nurses with their first patient death in a critical care setting. The research was conducted using interpretive description. Thorne, Reimer Kirkham, and MacDonald-Emes (1997) proposed interpretive description as a noncategorical qualitative method for developing nursing knowledge. Qualitative research is an accepted and important research method for expanding nursing knowledge (Struebert Speziale & Carpenter, 2007). Interpretive description is considered a noncategorical qualitative method because it does not draw from philosophy, sociology, or anthropology unlike phenomenology, grounded theory, or ethnography. Reflecting the philosophical and theoretical foundations of nursing, interpretive description evolved as "a qualitative approach to clinical description with an interpretive or explanatory flavor" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p.3). As a research method grounded in nursing, interpretive description is appropriate to describe and explain novice nurses' experiences with the death of their first patient in critical care. Interpretive description is generated through questioning, using reflective techniques, and critical examination (Thorne, Reimer Kirkham, & O'Flynn-Magee). Using the methodology of interpretive description to study novice nurses' experiences with death and dying should provide information that could be applied to nursing, critical care education, and orientation programs.

Research Design and Setting

This qualitative research study was conducted over a period of seven months utilizing unstructured interviews with participants and field notes recorded by the

researcher. The setting for the research study was a tertiary care hospital in a large health region in Alberta, Canada. The researcher recruited novice nurses from a medical-surgical intensive care unit.

Selection of Participants

The research study required a specific participant population with knowledge of a particular phenomenon or event; novice nurses who had experienced the death of their first patient in a critical care setting. Ensuring data are collected from the appropriate participants requires the use of purposeful sampling; the most suitable approach to obtain the data needed (Morse, 1991; Morse, Barrett, Mayan, Olsen & Spiers, 2002). Purposeful sampling ensures the researcher recruits participants with specific knowledge relevant to the research topic (Morse).

The foundation of interpretive description is smaller scale qualitative investigation of phenomena relevant to nursing and sample size reflects this tenet (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). For the purposes of this interpretive description research project five novice nurses were recruited for the sample.

The initial plan to recruit participants involved distributing information letters to novice nurses employed in critical care. Ethical approval was obtained from the University of Alberta Health Research Ethics Board (HREB) and administrative approval was received from the Nursing Division of the Health region where the research took place. When ethical and administrative approval had been secured, the researcher contacted Patient Care Directors (PCD) and Unit Managers (UM) to discuss the proposed research project and ask for their assistance distributing information letters about the study (Appendix A). The UM agreed to distribute letters to novice nurses working in their

unit hired within the last 18 months. To avoid any suggestion of coercion, the UM used the unit mail system to deliver the letters. UM involvement in the research project was limited to forwarding letters to novice nurses working in their unit. The UM received 30 information letters sealed in plain envelopes and indicated 26 had been distributed.

Two of the novice nurses who received an information letter approached the researcher indicating interest in the research project but acknowledged they had not experienced the death of a patient. One of these nurses later participated in the study. Four participants were recruited while the researcher was working in critical care. The researcher presented on death and dying in the critical care orientation programs and this role may have facilitated the recruitment of participants. Recognizing the researcher's interest in death and dying may have encouraged novice nurses to participate. Novice nurses expressing an interest in participating in the study were given an information letter; the same letter distributed by the UM and an interview was arranged.

The researcher used specific criteria to ensure those participating in the study were suitable candidates; commenced employment in critical care within 12 months of graduation from their nursing program and had experienced the death of a patient assigned to their care (Appendix B). Novice nurses experiencing their first patient death while being preceptored were eligible to participate in the study. Following confirmation that the novice nurse met the inclusion criteria, an interview date, time, and location were mutually determined by the participant and researcher. Four of the interviews were held in a meeting room on the University of Alberta campus and one was conducted as a telephone interview.

The five female novice nurses who participated in the research study were employed full-time in a medical-surgical ICU. Demographic information, such as age, gender, date of nursing graduation, clinical area of employment, and whether the participant had experienced the death of a family member or close friend, was obtained at the beginning of the interview (Appendix C). Their ages ranged from 22 to 30 years and nursing graduation dates were May 2004 to December 2005. Three of the participants attended nursing programs in Alberta and two in Eastern Canada. The length of time employed in critical care before experiencing a death was approximately five months although one novice nurse experienced a death on her first day while another nurse's death experience was almost two years later. Four of the participants indicated they had experienced death in their personal lives. One participant had been employed as a student nurse in a continuing care facility and although she participated in post-mortem care, she had not witnessed a patient's death.

Ethical Considerations

The research study was prepared using the Ethical Guidelines for Nursing Research Involving Human Subjects, as outlined by the Canadian Nurses Association (1983), and the University of Alberta "Instructions for Completing the Human Research Ethics Board (HREB) Request for Ethics Review-Panel B [research involving human subjects]", congruent with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (1998). Approval was obtained from the supervisory committee and the University of Alberta HREB (Appendix D) prior to recruiting volunteers for the study. The research study was thoroughly explained to each participant to ensure complete understanding of the project, including the benefits and risks of

participating (Appendix E). Participating in this study offered participants the opportunity to discuss a potentially stressful event with an interested individual (researcher) who has experienced the death of patients in a critical care setting. A potential risk for participants was to experience emotional duress while reliving a traumatic event. In anticipation that some participants may have difficulty dealing with the memories related to a patient's death, the researcher had information pamphlets on the Employee Assistance Program (EAP) available at the interview. The researcher was supportive during the interview but the intent was not to provide grief counseling for participants. At the conclusion of the interview the researcher encouraged the participants to contact her if they thought of anything else they wanted to discuss about their first experience with death. Although the discussion during the interview was of a personal and potentially emotional nature, none of the participants experienced emotional distress during the interviews. The participants were offered an EAP pamphlet at the end of their interview but they all declined.

The researcher explained the data collected would be used for her thesis and related publications. Informed consent was obtained after the research project has been discussed and all questions answered (Appendix F). The nurse participating in the telephone interview gave verbal consent over the telephone and then mailed a signed consent to the researcher. Participants were advised that they were free to leave the interview at any time or withdraw their information from the study at any point. Anonymity was assured by using a code name chosen by the participant and known only to the researcher to identify the audiotapes and corresponding transcripts. It is not possible to match the participant codes to the signed consents. In addition, anonymity is maintained by not reporting data that could potentially identify participants and their

experiences with the death of a patient. The names of patients, family members, unit staff, and dates related to deaths discussed during the interviews were changed to maintain confidentiality and anonymity. Consents are stored separately in a locked cabinet. Information will be kept private except when professional codes of ethics or legislation require reporting. The audiotapes of the interviews and the transcripts are also being stored separately in locked cabinets. All collected data will be kept in secure storage for the period of 5 years in accordance with the University of Alberta guidelines for storage and retention of research data. After that time the data will be destroyed.

Data Collection

The researcher is the primary instrument of data collection, interpretation, and analysis in this study. Data was gathered from the demographic questionnaires, unstructured interviews, and the researcher's field notes from each interview. The goal of the data collection is to ensure that the information collected is suitable to answer the research question (Morse & Field, 1995). An unstructured interview lasting approximately one hour was utilized to obtain a narrative describing the experiences of novice nurses dealing with their first patient death in critical care. Qualitative research studies often employ unstructured interviews to avoid restricting or directing participant responses (Struebert Speziale & Carpenter, 2007). As one of the main methods for data collection in qualitative research, interviewing requires that the researcher is nonjudgmental and receptive to the participant, listens intently, and carefully follows the story being told (Morse & Field). The researcher is a critical care nurse who is familiar with the equipment and technology utilized in the clinical setting. Having knowledge of the critical care unit plus professional experience with death and dying ensured the

researcher's ability to follow and understand the story being recounted by the participants.

In recognition that participants may become emotional while telling their story, privacy was ensured and interruptions avoided by posting a "Do not disturb, interview in progress" sign on the door. As all interviews were audiotaped, the researcher ensured the recorder was functional and extra tapes and batteries were available prior to each interview. Informed consent was obtained from the participant before the interview commenced.

The overall leading question for the interview was "What did you experience when your first patient died?" At the beginning of the interview the researcher asked the participant to "tell me what happened when your patient died." The researcher had a printed sheet of additional questions to ask during the interview if required. These questions included: "Was the patient's death expected?" "Were you alone with the patient at the time of death?" "Were family members present?" "What happened after the patient died?" "Who did you talk to about your patient's death?" and "Do you have any advice for other novice nurses experiencing their first patient death in critical care?" The researcher sought clarification from the participant if something was said that she did not understand. At the end of the interview, the researcher asked if there is anything else the participant would like to add.

After the interview, once I was alone, my observations and impressions of the interview were recorded in the form of field notes. It is important when conducting qualitative research to collect as much data as possible to accurately portray the event that has occurred (Sandelowski, 2000). Field notes are a "written account of what the

researcher hears, sees, experiences, and thinks in the course of collecting and reflecting on ... data" (Bogdan & Biklen, 1992, p. 107).

The original audiotape from each interview was copied to ensure no data were lost. At this time the researcher would listen to the interview and reflect further on the participant's experience. Each audiotaped interview was transcribed verbatim and the transcript was compared to the audiotape by the researcher to assure accuracy. Comparing the audiotape with the transcript and field notes ensures the nonverbal aspect of the interview, such as emotions displayed and body language observed are not lost as a component of the narrative.

The initial interview was expected to provide a full description of what the novice nurses experienced with the death of their first patients in critical care. However, the researcher asked participants if she could contact them after the interview was transcribed and read to clarify any content of the transcript. All participants agreed but this was not necessary. The initial interview with participants provided a rich description of their experience and a second interview was not required.

Data Analysis

The goal of interpretive description "is a coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon that is being studied and also accounts for the inevitable individual variations within them" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p.7). During data analysis the researcher identifies what is similar in all the experiences while being attentive to aspects that are unique to the individual. Data analysis begins during the interview process as the researcher is first exposed to the participant's experience and continues throughout the

data collection period as each audiotape is replayed and compared to the transcript and augmented by field notes (Sandelowski, 1995b).

The analytic framework of interpretive description encourages questions such as "what is happening here?" and "what am I learning about this?" to explore novice nurses' experiences with the death of their first patients in critical care (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997, p.174). During data analysis, the researcher must have explicit knowledge of the data, be able to distinguish relevant common themes, and formulate knowledge that is applicable to the individual (Thorne, Reimer Kirkham, & MacDonald-Emes). Repeated exposure to novice nurses' experiences with their first patient death during the data collection period intensified the researcher's awareness of this event. Throughout the data collection period, the researcher continually compared and contrasted the data to identify similarities and differences between participants' experiences.

The interview took place after the novice nurse participants experienced the death of their first patient, thus, it is possible that some data was lost due to the passage of time. Data collected in the interview was accepted as being true of the event as experienced by the participant. The experiences of novice nurses with their first death in critical care must be reported in a manner that remains true to the perspective of each participant and acknowledges the uniqueness of each event (Morse & Field, 1995).

Qualitative research methods often require that researchers "bracket" their thoughts, feelings and perceptions about the phenomenon in question before and throughout the data collection and analysis of a project (Struebert Speziale & Carpenter, 2007). It was important to acknowledge that my personal and professional experiences

with death may differ from the perceptions and experiences of the novice nurses participating in the study. Prior to beginning data collection, I reflected on my experiences with death during my nursing career and personal life. This process of reflection and journaling allowed me to be receptive to the data presented during the interviews. Interpretive description recognizes researchers may have theoretical knowledge and clinical experience within the area they are studying (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). It was essential that I remained attentive to my thoughts and feelings throughout the data collection period.

Data analysis began during each interview as I listened to the participant's first experience with death in the critical care setting. As I collected data each interview was compared to the previous ones to determine what was similar and different between the experiences. When data collection was completed each interview was reread and the experience of the participants summarized. A title, using actual text from the interview, was extracted from each summary to capture the essence of the novice nurse's experience of their first patient death in critical care. The titles selected for the five interviews were: "A hard way to die", "It's really lonely in the dark", "So we were just waiting", "I'm glad I was there...so he wasn't by himself", and "Ah! I didn't sign up for this."

Each time I listened to the audio tapes and read the transcripts I focused on what I was learning from these first experiences with death. The data collected from the five novice nurses describing their first patient death reflected experiences that were unique to those involved. Despite the individual nature of every death, threads of common experiences ran through every interview. The themes that emerged during this process were: anticipating death, transition from life to death, the moment of death, being with

the family, and carrying on. After identifying these themes from the data, the interviews were then reread and text supporting each theme was highlighted. The next step involved gathering text from the five interviews that supported each theme. It was interesting to note while organizing data with the appropriate theme, text initially coded for one theme was found to be more appropriate for another. The themes were well represented in the five interviews.

Credibility, Fittingness, and Auditability

The rigor of qualitative methodology is judged by unique criteria appropriate to the research method. Credibility, fittingness, and auditability are important criteria that must be addressed in qualitative research (Beck, 1993). Credibility ensures the description is rich and accurate to the data collected. The research findings should convey to the reader a vivid and believable picture of the participants' experiences. Fittingness guarantees that the data is representative of the participants. Description of the participants and the phenomena studied allows the reader to assess if the research findings are true to the source of information. Auditability describes the processes related to data collection, analysis, and reporting. This chapter attempts to meet the goal of audibility by providing the reader with detailed information outlining each step of the research study and how conclusions were reached.

Credibility of findings in interpretive descriptive research is assessed by "the way the specific analytic decisions are presented and contextualized within the larger picture" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p.15). Validation of interpretive description research occurs when study findings are accepted by experts in that specific

area as believable while also contributing new information about the phenomena (Thorne, Reimer Kirkham, & O'Flynn-Magee).

Chapter Four

Findings

This chapter includes the analysis of the novice nurses' experiences with their first death in critical care. Five themes emerged: anticipating death; transition from life to death; the moment of death; being with the family, and carrying on. These themes are presented and discussed. The code names chosen by the novice nurses participating in the research study were Lynn, Billie, Striker, Leslie, and Gail. Their verbatim words are identified in italics.

Theme One.

Anticipating death*: So we were just waiting*

> *When my shift first started, I came on knowing that the patient was already brain-dead; diagnosed as being brain-dead. This person was a post-asystolic cardiac arrest patient and basically was being kept alive via the ventilator and with some inotropes to keep his blood pressure up. Part of me was nervous because I'd never had a patient that died before and I knew he was going to die because the family had agreed to withdraw on him. So we were basically waiting for that family to come in. I didn't really know what to do, what my role as a nurse taking care of somebody that's dying and what the procedures were with this and what was appropriate and inappropriate. I didn't treat him any differently, I still talked through everything that I did and spoke with him. It was probably about 6 or 7 hours. A big part of that was the family didn't come in until almost 1:00. So we were just waiting.* Lynn

Lynn, a novice nurse, who had been working in ICU approximately four months, was assigned a patient who was brain-dead. Although Lynn had helped other nurses with their dying or deceased patients, she felt nervous about caring for this patient. As she waited for the family to arrive, Lynn knew he would die as soon as ventilatory support was withdrawn.

Anticipating death was the first theme that emerged from the novice nurses' experiences with death. A significant aspect of anticipating death was the nurses'

realization that their assignment involved a dying patient. In this particular ICU, nurses coming on shift check the assignment board for the patient(s) they have been assigned and then proceed to that bedside for report. The patient in each room is identified by Mr., Mrs., or Ms. followed by the first letter of their surname. FOIPP (freedom of information and protection of privacy) regulations mandate that surnames and diagnoses are not included on the assignment board. As a result, nurses coming on shift often know very little about their patients until they receive report.

Lynn, Leslie, and Gail described coming to work and being told in report their patients were expected to die. Sharing this fact was how they began their interviews. Leslie started by saying: *I got my report from the nurse and we knew it was compassionate care at that point.* Gail's patient assignment posed another challenge: *I came on shift and realized I was doubled ... but when I approached the two bedsides, one was withdrawal of treatment.* These nurses knew at the beginning of their shift that their patients were expected to die sometime during the next 12 hours.

Striker and Billie began their shifts caring for patients receiving active treatment. In comparison to the nurses assigned dying patients, Striker and Billie did not know the death of their patients was imminent. Interestingly, these two nurses were the participants with the most and least ICU experience respectively. Striker had been working in ICU for almost two years and this experience was reflected in her patient assignment: a critically ill patient with a TVP (transvenous pacemaker). The patient was a recent admission and during report Striker learned there was a DNR (do not resuscitate) order on the chart. Striker began the interview describing her patient's condition:

> *I started my shift at 7:00 o'clock and when I came on my patient had a TVP inserted during the day and he was really quite unstable and they didn't really*

> *know what was going on. Anyway, I kind of had a feeling things weren't going well and I had the intensivist look at the TVP and he was satisfied with everything. Except the patient started to ... was getting worse ... He was anuric and his blood pressure was dropping into the 70's ... He just wasn't doing well.*

Striker painted a bleak picture of this elderly man: heart failure, hypotension and anuria. The DNR status implied the patient's worsening condition was not unexpected and despite the TVP insertion there would be no further heroic measures. In contrast to Striker, Billie had just started in ICU and her patient assignment reflected the skill level of her preceptor. Billie described their patient at the beginning of her interview:

> *So we came in and took report and went in and I had never seen someone bleed so much in my entire life ... from the nose and mouth ... and it was an endless stream of blood coming from her rectum, pooling.*

Despite her inexperience as an ICU nurse, Billie's response to a comment made by a medical resident revealed she knew her patient's condition was life-threatening.

> *What did he say, "[Blakemore tubes] are for patients who are dying" implying that she wasn't at the brink of death yet. So I said to my preceptor "She's bleeding a lot and I know we're putting a lot of blood in but that's a lot of blood to be losing at the same time."*

Billie's vivid description of her patient's excessive blood loss is even more compelling knowing it was her first day in ICU.

Anticipating death included an element of the unknown for all the participants. Although some of the nurses knew their patients were expected to die, they did not know when the death would occur. The unknown for Striker and Billie hinged on whether their patients responded to treatment. Striker's ICU experience played a role in anticipating death as she assessed and monitored her patient. This familiarity with ICU patients may have influenced Striker's expectations for his outcome.

> *That's why I was looking at the monitor. Because I thought "He's really sick, I wouldn't be surprised if I turned him and didn't see anything." I thought that in my head. That's why I was watching the screen.*

In Billie's situation, anticipating death evolved as the futility of continuing treatment became apparent and discussion regarding the withdrawal of treatment occurred. Billie was the only novice nurse who experienced the progression from active treatment to compassionate care during her shift.

Nurses who begin working in ICU expect to encounter death and dying. Most of the novice nurses participating in this study had been working in ICU for approximately six months when they experienced their first death. Although it is difficult to predict when a nurse will encounter the death of their first patient, it is likely they will have had the opportunity to observe or assist their colleagues caring for dying or deceased patients. Gail acknowledged death and dying was inevitable in ICU: *Every day that you go in there you're hoping that your patient is not withdrawal of treatment and then finally one day you are withdrawing treatment.* Billie indicated she expected to encounter death and dying in critical care: *I knew that is the place I would go and probably see the most death.* Leslie described the timing of her first patient death: *About five to six months after I started working there. It wasn't soon, I don't think, but it was soon enough.*

Despite their expectations and recognition of the probability of encountering death and dying in ICU, the reactions to an assignment with a dying patient revealed varying emotions. Lynn indicated feeling nervous because it was her first death. Leslie's response to her assignment was *Can I go home? I just wanted to go home.* Gail described her feelings: *It was quite an overwhelming experience knowing not only are you doubled, but one of your patients is withdrawal of treatment.* Striker stated, *Two years, in [month]*

it will be two years. And I've never had my own patient die. So it was different. Although Billie acknowledged expecting to encounter death in ICU, she responded, *I hadn't really thought about it in the context of "I'm starting work and this is going to happen."*

Expressing feelings of nervousness, avoidance, distress, and surprise when confronted with a dying patient suggests that the novice nurses felt unprepared for their first death even though they considered death and dying part of critical care nursing. As most of the nurses were relatively new to critical care, it could be proposed that they were still learning the ICU routines and refining their care of patients. Their recent introduction to the critical care environment and its emphasis on life-sustaining technology may have seemed incongruent with caring for a patient as they died. Striker, who had worked in ICU the longest, described her first death as *different.* This was the first time death had terminated her responsibility for a patient. Transferring a patient to another unit or to the care of another nurse is entirely different from sending a patient to the morgue.

The process of helping or observing colleagues caring for dying or deceased patients certainly exposes nurses to this aspect of critical care nursing but may not necessarily prepare them to care for their own dying patient. Knowing patients die in ICU is one thing; being responsible for a dying patient and their family members is another. Experiencing the death of a patient for the first time was a significant event for these nurses.

Theme Two.

Transition from life to death: *A hard way to die*

> *It's a fast transition. Because at first that morning, they did a scope and we're running around like crazy and doing all this stuff and then all of a sudden, they're going to stop. And it's a very weird transition to go from you're so busy and a very different focus to we're going to shut all of this off and we're just going to*

> *make sure that she's comfortable and clean and whatever the family needs ... She was bleeding from so many places and so much that ... there was nothing they could do. I think the thing that I was surprised with the most with the whole situation was first of all, once they decided they were just going to make her comfortable and let her pass on was how quickly she did ... It's such a ... how do you put it? "A hard way to die" I thought.* Billie

Billie's initiation to ICU was an action packed morning with a critically ill patient, who transitioned quickly from aggressive treatment to compassionate care and ultimately death. This abrupt change in philosophy of care can be a difficult adjustment for nurses even if they understand the reasons behind the decision. Billie's first death reflected the trajectory of care that can occur in ICU: optimism for treatment options countered by the reality of a patient's condition and acceptance of the futility in continuing treatment. The expected outcome for a patient can change quickly, as Billie discovered, or be a gradual process during a lengthy ICU stay.

This second theme, **transition from life to death** encompasses the experiences of the novice nurses as they presided over their first death and observed their patients' passage from life to death. The word transition suggests a change or movement towards something different or new. What the nurses saw, heard, and felt as their patients died was revealed in the interviews. Leslie described the changes she observed in her patient:

> *When I first came on she didn't look well, pale, sleeping and ... not responding. But throughout the night ... the mottling in the hands, the feet, and the back; very cool to touch. The skin temperature was cold, cold, cold.*

Gail found the sound of her dying patient disturbing:

> *... the sounds of someone being withdrawn from [treatment] ... he was basically drowning on his own [secretions] ... it was scary for me but I can't imagine what the family felt when they heard this.*

These first experiences of caring for dying patients may have exposed the novice nurses to aspects of death and dying they had not considered. Being responsible for a

dying patient and the family members who are present at the bedside can be a daunting undertaking for a novice nurse. Leslie described the changes in her patient's vital signs suggesting impending death:

> *...the blood pressure started to drop; her heart rate was ... slowly going ... Her vital signs were going down ... trending down, slower, slower.*

Being present during the transition from life to death involved watching and waiting as their patient's life gradually ebbed away. Normally a low blood pressure or heart rate warrants prompt intervention but not this time. It may have seemed very unusual to let a patient die given that critical care nursing tends to focus on life support measures.

Time was an element in the transition from life to death. Lynn described waiting several hours before her patient was withdrawn from life support. Leslie also spent most of her 12-hour shift watching her patient's vital signs slowly drop.

> *It was a long night ... in a way I wish, just to make it easier on the family, make it easier on everyone ... including the patient, just to let go.*

In contrast, Billie's patient died soon after compassionate care was initiated and Gail's patient died at the beginning of her shift. Striker's patient died seconds after the TVP stopped working.

The nurses described their feelings as their patients moved closer to death. Billie was surprised by how quickly her patient died even though she knew her patient could not survive the continuous blood loss. Leslie recalled how difficult it was to witness the gradual deterioration of her patient throughout the night:

> *It's hard to watch ... You basically see it happen right before you. ... I remember her daughter saying "How long does this take? Sometimes I think this waiting is more hurtful then it just happening. Just happen, let me deal with it."*

In this instance Leslie monitored both her dying patient and the daughter sitting at the bedside. Despite her own discomfort watching her patient's slow decline, Leslie was acutely aware of the effect it was having on the daughter.

Knowing how to treat their dying patients and interacting with family members were other challenges the novice nurses faced. This was a completely new experience, one that lacked procedures or protocols to guide them. Nursing colleagues were identified as valuable resources for the support and advice they offered. Lynn described the help she received:

> *I had help from more experienced nurses ... they were really great with helping me through it ... what I needed to tell [the family] and once we withdrew do I keep the monitor on ... things like that that I didn't really know.*

Leslie also explained the assistance she received:

> *The senior nurse right next to me he was great, he said "Okay, this is what we do next" ... He's seen it before so he sort of knew the different stages ... The charge nurse came and she was really good too.*

Having access to the knowledge and expertise of experienced nurses was crucial for these novice nurses dealing with their first patient death. Comparing herself to more experienced colleagues, Leslie perceived they were less affected by a dying patient because of their previous exposure to death.

> *We [watched the cardiac monitor] at the station, I just found it hard to watch ... everyone else just glances at it ... I guess they've seen it more than me.*

Acknowledging how difficult it was to watch the steady deterioration of her patient, Leslie reveals the emotional toll associated with death and dying. Nurses actively caring for a dying patient and interacting with the family respond differently to the patient's death than nurses who are not directly involved.

Providing comfort measures for their dying patients was the focus of nursing care during the transition from life to death. The nurses also described being attentive to the appearance of their patients as family members were present with most of the dying patients. Although this was their first exposure to a dying patient, the novice nurses tried to ensure the family members were not disturbed by the appearance of their loved ones. Billie explained the priority of care for her patient when treatment was withdrawn:

> M*outh care and trying to keep her clean and the linen not showing a lot of the blood. We put tape over the endotracheal tube tapes because they'd been totally covered in blood...*

One of Gail's first actions with her dying patient was to suction him; this may have been her first exposure to the "death rattle" and she found it very upsetting especially with his family sitting in the room. Billie and Gail identified aspects of their dying patients that were disturbing and took steps to minimize the effect this could have on the family. Leslie described involving her patient's daughter with the nursing care:

> *I gave her a nice bath and the daughter wanted to stay ... It was important that I turned her ... and the daughter wanted to be in there, she wanted to help. And we put cream on her feet together and rubbed her back...*

As the novice nurses cared for their dying patients, they emphasised comfort measures such as eye, mouth, and skin care. Although this is standard nursing practice for patients in ICU, focusing on these familiar activities may have provided much needed structure as they faced the challenge of their first death. Keeping their dying patients clean and comfortable may have given them a sense of accomplishment during a difficult situation. Leslie tried to lessen the long vigil of her patient's daughter by including her in the nursing care. Gail's actions also spoke of making the death experience less distressing for her patient's family.

Although this theme deals with the transition from life to death for the patients involved, there was also a transition for the novice nurses. This was the first time they were responsible for patients who died during their shift. As most were recent nursing graduates, this experience represented another career "first" and one that can be viewed as a rite of passage for nurses.

Theme Three.

The moment of death: *I'm glad I was there ... so he wasn't by himself*

> *We gave my patient a fluid bolus to bring up his pressure and everything kind of stabilized so I started his bath and shaved him. I said "Okay, we're going to turn him now and I'm going to get his linen changed and wash his back." I was watching the monitor when I turned him; I made sure my TVP was set right. As soon as we turned him; all of a sudden on the screen all I saw was just pacer spikes with absolutely nothing to follow. There was no capture, nothing, so I checked to make sure that everything was in; all my connections were there. We just laid him flat on his back. I turned all my dials up; turned everything up to the max and still absolutely nothing. He went blue; he went cyanotic, his lips that dark, dark purple. Like boom, it was that quick. My patient thankfully was a DNR; he was an older gentleman in his eighties. I'm glad I was there when it happened. I'm glad I was right there in the room with him when it happened so he wasn't by himself.* Striker

Striker's patient died very quietly and peacefully during his evening bath. Knowing her patient was DNR tempered Striker's response: calmly checking the TVP and repositioning him supine, knowing CPR would not be performed on her elderly patient. The usual adrenaline fuelled response to a cardiac arrest was noticeably absent and Striker finished her patient's bath and prepared him for the morgue. Being present with her patient when he died was a significant aspect of Striker's first experience with death.

Transition from life to death concluded at **the moment of death;** the third theme identified which depicted cessation of life as experienced by the novice nurses. Striker

defined the moment of death by the sudden change in her patient's ECG (electrocardiogram) tracing and the colour of his face. Lynn observed the following when treatment was withdrawn from her patient:

> *Basically nothing happened, his chest just stopped rising and falling and that was it. After he passed away, his face was blanched and he became cold quite quickly.*

Gail was in her other patient's room when she heard the sound of an alarm:

> *So I heard, I kind of glanced out at the monitor and I saw that he had gone asystole. Right away he was cold to touch and he was already getting stiff.*

Leslie summoned her patient's daughter when death appeared imminent:

> *I just had a feeling, I have to go get her daughter because it's starting to trend down, slower, slower, even though she was up and down all night. So as we were walking back to the room things starting bonging off and I just peeked at the monitor and she was going. As soon as we walked in the patient was taking her last breath and the daughter was there and she knew because you can tell.*

These descriptions at the moment of death reveal what the nurses saw and heard as their patients died. Some of the visual and auditory signs of death were specific to ICU: pacing spikes without capture, asystole on the monitor, and alarms ringing while others were more common indicators of death: lack of respiratory movement, pallor, coldness, and stiffness. The moment of death presented with a sense of abruptness, a sudden and irreversible transformation of being.

The emotional responses generated by their first death varied among the novice nurses. Striker spoke of her feelings:

> *I can't believe my patient actually just died. I didn't think, "Is there anything else we can do?" It was more like, "Whoa, this really happened to me. This patient actually died!"*

Although Striker knew her patient was critically ill and suspected he may not tolerate being turned, there was disbelief when he died. Billie discussed the feelings she experienced driving home:

> *And then on the way home, I guess when you're driving is the first time that I sat back and went, "Okay, all of that happened, and whoa, oh my!" ... Going home and going to bed was probably the worst.*

This passage suggested a surreal quality to Billie's first day in ICU. The activity of the morning was matched by an equally busy afternoon which prevented Billie and her preceptor from discussing their patient's death. It was not until Billie left work that she had time to reflect on her first shift in ICU. Billie acknowledged the personal impact of witnessing the death of someone who is virtually unknown to you:

> *It was almost like for some reason you feel like you have to grieve for these people even though, it's kind of weird because you're only with them for ... 8 hours.*

Leslie described her thoughts leaving work after her patient died:

> *I was like, okay, I go home now. It was just weird how ... okay my patient just passed on me and now I'm going home to bed, it was just such a weird ... But I was sad ... I wasn't angry, I was just sad. I just felt for the daughter and what she was thinking at that point and just how sad it really is. And then of course I thought about the situations I've been through and it just brings back memories where you just know how they feel.*

Leslie was the only nurse in the group who acknowledged being able to identify with the daughter's loss. Leaving work after the death of her patient, Leslie recognized the incongruity of the situation. This very significant event is finalized by the patient being sent to the morgue, the patient's daughter leaving the hospital, and Leslie going home to bed. The ending of Leslie's shift was somewhat anticlimactic considering everything that had happened. There is irony in Leslie going home to sleep after her patient dies considering death is often characterized as eternal sleep.

Lynn explained her reaction to her patient's death: *It's just weird. I felt with my first death I thought it was ... there was just no connection there at all.* Assuming care for a patient who was brain-dead did not provide an opportunity for Lynn to know him as a person. This inability to form a meaningful relationship with her patient left Lynn feeling emotionally distant when he died.

Gail described her feelings towards her patient's death:

> *I guess one of the moments where it hit me that he really was dead was when we were putting him in the body bag for security to come take him to the morgue, just turning him and knowing how stiff he was and the discolouration and it just ... hits you that this gentleman has passed away and you wish you would have had more training on how to deal with it.*

Although Gail had observed asystole on the cardiac monitor and was present when the physician pronounced her patient, it was the act of placing his body in the shroud that confirmed his death. The patient's rigor mortis and mottled skin were concrete proof that death had occurred.

Once the patients were pronounced dead by the medical staff, the novice nurses were occupied with post-mortem care. Striker finished her patient's bath and worried about transferring her patient onto the morgue stretcher:

> *My biggest concern was his head, [hitting] on the stretcher when he went over. So I made sure ... the other nurses knew for sure not to let his head [drop].*

Lynn described preparing her patient for the morgue:

> *You always hear how they lose their bowels and ... that's exactly what happened. We turned him and cleaned him ... just making sure that you got him cleaned up and giving him that dignity ...*

Gail discussed preparing her patient for the morgue after his family left:

> *I remember cleaning him up and ... he had the traditional marking that his family had put on him. I remember thinking to myself, "Should I wipe it off?" ... You*

> *don't want to do something to the body that might insult the family. So of course I didn't wipe it off ... I just kept it as is.*

These passages concerning post-mortem care revealed the dignity and respect the novice nurses provided their deceased patients.

The novice nurses elaborated on their feelings of being with a deceased patient. Although Billie did not prepare her patient for the morgue she discussed her thoughts about being in the room with a dead patient.

> *I was kind of dreading ... Okay, we'll have to go in ... and clean up the body and the body bag and ... for some reason its just ... a weird feeling. It's a weird feeling ... it's a person but it's not. And it's that weird feeling of "Oh, my goodness" ... they've just died and I'm going to be there standing by myself and I don't know why, it gives that frantic kind of "Huhhhh, oh no!" find of feeling.*

Leslie talked about being with her deceased patient:

> *It doesn't bother me that they've passed but it's just a different feeling. You're waiting for them to take the breath, you're waiting, you're looking at the monitor, where's their heart rate? Where's their blood pressure? But I always find it a little, I don't want to say weird, a little eerie, it's just a strange different feeling. It just feels different, like the expectations you have ... I'm not used to being around a dead person basically. You expect them to be breathing, you expect ... they're going to open their eyes when I'm taking the tape off their arm and stare at me.*

Striker discussed being in her patient's room after he died:

> *I wasn't by myself once in the room. The nursing attendant stayed in there with me the whole time. It was nice, it was peaceful. [Being alone in the room] would have been a little more peaceful because it would have been quieter. But I think that would have made me a little more upset because I think that I would have been thinking more about it. With her there I could talk about, "This is really weird, I'm a little bit shocked this happened."*

Lynn compared her patient to other patients she helped prepare for the morgue:

> *There have been instances where I've helped get other patients ready for the morgue and it's kind of creeped me out a little bit. And I think it creeped me out because [while they were still alive] I've seen them open their eyes and try and communicate but my patient wasn't responding right from the beginning so there was really no change for me [after he died].*

Gail discussed her time alone with her deceased patient:

> *I remember for quite some time I was in there by myself and I kind of chose to be there by myself because it was a learning experience for me too. And just as I was doing up his lines and clamping his catheter and stuff all I could think about was I'm still telling him what I'm doing. Everything I did I would say "Okay, I'm just going to clamp this off" or "I'm going to wash your face now." It made me feel a little better but then a couple of minutes into it I'm like, "What am I doing? This gentleman passes away and I'm still talking to him like he's alive." It was a weird feeling but I think talking through it kind of eased my mind more.*

These passages revealed the novice nurses' feelings towards being in the presence of death and their unease is not surprising considering this was their first death. Although the nurses observed their patients dying, there is a sense of needing time to process the event and accept that death has occurred. Gail was the only nurse who acknowledged talking to her deceased patient which made the situation a little easier for her to accept.

Placing their patients into the shroud was an aspect of the post-mortem care the novice nurses found difficult.

> *I didn't like putting him in a body bag. I didn't like zipping that up.* Striker

> *It gives you kind of a strange feeling ... when you put somebody in a bag. Because you think "Oh, they can't breath in there!" But they're not breathing anyways. And how claustrophobic and I'm claustrophobic myself so I can imagine but of course if you're not alive anymore ...* Lynn

> *I zipped up the body bag and it was weird ... it was just that you knew this was the end for this life...* Gail

The act of putting the body in a shroud was viewed as a significant event that finalized the death of their patients. Understandably this is a disturbing process; positioning the body into a shroud and then zipping it up. Securing the zipper usually begins at the patient's feet and as the zipper closes one of the last features visible is the face. This can be a very disconcerting experience and even more so when it involves your patient. In the time it takes to zip up the shroud, the patient disappears leaving a plastic bag with the

outline of a body inside. Reconciling this sight with the person who was in the bed a short time ago only emphasizes the fleeting nature of life. Transferring the shroud-encased patient onto the morgue stretcher represented the nurses' final physical contact with their patients.

As the novice nurses described their first experience with death, they also discussed the quality of their patient's deaths. These comments provide insight about their feelings towards their first death.

> *All I could think about was how it was such a horrible way to die and it was just sad.* Billie

> *But a good death, I think I did okay for the first one in ICU and it was good .... I felt happy with how I approached the situation and handled it.* Leslie

> *It was nice because it felt like he died with some dignity.* Striker

Billie's first death was disturbing and her response was understandable. In contrast Leslie regarded her first death positively and was pleased with her professional and personal response. Classifying death as good may seem strange but it acknowledges the circumstances surrounding the event rather than the actual cessation of life. For Leslie being able to provide the type of care she felt was appropriate for dying patients and their family was important to how she viewed the death. In addition Leslie viewed her response to the situation positively. Striker also viewed her first death favorably because it was peaceful and dignified.

These first experiences with death are compelling for the poignant images they present. A sense of awe and the aura of mystery surrounding death emerged as the novice nurses discussed their thoughts and feelings. Nurses who have experienced the death of a patient would be familiar with the feelings identified in the presence of death.

Theme Four.

Being with the family: *It's really lonely in the dark*

> *The daughter was all alone and she had previously lost her dad. The daughter said to me that she didn't want to leave at all because as soon as she left her dad, he passed, so this was really bothering her. I sat with her for about 3 hours, and talked with her, not even about her Mom but just about what she does back home and her kids. It would be hard being there all by yourself. She was just sitting in a dark room by herself; I just couldn't imagine the thoughts going through her head. I sat with her in the room, which was really weird because usually we have so many things to do, but we weren't really doing much at that point other than just keeping her comfortable. But it was nice just to sit in there, I've never done that before, it's always been in and out, in and out, and you talk to families and establish a relationship with them but it felt nice actually to sit down and talk with her. I felt good, I felt like I was being a support. She came and thanked me "I really appreciate it and thank you for sitting down with me, it's really lonely in the dark".* Leslie

Leslie's relationship with her patient's daughter illustrated the connection nurses often make with patients and family members. Her first experience with death and dying demonstrated the encompassing care in ICU: caring for both the patient and family. Although Leslie initially expressed reluctance to care for a dying patient, she overcame those feelings and provided companionship and support to her patient's daughter during a long vigil. Leslie may have been a novice nurse experiencing her first death, but she recognized the need to tailor her nursing care specific to the dying patient and the family member who was present. The daughter acknowledged and thanked Leslie for her presence through a difficult time which contributed to Leslie viewing her first death as a positive experience.

Being with the family was the fourth theme identified in the data and revealed how the novice nurses interacted with the families of their dying patients. A low patient nurse ratio in ICU enables nurses to spend considerable time with patients and families providing care, information, and support. The availability of the nurse and their ability to

translate the unfamiliar ICU environment for patients and their families fosters the connection that occurs. Patients and their families who are in ICU for extended periods of time become well known to the staff and nurses can establish close ties with them. In turn, the patients and their families become comfortable with the nurses they see regularly and relationships can develop. It is not uncommon to see family members talking to the nurses they know in the hallways or have nurses assigned elsewhere in the unit come and talk with a patient and his/her family.

When a patient is critically ill and unable to communicate, often it is the family who speaks on their behalf. Family members faced with an uncertain outcome for their loved one will confide their hopes and fears with the nurses who are receptive and available to listen. Through this unique perspective the nurses become acquainted with patients and their families. These interactions influence the type of relationships nurses establish with families. Billie discussed the relationship that developed with her patient's family:

> *I think attachment; even in a sense of I was with my preceptor for seven hours or eight, so I had no previous history. Even though it's not like you're having huge conversations with these people, but you see them come in and they even ask little things. You have more of a relationship with the family, even though it's only an eight hour relationship, which kind of seems like a short time but at the same time, it's not ...*

This example reveals how quickly nurses can connect with a family during a crisis. As Billie and her preceptor cared for their critically ill patient, they also supported the family and answered their questions. In a short period of time the family experienced a progression from life-saving measures to compassionate care and ultimately death. The availability of Billie and her preceptor during this tumultuous time was a constant as the family dealt with this unexpected change in condition.

Gail talked about the difficulty of coming on shift and being with the family of a dying patient:

> *I was pretty much a stranger coming in to share the last moments of this patient's life with him. And trying to be there for the family when I didn't have rapport with them. I gained more rapport with them than I thought was possible.*

When she arrived at work, Gail saw she was assigned two patients or "doubled" and then learned one was very close to death. Not only was this Gail's first double, this was also her first assignment with a dying patient. Gail questions her ability to support this family through such a tragic and emotional loss when she is virtually unknown to them. Despite Gail's misgivings about the situation, she established a relationship with the family and was able to support them.

Lynn described the family dynamics she encountered:

> *I got the sense of an emotional detachment from him. I didn't get the sense that there was closeness within the family at all. And the whole time ... did not approach him, did not touch him, did not say anything to him really. The two daughters cried a little bit but the husbands especially the one ... After he passed away ... I said "Do you need more time?" ... And the first thing out of his mouth was "No, let's get this done, let's get moving." You get the sense of the families that you can go and give them a back rub or a pat on the shoulder or a hug ... They just did not seem like that type of family at all, very stoic. It wasn't that hard to interact with them ... but it was just very professional ... no sense of personal closeness to them at all.*

In this situation, Lynn observed the family's reserved manner and took this into account as she interacted with them. Lynn recognized not all families were receptive to demonstrative emotional support which highlights the importance of being able to distinguish what is appropriate for a family and responding accordingly.

As Striker's patient became more unstable she experienced a different family situation:

> *When we made the phone call to the family at about 10:30 they still made the decision not to come in, so maybe they did understand how sick he was and just didn't want to deal with it there. Maybe they just wanted to say their goodbyes [when they left at shift change] maybe they did say their goodbyes then. I was shocked the family didn't come in. It almost felt like something was missing with them not being there.*

It was difficult for Striker to accept that the family chose to stay home after being told the patient's condition had deteriorated. Even though Striker was able to rationalize why the family did not return; she still struggled with their decision. Striker described how she would have responded in this situation with her family:

> *I'm very close with my family. Even if they were expecting him to die, I think that I would still be there ... I wouldn't have left. And if I got that phone call I'd be right back there. For me it was a little odd that the family wasn't there.*

It is not uncommon for nurses to have deep-seated beliefs towards families' behaviour during end-of-life situations. This may include what is an appropriate response to the news that a loved one is doing poorly. If Striker's view of an ideal death involved peace and quiet with loved ones nearby this would explain why she felt something was missing. Having strong views on what is acceptable can make it difficult for nurses to understand a family's decision not to return to the hospital when called or to leave when their family member is close to death. The ability to be supportive of a family's decision even when the nurse disagrees with it can be a challenge for nurses.

Being with the family members as they navigated their way through the loss of their loved one was an important part of the novice nurses' first experiences with death. Each situation was unique and revealed the complexities of interacting with families facing the death of a family member. The novice nurses who established bonds with their patient's families did so by being physically and emotionally available to them. This was clearly demonstrated by Leslie's experience with her patient's daughter. The availability

of the nurse for the family was only one part; the family had to be receptive to the nurse. Leslie interacted with a family member who was very receptive and appreciative of her support, whereas, Lynn was available to her patient's family but recognized and respected their boundaries. In these emotionally charged situations, the novice nurses needed to pay attention to the nuances of family dynamics while at the same time being receptive and attentive to their needs.

Time was a factor in being with the family. Leslie described being able to sit and talk with her patient's daughter, providing companionship to someone who was otherwise alone with her dying mother. Billie and her preceptor were a vital presence for a family dealing with a rapid transition from active treatment to compassionate care and death. This was even more significant considering the short period of time involved. Gail struggled with the time restrictions she encountered; assuming care for a patient at the brink of death while being responsible for another patient.

The novice nurses participating in the study had not previously cared for the patient or met their family members before being involved with their death. Some of the deaths recounted involved patients who died soon after their admission to ICU. Caring for a dying patient and their family when the nurse has an established relationship with them may be a very different experience. Lynn described her response to another patient's impending death:

> *But a patient I had last week ... had a really wonderful, very sweet caring family and he was almost palliative and they withdrew on him yesterday and then I became very teary and emotional. I just went to see them ... to see how they were doing and I didn't realize that they were going to withdraw and the whole family was there ... The wife ... was so thankful and told us how wonderful we were and how she appreciated all the care that they'd given him ... you start to well up ...*

With her first patient's death, Lynn felt disconnected from the patient and his family, and this situation revealed very different feelings. Gail also described a similar experience:

> *The patient in the next pod passed away and it was quite a shock because I had cared for the lady for a couple of shifts. ... I felt like I could connect with the family more. There was a rapport there from weeks ago so when I walked in the room I almost felt like they had a sigh of relief that it was me who was coming in the room and it felt good under the circumstances. But it was still difficult to deal with because I was in a little shock because it was actually that patient that had passed away.*

In this instance Gail was confident she could comfort the family of a patient who died because of her previous relationship with them. However, knowing the patient and family proves to be a double-edged sword as Gail copes with her feelings towards the patient's death.

As the novice nurses discussed being with the family, the emotional impact of dealing with death and dying in a critical care setting became evident as they imagined their family members dying under similar circumstances. Billie revealed the following:

> *I couldn't imagine watching one of my loved ones in that bed. And I always think, especially in the ICU ... if that was my family member in the bed how would I be dealing with it, or just the looks of the patient, everything, and I found that watching the blood come out of her mouth was very hard and I think it was just hard because I thought "Oh my goodness if that was one of my family members or friends, that would be absolutely horrible to watch." I couldn't imagine my mother dying like that, with that much blood coming out of her ... mouth.*

Billie's first death was visually disturbing and this comes across strongly as she pictures her mother dying the same way. The death of Gail's patient was especially relevant to her personal life:

> *...especially being a young person, he was around my age. And I always think [this could have been my husband]. When I have patients who are around my age it could very well be anyone of us or anyone of the family members ...*

Gail's first death involved a young man who died from a self-inflicted injury. Her patient was the same age as Gail's husband and it may have been especially poignant consoling his wife.

Novice nurses also identified positive aspects associated with their first death experiences. Leslie discussed the favourable aspects of her patient's death: *That's how I would want to be treated, that's how I would want [my mother] to be treated.* Leslie considered her first experience with death a good death and one she would want for her mother. Striker also viewed her patient's death as a desirable way for a family member to die: *Yes, yes, I would love my family member being washed and with a couple people in there with him and just to go peacefully.* Being present with an elderly patient who died a peaceful and dignified death was important for Striker, especially in the absence of his family.

The experiences of the novice nurses with their first patient deaths in ICU revealed the complexities of death and dying in view of family dynamics and the relationships they formed with the patients and their families. Forming a significant connection with family members and providing comfort and support contributed to the experience being viewed positively. The belief that family members should be present with a dying patient made their absence difficult to understand. These initial experiences with death caused some of the novice nurses to contemplate their family members in similar circumstances and what they perceived to be a good or disturbing death.

Theme Five.

Carrying on: *Ah! I didn't sign up for this*

> *Maybe it's the nursing mentality but it's kind of like you just have to separate your emotion and get back to your work. And deal with whatever you're feeling when*

> *your shift is over. ... I quickly pulled it together and I just went on with my night. ... I've had my first withdrawal of treatment and I honestly thought that it couldn't have been more overwhelming just because of the whole doubling thing and the first withdrawal ... and it sounds bad but it was kind of a relief it was over. Because every day that you go in there you're hoping that your patient is not withdrawal of treatment and then finally one day you're withdrawing treatment and you're "Ah! I didn't sign up for this." ... I could have [cried] but I think the whole talking to the patient after he passed away really helped. After the body had gone down to the morgue I just went to the washroom and I just kind of you know, "Sigh" just let it go in a sense that I wasn't crying but I just felt like I should be and I felt that I knew I could but that it wasn't the right place or the right time. ... And I think if I didn't have another patient to take care of that night then I think that [I would have had a different response to the death].* Gail

As a novice nurse experiencing her first death, Gail realized she needed to keep her emotions under control in order to care for her other patient and finish the shift. She expressed conflicting emotions towards her first death; despite dreading an assignment involving a patient undergoing withdrawal of treatment there is relief when it finally happens. The conditions surrounding Gail's first death were not ideal; not only was she doubled with two patients but one of them was close to death. It is only after Gail sends her patient to the morgue that she spends a few minutes in the staff bathroom reflecting on what has just happened. This may seem a strange sanctuary but her privacy is guaranteed behind the locked door. Carrying on is epitomized by Gail's decision to deal with her feelings after work. The emotional impact of her first death is revealed as Gail acknowledges her brief bathroom break does not constitute the right place or time to express her feelings towards her patient's death. By keeping her emotions under control, Gail is able to continue working and protects her other patient from knowing someone has died.

Carrying on was the fifth theme that emerged from the data and described the novice nurses coping with their first death. These first experiences with death were

significant events but when put into the context of a 12-hour shift constituted only one part of the shift. An element of "life goes on" emerged as the novice nurses discussed what they did after their patients died. There were practical and emotional components related to carrying on. Practical aspects involved preparing the deceased patient for the morgue, cleaning and restocking the room, taking another patient assignment, or being available to help in the unit. This suggests the functioning of the unit and patient care took precedence over the fact that these nurses had just experienced their first death.

The emotional component was more complicated; the novice nurses had to deal with their emotions and support the grieving family while ensuring the tasks associated with a patient's death were completed. They may not have welcomed any special attention and sought to deal with their emotions away from the unit as Gail described. Carrying on until the end of the shift involved a reluctance to display emotion at work and the challenges of having another patient assignment.

Gail exemplified carrying on; doing what was needed for the deceased patient, preparing the room for cleaning, and caring for her other patient. Billie also experienced a similar situation when she and her preceptor admitted another patient soon after their first patient died:

> *All of a sudden we had to admit, so we sort of just jumped on to the next person. We had the next patient come and she had to be intubated and everything quite quickly. She was quite sick and it was one of those things where in 45 minutes she was intubated and all this sort of stuff and it was just like "Oh my, here we go again!" ... We just flipped to another person and it was like a whole new beginning ... And it was a brand new family...*

Even though Billie and her preceptor spent a busy morning with a patient who died, they were required to admit another critically ill patient, even before their first patient went to the morgue. Billie and her preceptor moved on to the new admission leaving other staff to

complete post-mortem care. There was little time for Billie and her preceptor to debrief after their first experience before they were exposed to a second patient. It was only after Billie arrived home that she acknowledged the emotional impact of her first day in ICU:

> *Just sort of one of those things where you're like, "Oh, I just have to let it out and then I'll feel a little bit better."*

Billie identified crying as a way of dealing with her emotions and was able to cry in the privacy of her bedroom. This was similar to Gail's response. Even though Billie was able to express her emotions there were limits imposed; *Just a little bit of a cry and then I'll just move on and keep going.* In spite of Billie's horrific first shift in ICU, she carried on by returning to work the next morning: *The next day was fine, that wasn't a big deal. It didn't really bother me about going to work the next day.*

Lynn spoke about what happened after her patient died:

> *They kept saying "When are you going to be done? We need you to take over for this double such and such." So I said okay, and it was just so rushed. I had no time to think about it actually.*

This is another example of ICU nurses needing to be able to move quickly from one situation to the next. As soon as Lynn sent her deceased patient to the morgue, she assumed care of another patient. The quick turnover between assignments did not provide an opportunity for Lynn to reflect on her first death.

Leslie described dealing with her patient's death:

> *I was okay the next day. I talked with one of my close friends ... And you sort of get ... not used to it, but I was okay with it. ... But just the daughter, I think about it once in a while, when I pass the room. I know I was in there and I was thinking that her mother passed in that room.*

Although Leslie accepted her patient's death and viewed her first death as a positive experience, the emotional impact lingered.

Striker described her response to her patient's death:

> *I phoned [my husband] and said "Hon, can you come get me?" So ... we went and had tea [during my break]. That was nice ... we just talked about other things. [For the rest of my shift] I was extra, helping out. That gave me the opportunity to talk to everyone about it ... [I went home and to bed] and then I woke up and I never really thought about it again.*

Striker coped with her patient's death by spending time with her husband and talking to unit staff. Spending her break with her husband gave Striker time to refocus before returning to work. In addition, the opportunity to discuss her first death with nursing colleagues soon after the experience provided Striker with support and reassurance.

These first experiences with death were viewed as learning opportunities by the novice nurses. Their exposure to death provided them with specific knowledge they would need again. Most of the knowledge gained was practical; how to monitor a dying patient or prepare the body for the morgue. Consoling and supporting the family of a dying patient was another first experience for the novice nurses. Gail described feeling more confident interacting with the family when she encountered her second death.

After the novice nurses experienced their first death they had to complete the paper work or "death bundle" required after a patient dies. This appeared to pose yet another challenge for them. Gail described her reaction:

> *I got all the paperwork out that I was supposed to do and I asked for help from my pod mate ... because I'd never seen it before in my life...*

Leslie also discussed the death bundle:

> *But we have the package to fill out after, so I've never done that and then the charge nurse came "I'll sit down with you and we'll go through this." I don't remember what exactly was on it, stickers and okay this goes where and the doctor has to sign ... If I had to do it again I'd have to ask someone, I honestly would.*

Striker described her response after her patient died:

> *Afterwards I had no idea what to do. So I just had to get somebody to help me find the bag, find the package for the doctor to fill out, how [to] pronounce them ... where their belongings go and that sort of thing. So, just kind of figuring that stuff out and just asking questions.*

Lynn also identified the procedures after a death:

> *I knew I needed to get the cadaver bag and then just in terms of all the paper work and stuff I needed to fill out I wasn't really sure what my role was, I knew the doctor had to do something, so of course I got the physician to come in and pronounce him. All the little, I guess legalities, and logistical things that I needed to do, that I wasn't too clear on that needed to be done. And really it's quite simple now that I know how to do it.*

It is only after the death of a patient that a nurse is exposed to the death bundle, an imposing stack of papers. Although filling out paperwork may seem minor considering everything else that had transpired during their shift, the paperwork represented yet another new and unfamiliar task to master. As well, this formality associated with death heralded the fact these nurses had experienced their first death. They were responsible for ensuring the paper work specific to nursing was correctly completed; documentation that would forever link them with this death.

Although novice nurses found aspects of their first death difficult, they also viewed it as a milestone in their nursing career. Despite the circumstances of Gail's first death she was relieved to have experienced her first death. Striker described similar feelings:

> *Emotionally, yes, it was kind of nice to get that under my belt and deal with the emotional part of it.*

Lynn discussed the practical aspects of her first death:

> *I could focus more on what I needed to do and not worry so much about what I was feeling. So then, come the time when a different situation comes up and it's a little more emotional, I at least know that other aspect of it ...*

Billie regarded her first experience with death as a benchmark for future deaths:

> *I think it will also be interesting to see if, that was my first death and what it's like in a year from now, when you have a patient that dies. Because I wonder if you still react to it the same way, in the sense of driving home and just being ... "Oh my!"*

The novice nurses experiencing their first death revealed varied responses to the dying process and the actual death. Although aspects of their first death were difficult, they were able to accept their patient's death and move on. They recognized dealing with death and dying was part of their role as critical care nurses and acknowledged relief they had experienced their first death.

Although the novice nurses received advice and support from their colleagues to deal with the practical aspects of a patient's death, it appeared they were left on their own to sort out their emotions towards their first death. Striker was the only nurse who described talking to colleagues at work about her first death. This may reflect the amount of time she had worked in the unit and the fact she was an extra nurse for the remainder of the shift. It did appear some of the nurses preferred to be on their own. Gail identified saying she chose to be alone with her deceased patient. She also spent time in the bathroom to regroup after her patient went to the morgue. Leslie spoke of needing some solitude at the end of her shift:

> *But I didn't want to talk to anybody, not that I, because I'm a talker, I like talking about things...*

Although Gail and Leslie spent some time reflecting on their feelings about their first death they also described sharing their experience with others. Gail described driving home with her husband after her shift:

> *My husband came to pick me up so it was kind of like a vent session on the way home .... He just listened and I think in that circumstance that's all I needed was for someone to listen.*

Leslie spoke to a friend:

> *I talked with one of my close friends, she relates ... She likes the nursing field and she always respects what we do and she was talking about it with me and just listening so that was nice.*

The novice nurses displayed a variety of strategies to cope with the emotions generated by their first death. Carrying on for some occurred immediately after their patient went to the morgue but others described needing time alone to reflect and process the experience. The ability to share their experience with someone willing to listen was an important component of carrying on for the novice nurses.

Conclusion

This chapter provides the reader with poignant images as novice nurses recount their first experience with death in critical care. These experiences reveal not only the challenges critical care nurses face caring for dying patients and their families but also the rewarding aspects. In spite of their limited experience with death, the novice nurses focused their attention on comfort measures for their dying patients and supporting the family members present. Satisfaction with the care they provided and feeling they had met the family's needs were significant factors in the novice nurses viewing their first death favourably. These first experiences with death illustrate the novice nurses' progression from anticipating death to carrying on.

Chapter Five

Discussion

These personal and heartfelt accounts of the novice nurses' first death provide an opportunity to examine their initiation to death and dying in a critical care setting. As a critical care nurse I could identify with the emotions experienced and relate to the disturbing aspects of caring for a dying patient. However, these descriptions also presented the perspective of seeing death for the first time through the eyes of a novice nurse. The research question, "What are the experiences of novice nurses with their first death in critical care?" arose from the increasing numbers of novice nurses beginning their careers in critical care.

In the past, it was an expectation that nurses hired for critical care had previous nursing experience which would have likely included exposure to death and dying. This premise is not necessarily applicable to novice nurses starting employment in critical care. Unfortunately there is very little research examining novice nurses' experiences with death and dying and the two studies that have been conducted are situated in the acute care setting (Hopkinson, 2001; Hopkinson et al., 2003). Conducting a qualitative research project focusing specifically on novice nurses in critical care provides an opportunity to describe their perspective of experiencing the death of a patient. Although research has examined the role of critical care nurses with death and dying, participants were identified as having several years of nursing experience which makes it difficult to generalize the findings to novice nurses (Isaak & Paterson, 1996; Jones & FitzGerald, 1998; Kirchhoff et al., 2000; McClement & Degner, 1995; Simpson, 1997; Yang & Mcilfatrick, 2001). This research study will increase awareness of the challenges novice

nurses face with death and dying as they begin their nursing practice in critical care. In this chapter the research findings from this study are discussed in relation to the existing literature related to student, novice, and experienced nurses' involvement with death and dying. Following this, the implications and recommendations for nursing education and practice are suggested. The strengths and limitations of the study are identified and recommendations for future research are made.

Findings from this research study revealed the novice nurses felt unprepared to care for their dying patients. This could be related to minimal classroom instruction and discussion or the lack of actual involvement caring for dying patients during their student years. It is also possible that their death-related experiences were not transferable to critical care. Recounting their first experiences with a patient's death in ICU, the novice nurses did not mention situations that had occurred during their student years. Although the novice nurses stated that they expected to encounter death and dying in critical care, their initial response to an assignment with a dying patient suggested otherwise. Feeling unprepared or not knowing what to do when confronted with a dying patient is supported by research examining the experiences of student nurses (Cooper & Barnett, 2005; Kelly, 1999, Kiger, 1994) and novice nurses (Hopkinson, 2001; Hopkinson et al., 2003). However, this study also demonstrated that in spite of their first reactions, the novice nurses responded to their dying patients with compassionate nursing care. The emphasis on providing comfort measures to their dying patients is supported in the research focusing on student nurses (Beck, 1997; Cooper & Barnett) and experienced nurses (Halcomb et al., 2004; Kirchhoff et al., 2000; McClement & Degner, 1995; Rittman, et al., 1997; Simpson, 1997; Yang & Mcilfatick, 2001).

Caring for a dying patient exposed the novice nurses to aspects of death they had not previously considered or experienced. Researchers have reported that student nurses (Kelly, 1999; Kiger, 1994) and novice nurses (Hopkinson et al., 2003) revise their image of death after their first encounter with a dying patient. The novice nurses also spoke of responding to disturbing sights and sounds in an attempt to make the situation easier for the family. Students and experienced nurses have identified their efforts in maintaining a normal environment when a patient is dying (Cooper & Barnett, 2005; Simpson, 1997). This can involve removing the discontinued equipment such as infusion pumps, dialysis machines or ventilators; shutting off the cardiac monitor, and dimming the lights in the room. Minimizing the use of technology normally associated with critical care changes the patients' surroundings so they are not overshadowed by the equipment around their bed. This also allows the nurses to focus on the patients' comfort and the families' needs.

The significance of the relationship nurses developed with their patients' families was highlighted in this study. Although some of the novice nurses did not have an opportunity to interact with the family, those who did described the emotional impact of their involvement. Research has shown student and experienced nurses are more affected by a patient's death when a relationship exists with the patient or his/her family (Cooper & Barnett, 2005; Halcomb et al., 2004; Isaac & Patterson, 1996; Simpson, 1997). The difficulty of caring for dying patients and their families when the nurse did not know them was acknowledged by some of the participants in this study and is also documented in previous research involving novice and experienced nurses (Hopkinson, 2001; Isaak & Patterson, 1996). The novice nurses met the families' needs by ensuring unlimited time with the patients, including them in the patients' care, and offering emotional support.

These actions are consistent with research studies describing student and experienced nurses' involvement with the families of dying patients (Beck, 1997; Halcomb et al.; Kirchhoff et al., 2000; McClement & Degner, 1995; Rittman, et al., 1997; Simpson; Yang & Mcilfatick, 2001).

When discussing their patients' deaths, the novice nurses recalled feelings of awe, surprise, and disbelief as they witnessed their patient die. The very fact of being with a dead body was discomforting because it was a new and unfamiliar experience. This reaction to a patient's death is not unusual: similar responses have been described by student and novice nurses in previous studies (Beck, 1997; Cooper & Barnett, 2005; Hopkinson et al., 2003; Kelly, 1999; Yang & Mcilfatick, 2001). Most of the novice nurses experienced sadness when their patient died and this is a common response noted in other research (Beck; Cooper & Barnett; Isaak & Patterson, 1996; Kelly; Loftus, 1998; Simpson, 1997; Yang & Mcilfatick). There were aspects of the post-mortem care that the novice nurses found difficult and researchers have reported that student nurses struggle with post-mortem care (Cooper & Barnett). As the novice nurses prepared their patients for the morgue they used that time to reflect on the death which is also found in the research focused on experienced nurses (Isaac & Patterson; Maeve, 1998). Treating their deceased patients with respect during post-mortem care was also discussed by the novice nurses and corresponds to the practices of experienced nurses (Isaac & Patterson; McClement & Degner, 1995).

In response to the death of their patients, the novice nurses spoke of controlling their emotions and focusing on what needed to be done. This was clearly revealed in the following comment by one of the participants: ... *it's kind of like you just have to*

separate your emotion and get back to your work. And deal with whatever you're feeling when your shift is over. ... I quickly pulled it together and I just went on with my night. These coping strategies are documented in the research involving student, novice, and experienced nurses (Badger, 2005; Cooper & Barnett, 2005; Halcomb et al., 2004; Hopkinson et al., 2003; Isaac & Patterson, 1996). The novice nurses also discussed the need of keeping their emotions under control because they had other work-related responsibilities which is similar to experienced nurses (Isaac & Patterson; Kirchhoff et al., 2000). Although the novice nurses were able to control their emotions when their patient died, some described needing to release their emotions when they were alone or had left work. These findings have also been reported in research on student, novice, and experienced nurses (Cooper & Barnett, Hopkinson et al.; Isaac & Patterson, 1996; Kiger, 1994, Loftus, 1998; Maeve, 1998).

Most of the participants in this study described talking to someone outside of work about their first experience with death. Some of the novice nurses chose not to discuss their experiences with family members because they felt it was too upsetting or they would not understand as revealed by the following comment: *[My husband] doesn't really understand [ICU], right? So we just talked about other things.* This reluctance to discuss the death of a patient at home has also been reported by experienced nurses (Badger, 2005; Kirchhoff et al., 2000). Researchers have identified that student nurses find talking to other students, friends, or nursing staff beneficial (Cooper & Barnett, 2005; Kiger, 1994; Loftus, 1998) whereas experienced nurses cite the importance of being able to talk with colleagues (Badger; Jones & Fitzgerald, 1998; Kirchhoff et al.).

Participants in this study did not acknowledge receiving emotional support after the death of their patient and this is congruent with the findings of researchers investigating student, novice, and experienced nurses (Halcomb et al., 2004; Hopkinson et al., 2003; Kiger, 1994; Loftus, 1998; McClement & Degner, 1995). These researchers identified that students and nurses felt they were left to cope on their own after the death of a patient in the clinical setting.

The novice nurses discussed positive aspects of their first experience with death; feeling satisfied with the care they provided and expressions of appreciation by the patients' families. These findings are similar to the research involving novice and experienced nurses (Hopkinson et al., 2003; Kirchhoff et al., 2000). The novice nurses also acknowledged learning from these first experiences with death. They identified gaining practical knowledge about caring for a dying patient, preparing a body for the morgue, and completing the paper work. The novice nurses also gained experience with the emotional aspects of supporting a grieving family, seeing a patient die, and coping with their own feelings as these events transpired. This is supported by researchers who identified that student, novice, and experienced nurses learn from death-related experiences (Badger, 2005; Beck, 1997; Hopkinson, 2001; Hopkinson et al.; Kiger, 1994; McClement & Degner, 1995). For example, Hopkinson reported that experience caring for dying patients influenced the nursing practice of novice nurses.

These first experiences with death in critical care did not expose the novice nurses to any of the issues at the end-of-life that critical care nurses find distressing (Badger, 2005; Halcomb et at., 2004; Isaac & Patterson, 1996; Jones & FitzGerald, 1998; Kirchhoff et al., 2000; Simpson, 1997; Yang & Mcilfatrick, 2001). Most of the novice

nurses in this study experienced their first death caring for patients who were compassionate care or DNR. It was apparent during the interviews that the novice nurses understood their patients had a poor or nonexistent chance for a meaningful recovery and agreed with the decision to withdraw or withhold treatment. Although researchers have documented that student nurses and inexperienced nurses have difficulty understanding the reasons for withdrawal of treatment or DNR, this was not supported in this study (Cooper & Barnett, 2005; Simpson).

A finding from this study that is not reported in previous research focusing on student or novice nurses is the relief the novice nurses acknowledged after experiencing their first death. In spite of the challenges they faced and the emotional impact of their first death, the novice nurses were relieved to have this experience behind them. This is not surprising considering they expected to encounter death and dying in critical care and may have been exposed to colleagues caring for dying patients or witnessed the emergent resuscitation of a patient. Considering the potential scenarios for a death in critical care, the relief of the novice nurses could be related to the fact they encountered deaths that were expected and peaceful although one was visually disturbing. The absence of participants who experienced unexpected deaths could be a limitation of this study.

Implications and Suggestions for Nursing Education and Nursing Practice

Although one may assume that student nurses acquire experience with death and dying during their nursing education, there is a distinct possibility of novice nurses beginning their nursing careers without previous exposure to death and dying. An examination of the death education provided in Canadian nursing degree programs revealed that instruction on death and dying is integrated into the curriculum of most

nursing education programs in Canada (Goodwin, 2005). Findings from this study also indicate that many students do not encounter dying patients during their nursing education. However, students also need to be involved with dying patients in the clinical setting. Ensuring every student has suitable experiences with death and dying during their nursing education can be extremely challenging for program organizers and is thus unlikely to occur for every student. One challenge for nursing programs is the shortage of suitable clinical placements for students (Goodwin). Nurse educators working with students in the clinical setting need to acknowledge the importance of providing students with death-related experiences while also assuming responsibility for providing emotional support.

Clinical managers and nurse educators also face difficulties trying to ensure novice nurses are prepared to encounter death and dying in critical care. Orientation to a critical care unit may not necessarily include instruction to deal with death and dying. This places the onus on the novice nurses to identify their lack of experience with dying patients or the death of a patient. Unit orientation in the critical care setting used for this study addresses how to call for the morgue stretcher and where the shrouds and death bundles are located. While this may sound somewhat impersonal it reflects the practical aspects of orientating to a new work environment. There is also an opportunity during orientation for the Chaplain and Social Worker to introduce themselves to new hires and explain their role with patients, families, and staff in the unit. This provides an introduction to other members of the multidisciplinary team who are available as resources for the nurses.

The difficultly in predicting when a novice nurse will encounter death in the clinical setting can impact the ability of the clinical managers and nurse educators to ensure they are prepared or have adequate support when this does happen. An opportunity to discuss DNR or compassionate care with novice nurses may not necessarily prepare them for such an assignment. The ability of clinical managers or nurse educators to provide support when a novice nurse is assigned a dying patient can be limited depending on their workload. In addition to the orientation of new hires in ICU, the clinical nurse educators are also responsible for nursing education related to specialized clinical competencies, new equipment, and procedures which may influence their availability. The constant turnover of nursing staff also impacts who is available to preceptor and mentor new staff. Rotating day/night schedules can make it difficult for the clinical managers and nurse educators to follow the novice nurses. Assignments in critical care often reflect the acuity of the patients and clinical managers or charge nurses may not have a choice when novice nurses are assigned dying patients. Ideally the novice nurses would be able to rely on their colleagues as a resource but a busy unit can make that challenging. Staffing shortages could result in a novice nurse being assigned a patient who is dying in addition to another patient. Although not an ideal situation, this is a possible scenario in the clinical setting especially given the current nursing shortage.

Employee assistance programs (EAP) and debriefing sessions are available for nurses who have experienced a traumatic event in the unit. It is the responsibility of the nurse involved to arrange for EAP and the novice nurses who participated in this research study were aware of this service. Debriefing sessions are organized by the clinical managers in response to a traumatic event but there can be delays due to the schedules of

those involved. Chaplains are available to the unit on call but it would be up to the nurse to contact them unless the unit's Chaplain is aware of an impending death. Social Workers are available during the week days and meet with patients, families, and nurses as needed. Although assistance is available to nursing staff struggling with a difficult situation, often the onus is upon the individual to initiate contact. Reluctance to participate in debriefing sessions (Jones & FitzGerald, 1998) and fear of being ridiculed by colleagues (Halcomb et al., 2004) has been identified by researchers as obstacles for nurses seeking help. However, it is also the responsibility of clinical managers and nursing educators to ensure nurses know these services are available. Providing charge nurses with the information required to initiate a debriefing session could expedite the process of organizing a session especially on weekends.

In this particular health region, all new hires without previous critical care experience attend a critical care orientation program that includes an informal discussion on death and dying. The presentation focuses on the needs of dying patients and their families and the nurse's role with end-of-life care. This content is reinforced with anecdotes from the presenter's experience as a critical care nurse. This discussion has been favourably received by several classes and the evaluations often thank the speaker for acknowledging patients die in critical care.

Strengths and Limitations

The intent of this research study was to increase awareness of a specific clinical event; novice nurses' first experience with the death of a patient in critical care. Interpretative description, a qualitative research method, was chosen because it reflects the philosophical and theoretical foundations of nursing (Thorne, Reimer Kirkham, &

MacDonald-Emes, 1997). An unstructured interview provided a forum for the novice nurse to share her experience with the researcher. One limitation of this format is that the interviews occurred after the patient's death and it is possible that the novice nurses may have forgotten certain details. Interviewer expertise is also a factor in the collection of data and the researcher's inexperience as a qualitative researcher may have been a limitation in this study. However, the researcher' critical care experience and familiarity with the clinical setting were strengths for this research study. Working in the unit with the participants would have given the researcher credibility as a critical care nurse and facilitated recruitment for the study. Those novice nurses who attended the presentation on death and dying would have been aware of the researcher's interest in death and dying which could have been a factor for their participation in the research study and the information they shared in their interviews.

The foundation of interpretive description is qualitative investigation of phenomena relevant to nursing on a smaller scale which is reflected by the sample of five novice nurses recruited for the research project (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). A limitation of this sample is that all the participants worked in the same clinical area and were female. Although 26 information letters were distributed in two separate clinical areas, this did not elicit responses from eligible participants in either clinical area. The novice nurses who participated in this research study were recruited by the researcher through work-related activities associated with one clinical setting. This lack of response to the information letters may be related to the personal and potentially emotional nature of the research topic and a reluctance to discuss this with a stranger. Although the researcher did not know who received her information letters, it was

possible that there were male novice nurses working in critical care during this time. The absence of male novice nurses in this study also highlights the voluntary nature of participation in research projects.

Another limitation of this research study is that the participants experienced the death of a patient after treatment was withdrawn or withheld. Novice nurses experiencing sudden and unexpected deaths may have contributed an entirely different perspective of death in critical care. It is possible that the novice nurses who experienced unexpected deaths viewed the event negatively and were unwilling to discuss the death of their patient with the researcher. Although this is identified as a limitation, the type of deaths experienced by the participants was beyond the researcher's control.

Recommendations for Future Research

This study was conducted to add to the nursing knowledge of novice nurses' first experiences with death and dying. Considering the exploratory nature of this research design and the limited research available describing novice nurses' experiences with death and dying, further research on this topic is warranted. This study was conducted in one medical-surgical intensive care unit and repeating this study in similar units in other hospitals, or different speciality areas within critical care and acute care may provide different perspectives. Conducting similar research in pediatric or neonatal critical care would add another dimension to what is known about novice nurses' experiences with death and dying. Additional research focusing on the overall experiences of novice nurses in critical care would provide useful information that could be considered for recruitment and retention purposes. Identifying the challenges that novice nurses face beginning their careers in critical care could be utilized to ensure they receive the preparation and support

required to remain working in the speciality area. In addition, the findings from research investigating why novice nurses leave critical care could provide specific information that could be applied to orientation programs and preceptorship of new hires to retain staff. Although this research study has focused on novice nurses in critical care, there are recommendations for research involving student nurses. Findings from this study revealed the novice nurses felt unprepared to interact with dying patients; therefore it may be beneficial to explore what types of experiences student nurses have with death and dying and when this occurs in their program.

Conclusion

In this chapter, the research findings have been reviewed in relation to previous published research on novice, student, and experienced nurses. The implications and suggestions for nursing education and nursing practice were discussed. In addition, the strengths and limitations of the study were identified and future research arising from this work was presented.

The findings of this study are supported by the research that investigated novice nurses' experiences with death and dying in acute care. In addition, this study also revealed that the novice nurse shared many similarities with students and experienced nurses in relationship to their involvement with death and dying. This is not surprising considering the novice nurse's role represents the transition from student to registered nurse and their nursing experience and knowledge is a reflection of their exposure to the clinical setting. This research also acknowledges that in order for novice nurses to incorporate death and dying into their nursing practice, they need to experience the death of a patient.

References

Amos, D. (2001). An evaluation of staff nurse role transition. *Nursing Standard, 16*(3), 36-41.

Anderson, C. A., & Basteyns, M. (1981). Stress and the critical care nurse reaffirmed. *Journal of Nursing Administration, 11*(1), 31-34.

Badger, J. M. (2005). A descriptive study of coping strategies used by medical intensive care nurses during transitions from cure to comfort-oriented care. *Heart & Lung, 34*(1), 63-68.

Bailey, J. T., Steffen, S. M., & Grout, J. W. (1980). The stress audit: Identifying the stressors of ICU nursing. *Journal of Nursing Education, 19*(6), 15-25.

Beck, C. T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research, 15*(2), 26-29.

Beck, C. T. (1997). Nursing students' experiences caring for dying patients. *Journal of Nursing Education, 36*(9), 408-415.

Bogdan, R. C., & Biklen, S. K. (1992). *Qualitative research for education: An introduction to theory and methods* (2nd ed.). Needham Heights, MA: Allyn Bacon.

Boychuk Duchscher, J. E. (2001). Out in the real world: Newly graduated nurses in acute-care speak out. *Journal of Nursing Administration, 31*(9), 426-439.

Canadian Nurses Association. (1983). Code of Ethics for Registered Nurses. Ottawa: Author.

Charnley, E. (1999). Occupational stress in the newly qualified staff nurse. *Nursing Standard, 13*(29), 33-36.

Cooper, C. L., & Mitchell, S. (1990). Nursing the critically ill and dying. *Human Relations, 43*(4), 297-311.

Cooper, J., & Barnett, M. (2005). Aspects of caring for dying patients which cause anxiety to first year student nurses. *International Journal of Palliative Nursing, 11*(8), 423-430.

Davenport, J. M. (2000). The experience of new nurses beginning critical care practice: An interpretive phenomenological study. *Dissertation Abstracts International, 61*(04), 1868B. (UMI No. 9970698)

Delaney, C. (2003). Walking a fine line: Graduate nurses' transition experiences during orientation. *Journal of Nursing Education, 42*(10), 437-443.

Foxall, M. J., Zimmerman, L., Standley, R., & Captain, B. B. (1990). A comparison of frequency of sources of nursing job stress perceived by intensive care, hospice and medical-surgical nurses. *Journal of Advanced Nursing, 15*, 577-584.

Glaser, B. G., & Strauss, A. L. (1965). *Awareness of dying*. Chicago: Aldine.

Goodwin, B. L. (2005). *An examination of the death education provided in Canadian nursing degree programs*. Unpublished master's thesis, University of Alberta, Edmonton, Alberta, Canada.

Gray-Toft, P., & Anderson J. G. (1981). Stress among hospital nursing staff: Its causes and effects. *Social Science and Medicine, 15A,* 639-649.

Halcomb, E., Daly. J., Jackson, D., & Davidson, P. (2004). An insight into Australian nurses' experience of withdrawal/withholding of treatment in the ICU. *Intensive and Critical Care Nursing, 20,* 214-222.

Hopkinson, J. B. (2001). Facilitating the development of clinical skills in caring for

dying people in hospital. *Nurse Education Today, 21,* 632-639.

Hopkinson, J. B., Hallet, C. E., & Luker, K. A. (2003). Caring for dying people in hospital. *Journal of Advanced Nursing, 44*(5), 525-533.

Huckabay, M. D., & Jagla, B. (1979). Nurses' stress factors in the intensive care unit. *Journal of Nursing Administration, 9*(2), 21-26.

Hurtig, W. A., & Stewin, L. (1990). The effect of death education and experience on nursing students' attitude towards death. *Journal of Advanced Nursing, 15,* 29-34.

Isaak, C., & Paterson, B. L. (1996). Critical care nurses' lived experience of unsuccessful resuscitation. *Western Journal of Nursing Research, 18*(6), 688-707.

Jones, T., & FitzGerald, M. (1998). Withdrawal of life-support treatment: The experience of critical care nurses. *Australian Critical Care, 11*(4), 117-121.

Kelly, C. T. (1999). The lived experience of female student nurses when encountering patient death for the first time. *Dissertation Abstracts International, 59*(10), 5311B. (UMI No. 9910958)

Kiger, A. M. (1994). Student nurses' involvement with death: The image and the experience. Journal of Advanced Nursing, 20(4), 679-686.

Kirchhoff, K. T., Spuhler, V., Walker, L., Hutton, A., Vaughan Cole, B., & Clemmer, T. (2000). Intensive care nurses' experiences with end-of-life-care. *American Journal of Critical Care, 9*(1), 36-42.

Kramer, M. (1974). *Reality shock: Why nurses leave nursing.* St. Louis, MO: CV Mosby.

Loftus, L. A. (1998). Student nurses' lived experiences of the sudden death of their patients. *Journal of Advanced Nursing, 27*(3), 641-648.

Maeve, M. K. (1998). Weaving a fabric of moral meaning: How nurses live with suffering and death. *Journal of Advanced Nursing, 27*(6), 1136-1142.

Mallory, J. L. (2003). The impact of a palliative care educational component on attitudes toward care of the dying in undergraduate nursing students. *Journal of Professional Nursing, 19*(5), 305-312.

McClement, S. E., & Degner, L. F. (1995). Expert nursing behaviours in care of the dying adult in the intensive care unit. *Heart & Lung, 24*(5), 408-419.

Morse, J. M. (Ed.). (1991). *Qualitative nursing research: A contemporary dialogue* (Rev. ed.). Newbury Park, CA: Sage.

Morse, J. M., Barrett, M., Mayan, M., Olsen, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), Article 2. Retrieved October 25, 2005 from http://www.ualberta.ca/~ijqm/

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.

Quint, J. C. (1967). *The nurse and the dying patient.* New York: Macmillan.

Rittman, M., Paige, P., Rivera, J., Sutphin, L., & Godown, I. (1997). Phenomenological study of nurses caring for dying patients. *Cancer Nursing, 20*(2), 115-119.

Ross, H., & Clifford, K. (2002). Research as a catalyst for change: The transition from student to registered nurse. *Journal of Clinical Nursing, 11*(4), 545-553.

Sandelowski, M. (1995b). Qualitative analysis: What it is and how to begin. *Research in Nursing and Health, 18*, 371-375.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in*

Nursing and Health, 23, 334-340.

Simpson, S. H. (1997). Reconnecting the experiences of nurses caring for hopelessly ill patients in intensive care. *Intensive and Critical Care Nursing, 13*, 189-187.

Streubert Speziale, H. J., & Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative.* (4th ed.). Philadelphia, PA; Lippincott.

Thorne, S., Reimer Kirkham, S., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health, 20* 169-177.

Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3*(1). Article 1. Retrieved November 4, 2005 from http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/thorneetal.pdf

Wong, F. K. Y., & Lee, W. M. (2000). A phenomenological study of early nursing experiences in Hong Kong. *Journal of Advanced Nursing, 31*(6), 1509-1517.

Yang, M., & Mcilfatrick, S. (2001). Intensive care nurses' experiences of caring for dying patients: A phenomenological study. *International Journal of Palliative Nursing, 7*(9), 435-441.

Appendix A

Information Letter to Graduate Nurses

Project Title: Experiences of Graduate Nurses with the Death of Their First Patient in a Critical Care Setting

Date

Dear Graduate Nurse

My name is Gwen Thompson and I am a graduate student in the Faculty of Nursing. I have a particular interest in the experiences of graduate nurses with their first death in a critical care setting. My interest in this topic stems from my experiences as a critical care nurse.

To further my understanding of graduate nurses' experience with their first patient death, I would like to talk with you about your experiences by organizing a face-to-face interview. I have received ethics approval by the University of Alberta Health Research Ethics Board and Administrative Approval from the Nursing Division at Capital Health. If you agree to participate in this study, you will be interviewed at least once with the possibility of a second interview if needed to discuss your experiences with your first patient's death in the critical care unit.

If you began working in critical care as a graduate nurse, experienced the death of your patient in this area and are interested in discussing your experience, please contact me at 439-5464. When you call, we will arrange an interview at a day, time, and location that are mutually convenient. Possible locations are your home, the hospital, or a meeting room at the University of Alberta. The first interview will take approximately one hour and if a second interview is required, it will take approximately 30-45 minutes. For research purposes, all interviews will be tape recorded and transcribed so that I can read them, analyze them, and synthesize the experiences shared by all participants.

It is important that you know that ALL information shared during the interviews will be kept completely confidential. A confidentiality agreement will be obtained from the transcriptionist. Access to the audiotaped interviews and transcripts is limited to my supervisory committee. At no time will the individual experiences be released to anyone. Your experiences will have complete anonymity because I will use a code name of your choice. The audiotape and transcript of your interview will be stored in a locked cabinet that only I can access. If information from your interview is reported in the findings of the study, your code name will be used to protect your identity.

Dr. Joanne Profetto-McGrath is my thesis supervisor and you may contact her at 492-1597 if you have any questions or concerns about this research study.

I look forward to hearing from you. Thank you in advance for your interest and time.

Sincerely,

Gwen Thompson, RN
Master of Nursing Student
Faculty of Nursing, University of Alberta

Identifying participants as graduate nurses was changed to novice nurses during data analysis to reflect that participants were recent nursing graduates.

Appendix B

Participant Eligibility and Tracking Form

Name: _____

Contact information: _____

Date and time of initial contact: _____

Hospital site: _____

Clinical area: _____

Date of graduation: _____

Interview date: _____ Time: _____

Location of interview: _____

Date of follow up phone call after first interview: _____

Second interview required: Yes_____ No_____

Date second interview scheduled: _____

Date of follow up phone call after second interview: _____

Employee assistance information provided: Yes_____ No_____

Appendix C

Demographics Data Form

Personal information

Participant Name: _____

Selection of code name: _____

Date and time of interview: _____ _____

1. Age:_____
2. Gender: Male_____ Female_____
3. Date of nursing graduation:_____
4. Clinical area of employment:_____
5. Work status: FT _____ PT _____ Casual _____
6. Experience with death of family member or friend:
   Family member: Yes _____No _____ Friend: Yes _____ No _____

Appendix E

Research Consent Information Form

Project Title: Experiences of Graduate Nurses with the Death of Their First Patient in a Critical Care Setting
Researcher: Gwen Thompson, RN

Background: The curative focus of critical care and the advanced technology and life support measures available may overshadow the fact that critically ill patients often die. The low patient nurse ratio in the critical care setting facilitates interaction with patients and their families and can lead to significant nurse involvement when a patient is dying. Graduate nurses with limited practice experience and who have not been exposed to death and dying during their nursing program may find themselves unprepared to deal with this aspect of critical care nursing.

Purpose: The purpose of this research study is to explore the experiences of graduate nurses with their first patient death in critical care.

Procedure: Participation in this study will take the form of interviews. If you decide to participate in this study, you will be interviewed once or twice in person. The first interview will take approximately one hour; the second interview if necessary will take approximately 30-45 minutes. Interviews will be audio-taped and transcribed so that the researcher can reflect on and interpret the interview.

Possible Benefits: A possible benefit for participants is the opportunity to discuss a potentially stressful event with an interested individual (researcher) who has experienced the death of patients in a critical care setting.

Possible Risks: It is possible that participants will experience emotional duress while reliving a traumatic event. In anticipation that some participants may have difficulty dealing with the memories related to a patient's death, the researcher will have information on the Employee Assistance Program available at the interview.

Confidentiality: Information shared during the interview is completely confidential and at no time will your name or identity be connected to the findings of the study. All information will be kept private except when professional codes of ethics or legislation require reporting. Only members of the supervisory committee will have access to the tapes and transcripts. The audiotapes and transcripts will be stored in a locked cabinet accessible only by the researcher for a period of 5 years after which time they will be destroyed.
The transcripts may be used for future research studies; however, ethical approval will be sought prior to their use. The information and research findings may be published or presented at conferences without information that identifies you. If information from your interview is reported in the findings of the study, the code name you have chosen will be used to protect your identity.

Project Title: Experiences of Graduate Nurses

Voluntary Participation: You are in no way obligated to participate in this study and you may withdraw at any time during the study without any direct impact on you or your work.

Reimbursement of Expenses: Parking expenses incurred by participants will be reimbursed by the researcher.

Contact Names and Telephone Numbers:
If you have concerns about your rights as a study participant, you may contact the Health Research Ethics Board at 492-0302.

Please contact any of the individuals identified below if you have any questions or concerns.

Gwen Thompson
MN Student
Telephone number 439-5464

Dr. Joanne Profetto-McGrath
Student Supervisor
Telephone number 492-1597

Identifying participants as graduate nurses was changed to novice nurses during data analysis to reflect that participants were recent nursing graduates.

Appendix F

HREB Research Consent Form

Part 1 (to be completed by the Principal Investigator):

Title of Project: Experiences of Graduate Nurses with their First Patient Death in Critical Care
Principal Investigator: Gwen Thompson Phone Number: 439-5464

Part 2 (to be completed by the research subject):

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time without having to give a reason?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your records?	☐	☐

Who explained this study to you?

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Subject _____

(Printed Name) _____

Date: _____

Signature of witness_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee_____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Identifying participants as graduate nurses was changed to novice nurses during data analysis to reflect that participants were recent nursing graduates.