Understanding the bereavement care roles of nurses within acute care: a systematic review

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Understanding the bereavement care roles of nurses within acute care: A systematic review.

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**Aim and objectives:** To investigate nurses’ roles and responsibilities in providing bereavement care during the care of dying patients within acute care hospitals.

**Background:** Bereavement within acute care hospitals is often sudden, unexpected and managed by nurses who may have limited access to experts. Nurses’ roles and experience in the provision of bereavement care can have a significant influence on the subsequent bereavement process for families. Identifying the roles and responsibilities nurses have in bereavement care will enhance bereavement supports within acute care environments.

**Design; Methods:** A mixed-methods systematic review was conducted utilising the databases Cumulative Index Nursing and Allied Health Literature (CINAHL Plus), Embase, Ovid MEDLINE, PsychINFO, CareSearch and Google Scholar. Included studies published between 2006 to 2015, identified nurse participants, and the studies were conducted in acute care hospitals. Seven studies met the inclusion criteria and the research results were extracted and subjected to thematic synthesis.

**Results:** Nurses’ role in bereavement care included patient-centred care, family-centred care, advocacy and professional development. Concerns about bereavement roles included competing clinical workload demands, limitations of physical environments in acute care hospitals and, the need for further education in bereavement care.

**Conclusions:** Further research is needed to enable more detailed clarification of the roles nurse undertake in bereavement care in acute care hospitals. There is also a need to evaluate the effectiveness of these nursing roles and how these provisions impact on the bereavement process of patients and families.

**Relevance to clinical practice:** The care provided by acute care nurses to patients and families during end-of-life care is crucial to bereavement. The bereavement roles nurses undertake is not well understood with limited evidence of how these roles are measured. Further education in bereavement care is needed for acute care nurses.

**Key words:** bereavement, grief, death, nurses, acute care, hospital, inpatient

**INTRODUCTION**

The experience of bereavement is a very individual, extensive and often a difficult journey for the bereaved individual. The bereavement process refers to coping with grief, and has been described as the entire period of anticipation, death and subsequent adjustment to living, following the death of a significant other (Christ, Bonanno, Malkinson, & Rubin, 2003). The experience of bereavement is recognised as one of life’s greatest stressors and this period has been associated with a decline in health status, risk of mortality and psychological morbidity (Buckley et al., 2015). Bereaved family members are also known to be at a much higher risk of developing mental and physical health problems (Valks, Mitchell, Inglis-Simons, & Limpus, 2005).
Bereavement care refers to provisions of nursing care that impact on the grief and the bereavement process for families, this care is commonly provided during end-of-life care for dying patients. Nurses within acute care hospitals are in the unique position to meet the needs of the suddenly bereaved and skilled interventions are necessary in providing psychosocial support to families during end-of-life care (Walker & Deacon, 2015).

It has been suggested that a nurse’s manner and preparedness for the death of a patient can have a positive impact on the subsequent bereavement experience for families (Buckley et al., 2015). Nursing bereavement care for families may include psychosocial care, referral to and supported implementation of interdisciplinary services and the clinical interventions performed to maintain the comfort needs of dying patients (Fauri, Ettner, & Kovacs, 2000; Jackson, Mooney, & Campbell, 2009). Bereavement care includes the process of preparing families for impending death and continues immediately following death and up until patient death (Buckley et al., 2015).

Nursing bereavement care is provided for families during end-of-life care. End-of-life pathways and protocol directives also include bereavement care measures (Jackson et al., 2009). The origins of the Pathway for Improving the Care of the Dying (PICD) was to import the principles of palliative care into general hospital wards (Jackson et al., 2009). Clarification of the exact bereavement roles that nurses undertake during end-of-life care will help identify exactly what clinical supports are put into place for grieving families within acute care hospitals.

Acute care refers to care received within a hospital setting where a patient receives active but short-term treatment for acute injury or episodes of illness with intent to restore health (World Health Organization, 2015). Death within acute care can therefore be an unexpected event, with the resultant grief and bereavement for families of dying patients more pronounced (Fauri et al., 2000; Kent & McDowell, 2004; Brown et al., 2006; Van der Klink et al., 2010). The acute care environment is clinically focused, treatment orientated and often not practical to accommodate griefing families (Valks et al., 2005; Caswell, Pollock, Harwood, & Porock, 2015). There is also a need for hospitals to have more suitable quiet rooms with adequate space, and privacy for bereaved families (Al-Quarainy, Collis, & Feuer, 2009).

Some families also feel that they receive minimal information about the end-of-life practices, and others report a discrepancy between the clinical information provided and a need for follow-up bereavement services (Van der Klink et al., 2010). Communication between hospital staff and bereaved family members has been reported as ineffective, causing distress and dissatisfaction (Caswell et al., 2015). Nurses in acute care settings are also described as lacking confidence in dealing with the psychosocial needs of patients and report they have received insufficient preparation in the care of terminally ill patients (Addington-Hall & O’Callaghan, 2009).

In 1994, Palliative Care Australia devised thirteen Australian National Standards for quality palliative acute care (2005). Similarly, the Australian Commission on Safety and Quality in Healthcare (ACSQHC) also specify ten essential elements for safe and high quality end-of-life care (2015). In the United Kingdom, the National Institute for Health and Care Excellence (NICE) described sixteen quality statements guiding end-of-life care (2014) and in the USA, eight domains of clinical practice guidelines are described for quality palliative care (National Consensus Project, 2013). These extensive and detailed recommendations seek to ensure quality and consistent practice measures are maintained for patients and their families during end-of-life care. The quality care

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recommendations are detailed and highlight elements such as the need for a support system, utilisation of a team approach in facilitation of care, thorough assessment and planning, patient-centred communication, bereavement counselling and holistic care encompassing spiritual and religious measures (Palliative Care Australia, 2005; National Consensus Project, 2013; NICE, 2014; ASQHC, 2015). Despite these recommendations the role/s that nurses undertake in bereavement care within acute care hospitals are not entirely clear. Nor is it clear, how these recommendations are reflected or measured in the care of patients and their families.

Investigating the roles and responsibilities of nurses’ during the care of dying patients, can clarify what is involved in the process of bereavement care for families in acute care hospitals. A clearer understanding of bereavement roles will also enable a better measure of how such nursing provisions align with the recommendations of safe and high quality end-of-life care. It is also anticipated that a clearer understanding of bereavement care, will help to inform the development of bereavement resources and nursing strategies that may facilitate and improve the experience of death in acute care hospitals for patients and families.

AIM: The aim of this systematic review was to investigate nurses’ roles and responsibilities in providing bereavement care during the care of dying patients within acute care hospitals.

METHODS:

Relevant publications were found in an extensive literature search involving the databases CINAHL Plus, Embase, Ovid MEDLINE, PsychINFO, and CareSearch and Google Scholar.

The initial search terms used were as follows: ‘(bereav* OR (grie* AND death)) AND nurs* AND hospital* AND inpatient*’. These search terms generated limited research studies and the search was broadened to ‘bereave* care AND nurs*’. The search was then expanded following review of the related research publications and the reference list of relevant studies. Both quantitative and qualitative design studies were included in the review. The search dates started from 2005, following on from a literature review on bereavement care within acute care hospitals conducted by Brown et al. (2006) and all studies up until December 2015 were considered for inclusion in this systematic review. The systematic review was completed using the guidelines of the Joanna Briggs Institute (JBI) (2014).

The inclusion criteria utilised for this systematic review included research publications concerning nursing bereavement care in acute care hospitals and nursing bereavement care concerning adult death. The exclusion criteria included research publications involving multidisciplinary bereavement care other than nursing where nursing bereavement data was not reported separately, palliative care specialty nurses or palliative care settings, paediatric or neonatal patient groups, community services, opinion, commentary, letters to editors, discussion papers and literature reviews.

The database search identified n=344 research publications. Duplicates were removed and the studies were appraised on relevance of the title and abstract. Inclusion of studies at this stage was reduced significantly by the following exclusion criteria; studies not reporting data provided by nurses separately from other health professionals, studies not reporting data about bereavement roles, studies reporting on bereavement care related to the care of children and not that concerning adult death. Finally, the full text of n=27 studies were examined in detail. A further 19 studies were
excluded as nursing data was not reported separately or nursing roles were not adequately described and eight studies remained. The included eight studies were subject to critical appraisal utilising the JBI guidelines which outlined a process for the appraisal of qualitative and quantitative evidence (2014). Three researchers undertook the critical appraisal process independently and studies scoring less than 50% were excluded, resulting in one study being excluded based on low score (Donnelly & Dickson, 2012). Having three authors appraise each study independently minimised biases in appraisal scoring and the critical appraisal scores were highly consistent between the three assessors. On completion of the critical appraisal n=7 studies of which four were qualitative, and three were quantitative. Refer to Appendix 1.

The qualitative findings were extracted and subjected to critical review by the researchers to determine the levels of finding credibility (JBI, 2014). Findings were rated as: Unequivocal (UE) if the findings were considered to be beyond reasonable doubt; Credible (C) where the finding was accompanied by an illustration but lacked clear association; Unsupported (US) if the finding was not supported by illustration (JBI, 2014). Only one finding, ‘Family as a patient’ (Popejoy, Cheyney, Beck, & Antal, 2009) was excluded from the synthesised findings as it was rated as US. The qualitative findings were then evaluated via means of thematic content analysis. Thematic content analysis refers to the process of grouping finding illustrations into similar categories (Polit & Beck, 2014). Finding illustrations from each of the included studies were also assessed by each of the authors to determine suitability in each category. Themes were generated to suit the finding illustrations within each category. The themes needed to describe the role that the acute care nurse was providing during end-of-life care for patient and families as specified in the overall aim of the systematic review. These categories became the overall synthesised themes. Some synthesised themes required the generation of further sub-themes to better represent the findings.

Whilst meta-synthesis is the most common method used for combining and integrating evidence from a number of different studies (Finfgeld-Connett, 2010), meta-synthesis was not suitable in this case as the statistical measures used in the studies were not consistent, and hence did not enable comparison (Cooper, Hedges, & Valentine, 2009). As a result, critical interpretive synthesis was used to incorporate the findings and enable the integration of qualitative and quantitative evidence in a cross study synthesis of findings (Mays, Pope, & Popay, 2005; Flemming, 2009). Each statistical quantitative data finding was matched to a synthesised qualitative theme adding evidence to the overall synthesised themes. The qualitative findings fitted with the recommendations of the quantitative research and findings were grouped accordingly (Flemming, 2009). A synthesised theme table was then generated to demonstrate the mixed-method finding results with the relevant overall themes and subthemes. Refer to Appendix 3 for the synthesised systematic review findings.

RESULTS:

There were four synthesised themes generated from this systematic review, including; patient-centred care, family-centred care, advocacy and professional development.

Of the seven studies included in the systematic review all studies used acute care nurses as participants. Three of the four qualitative studies describe the use of phenomenology and interpretive descriptive approach as a methodology. The sample size of the qualitative studies ranged from 15-22 participants. Two of the three quantitative studies detailed a post-test-only survey and Likert scale design. The sample size of the quantitative studies ranged from 91-406
Nursing roles in bereavement care

This systematic review identified that nurses undertake varied roles in the provision of bereavement care and these roles were complex. The bereavement roles could be separated into four synthesised themes based on the finding data. The overall synthesised themes included patient-centred care, family-centred care, advocacy and professional development (Nelson et al., 2006; Hansen, Goodell, Dehaven, & Smith, 2009; Popejoy et al., 2009; Arbour & Wiegand, 2013; Chan, Lee, & Chan, 2013; Mak, Chiang, & Chui, 2013; Kurian et al., 2014).

The theme patient-centred care was represented in all the included studies and was the most significant theme with four subthemes. Patient-centred care was illustrated by finding data that represented the nurse managing the physical comfort needs of patients, maintaining palliative measures as part of end-of-life care and also the emotional comfort needs of patients. The patient-centred care theme also included the clinical workloads of nurses and the physical environment in which nurses worked. The themes of physical care and emotional care were both equally represented as a nursing role in the findings, as both themes were identified in four of the seven studies (Hansen et al., 2009; Arbour & Wiegand, 2013; Chan et al., 2013; Mak et al., 2013; Kurian et al., 2014). Seventy percent of intensive care nurses in the study by Kurian et al. (2014) indicated their role was to help dying patients come to terms with grief. Facilitating emotional care, another synthesised subtheme for patient-centred care, involved nurses supporting patients as they come to terms with death. Emotional support within the studies was reflected as supporting and facilitating traditional, cultural or religious practices and spending time with patients to provide psychological support (Hansen et al., 2009; Mak et al., 2013). Popejoy et al. (2009) describe nurses’ actively involving patients in end-of-life planning and provide examples of enabling home visits and family to stay/sleep at the bedside as means of emotional support measures for dying patients.

The provision of patient-centred care was also seen to be highly proportional to the clinical workload and physical environment, as both subthemes impacted significantly on the level of patient-centred care that nurses were providing. Four studies indicated that patient workload dictated the amount of time that nurses could spend with dying patients and their families (Nelson et al., 2006; Hansen et al., 2009; Arbour & Wiegand, 2013; Mak et al., 2013). The physical environment was also a factor that impacted on the quality of patient-centred care with issues of limited space and privacy for patients (Hansen et al., 2009; Chan et al., 2013; Mak et al., 2013). The studies indicate that nurses spend the majority of bereavement care, attending to the provision of patient-centred care. The provision of patient-centred care is challenging for nurses due to the multiple responsibilities this incorporates and the fact that this care was highly subject to patient workload and working in less than ideal physical environments to care for dying patients (Hansen et al., 2009; Arbour & Wiegand, 2013; Chan et al., 2013; Mak et al., 2013; Kurian et al., 2014).

A need for increased professional development in the area of bereavement care was identified as another highly significant synthesised theme, evident in six of the seven included studies (Nelson et al., 2006; Hansen et al., 2009; Arbour & Wiegand, 2013; Chan et al., 2013; Mak et al., 2013; Kurian et al., 2014). The lack of professional development in the area of bereavement care was frustrating for nurses and they often sought guidance from more senior colleagues (Hansen et al., 2009; Arbour &
Nurses also spent considerable time reflecting on the bereavement care they provided and the measures put in place during end-of-life care for patients and their families, in an attempt to evaluate their own clinical performance and potential for improvement (Nelson et al., 2006; Hansen et al., 2009; Popejoy et al., 2009; Chan et al., 2013; Mak et al., 2013). Little direction or structure in the process of bereavement support for patients and families was evident, this included the use of interdisciplinary team members and the coordination of their services, spiritual or chaplain care and additional or follow-up care support measures (Kurian et al., 2014). The lack of spiritual support and/or chaplaincy support after hours was another issue, impacting on the quality of bereavement supports (Kurian et al., 2014).

Family-centred care was another role of nurses caring for dying patients and this involved ensuring that family members were given the opportunity to be present at the bedside of patients and making time to support and spend with families (Hansen et al., 2009; Popejoy et al., 2009; Arbour & Wiegand, 2013; Kurian et al., 2014). It was evident that a large part of the role that nurses undertook was ensuring that families were provided with opportunities to be with patients; and this involved judging when to contact family members due to change in patient condition and supporting family members at the bedside during their grief (Popejoy et al., 2009; Arbour & Wiegand, 2013; Chan et al., 2013). Sixty-eight percent of nurses indicated that providing bereavement support for families of those patients under their care was considered standard routine work (Kurian et al., 2014). Family support measures took the form of providing information about the dying process and providing emotional support and reassurance during end-of-life care (Hansen et al., 2009; Arbour & Wiegand, 2013). Family support also included the encouragement of a family presence at the bedside which was said to assist families in a better understanding of the dying process and enabled families to say final goodbyes (Popejoy et al., 2009; Arbour & Wiegand, 2013). Part of the family-centred care also involved a nurse’s attempts to create positive memories in ensuring that dying patients looked comfortable, clean and with minimal technological intervention (Arbour & Wiegand, 2013).

The final theme was the advocacy role the nurse performed at the bedside. The studies found that nurses ensured that relevant clinical information based on the requests of the patient, family and doctor was communicated and advocated for (Nelson et al., 2006; Hansen et al., 2009; Popejoy et al., 2009; Arbour & Wiegand, 2013; Chan et al., 2013). The need to be an effective communicator was paramount to the advocacy role and this role was also connected with the provision of patient-centred care and family-centred care (Popejoy et al., 2009; Chan et al., 2013). Nurses needed to be patient advocates to ensure that the physical and emotional care needs of patients were being managed (Nelson et al., 2006; Hansen et al., 2009; Popejoy et al., 2009; Arbour & Wiegand, 2013; Chan et al., 2013). Advocacy roles include communicating with doctors to ensure the patients had appropriate symptom management, listening to the patient and ensuring that their wishes will be honoured and helping the family let go or understand the need to withdraw aggressive or curative care and start palliative and end-of-life care (Arbour & Wiegand, 2013). It was also evident within this synthesised theme that families of patients placed heavy reliance on nurses to contact them whenever any change in a patient’s condition occurred (Chan et al., 2013). Nurses often described themselves as communication mediators between the family, physician and hospital during bereavement care (Popejoy et al., 2009)
DISCUSSION:

This systematic review has identified the multiple and complex bereavement roles, that nurses have within acute care hospitals. The quality of bereavement care provided to patients and families may be highly dependent on nursing workload demands and the physical environment in which the nurse is working. Bereavement care is also highly influenced by the clinical experience of nurses and the level of professional education in end-of-life care and levels of death competence. There is also some indication that increased guidelines or bereavement programs could better support nurses’ providing end-of-life care within acute care hospitals. The systematic review findings are discussed in relation to four themes; patient-centred & family-centred care, workload & physical environment, professional development, collaboration & advocacy.

Patient-centred & family-centred care

Nurses were seen to be integral to the provision of patient-centred care and this systematic review, like other studies (Thompson, McClement, & Daeninck, 2006; Arbour & Wiegand, 2013; Chan et al., 2013; King & Thomas, 2015), has demonstrated that nurses were committed to ensuring patients received a ‘comfortable death’ or ‘good death’. Routine physical care could also be described as a constant backdrop that facilitated nursing interactions with families (Pincombe, Brown, & McCutcheon, 2003). It was during provisions of patient-centred care that nurses commonly engaged with family members to explain end-of-life care measures and provide support. It was also identified that patient-centred care created opportunities for family involvement in physical care with significant attention provided to a patient’s physical appearance (Donnelly & Dickson, 2012; Bloomer, Endacott, Copnell, & O’Connor, 2015). The systematic review findings were not indicative of when nurses’ cease bereavement care for families. There was also a lack of evidence to indicate exactly what roles nurses have with families after the death of patients. Follow up contact with families, referrals to bereavement counsellors and/or support groups or the provision of written information about grief and bereavement was not evident in the findings and worthy of further research. It was also unclear how long family members remained with patients after death and how this is accommodated in acute care hospitals by nurses.

The international quality care recommendations produced by Palliative Care Australia, ACSQHC, NICE, and the National Consensus Project to ensure quality and consistent practice measures are followed for patients and families during end-of-life care, are essentially very difficult to measure within acute care hospitals, due to a lack of understanding of the procedure and process of bereavement care (Palliative Care Australia, 2005; National Consensus Project, 2013; NICE, 2014; ASQHC, 2015). The results of this systematic review provide some indication of the roles and responsibilities of nurses during bereavement care however the limited quality evidence validates the need for further research in this area. The quality care recommendation that advised patient-centred communication and shared decision-making was the one quality care recommendation supported as an outcome of the systematic review findings. The synthesised findings which support nurses’ acting in an advocacy role confirmed open communication lines between the patient, family and the supporting medical teams, during the care of dying patients’ as indicated by these guidelines (Nelson et al., 2006; Hansen et al., 2009; Popejoy et al., 2009; Arbour & Wiegand, 2013; Chan et al., 2013). Although recommendations exist for safe and high quality end-of-life care, the inability to measure quality bereavement care or how these recommendations are reflected in...
practice continue to impact on the quality of end-of-life care, which many studies still describe as extremely poor ( Valks et al., 2005; Addington-Hall & O’Callaghan, 2009; Al-Quarainy et al., 2009; Van der Klink et al., 2010).

Workload & physical environment

The clinical workload of nurses and the physical environment pose significant challenges to the provision of bereavement care during the death of patients and potentially after death for families. Nurses providing bereavement care also managed other clinical workloads and demands which hindered the amount of time and care nurses could provide for patients and families (Hansen et al., 2009; Arbour & Wiegand, 2013; Mak et al., 2013). The issue of juggling clinical workload demands and providing bereavement care was a regular occurrence (Thompson et al., 2006). Issues such as limited space for family meetings and the lack of privacy were identified as physical barriers to quality bereavement care (Thompson et al., 2006; Al-Quarainy et al., 2009; Nelson et al., 2010; Chan et al., 2013; Slayter, Pienaar, Williams, Proctor, & Hewitt, 2015). Peaceful deaths for patients and improved bereavement outcomes for families have been attributed to provisions of privacy and adequate space to dying patients in acute care hospitals (Thompson et al., 2006; Al-Quarainy et al., 2009; Slayter et al., 2015). In a study by Thompson et al., it was seen that nurses manipulated the care environment to optimise end-of-life care which involved creating privacy by the potential utilisation of private rooms, relaxing the numbers of family permitted to visit and visiting hours times (2006). It is however not known how the issue of workload demands and acute care hospital environments impact on the provisions of bereavement care after the death of patients for families.

Professional development

Professional development needs in bereavement care should be considered in terms of death competence. Shortcomings in death competence for nurses, was identified within this systematic review. Death competence has been described as a specialised skill in tolerating and managing patients’ problems related to dying, death and bereavement ( Gamino & Ritter, 2011). Death competence relates to the development of the necessary cognitive and emotional competencies required to manage death or matters related to death ( Gamino & Ritter, 2011). Cognitive competencies include having the appropriate training and field experience in bereavement care which allow for the identification of individuals who need grief counselling ( Gamino & Ritter, 2011). Areas such as effective communication, sensitivity in cultural diversity and self confidence in providing palliative care have also been described as self-competence in death work ( Chan, Tin, & Wong, 2015). This systematic review highlighted that nurses would benefit from additional professional development to improve their readiness and competencies in the provisions of quality bereavement care ( Nelson et al., 2006; Addington-Hall & O’Callaghan, 2009; Hansen et al., 2009; Arbour & Wiegand, 2013; Chan et al., 2013; Mak et al., 2013). It was also evident that over fifty percent of the nurses had not received sufficient education, training or experience for dealing with newly bereaved families and this finding was heightened if the nurse was beginning practice or novice nurse ( Popejoy et al., 2009) with limited experience ( Benner, 2013). Deficiencies in levels of professional development was also complicated by the lack of written instruction and/or limited procedures, protocols or algorithms for nurses to guide the bereavement care process and assist with the timeliness of end-of-life decisions ( Hansen et al., 2009; Chan et al., 2013). The positive impact of written instruction and structured bereavement programs to support dying patients and
their families was also recommended in a number of studies (Pincombe et al., 2003; Walks et al., 2005; Hansen et al., 2009; Van der Klink et al., 2010; Kurian et al., 2014). The mentoring of novice nurses by more senior clinicians in end-of-life care was also described as necessary in the data findings (Arbour & Wiegand, 2013). There was evidence to suggest nurses appeared to be learning ‘on the job’ from other colleagues who provided good examples of bereavement care (Hansen et al., 2009; Chan et al., 2013). Nurses also spent considerable time reflecting on the bereavement care they had provided and how their interventions had influenced dying patients and families (Nelson et al., 2006; Hansen et al., 2009; Popejoy et al., 2009; Chan et al., 2013; Mak et al., 2013). Previous experiences of sudden and anticipated deaths of patients and the traumatic responses of families also ‘haunted’ nurses as they provided care and this experience was emotionally taxing (Hansen et al., 2009; Shorter & Stayt, 2010; Kurian et al., 2014). These nursing issues relate to limitations in death competence and more specifically emotional competence. Emotional competence relates to having the emotional intelligence and experience to cope and face the suffering of patients and bereaved families (Gamino & Ritter, 2011; Chan et al., 2015; Chan et al., 2016).

Collaboration & Advocacy

Decisions regarding the care of dying patients and families were highly influenced by nurses functioning in an advocacy role during end-of-life care. The activities of nurses and communication of information regarding a patient’s condition, was integral to decision making concerning bereavement care. Nurses working in advocacy roles facilitated communication between families and medical teams, to assist in the understanding of end-of-life and bereavement care (Caswell et al., 2015; Walker & Deacon, 2015). Nurses were also identified as interpreters of information, being able to speak in ‘plain language’ for families and translating medical information to assist in decision making (Caswell et al., 2015; Slayter et al., 2015; Walker & Deacon, 2015). The systematic review similarly identified multidisciplinary collaboration, which was integral for the provision of bereavement care in acute hospitals (Pincombe et al., 2003; Porock, Pollock, & Jurgens, 2009; Caswell et al., 2015; Chan et al., 2016). Multidisciplinary teams commonly included doctors, nurses and social workers who met frequently to plan patient care and family support (Porock et al., 2009; Chan et al., 2016). Nurses also advocate for dying patients and influence family decisions to attend hospital. Other studies have similarly identified nurses recognising symptoms of patients being close to death and contacting family with information to facilitate a family presence during death (Caswell et al., 2015; Slayter et al., 2015). However, following the death of patients within acute care hospitals it was unclear if multidisciplinary collaboration continued in attempts to support families with bereavement care. Further research is necessary to determine if after patient death nurses work in isolation with families or if they still utilise multidisciplinary teams in the provision of bereavement care.

CONCLUSION:

Limited research has been conducted in the role of nurses in the provision of bereavement care in acute care hospitals. Only seven international studies were of high enough quality and met the inclusion criteria for this systematic review. The findings from this systematic review have identified the multiple and complex roles that nurses have in the provision of bereavement care. The synthesised findings of the studies demonstrate that bereavement roles for nurses include patient-
centred care, family-centred care, advocacy and professional development. The effectiveness of these nursing roles on bereavement outcomes for families still remains unclear, with further research in this area imperative to help generate conclusive recommendations. The impact of clinical barriers, such as the physical working environment and workload demands also require further clarification on the provision of quality bereavement care during end-of-life care and after death. The findings of this systematic review imply that nurses may feel underprepared and undereducated in the provision of bereavement care and may have deficient levels of death competence. Further investigation is needed to determine the scope and extent of education and training needed by nurses, to enable them to provide quality bereavement care. The issue of professional development needs to also be considered in terms of competence versus confidence. It should be established whether acute care nurses actually lack competence in knowledge and skill acquisition in bereavement care or instead lack confidence, in applying their knowledge and skills during the care of dying patients and their families. The lack of clear protocols and directive guidelines to support the bereavement process, may impact on the quality of bereavement care provided and compound the deficiency in education and professional development within acute care hospitals. It should also be acknowledged that a lack of evidence exists regarding bereavement care roles for nurse after the death of patients and whether nurses work in isolation or continue to function as part of a multidisciplinary team during this period. The duration of post-death bereavement care is unclear, including how bereavement care after death is accommodated by nurses within acute care hospitals.

RELEVANCE TO CLINICAL PRACTICE:

The findings of the systematic review indicate the complex and multiple roles nurses have in bereavement within acute care hospitals. It is evident that workload demands and the environment impact on the quality of bereavement care that can be provided. Acute care nurses find bereavement care challenging and often seek further professional development. It is also evident that whilst national practice recommendations exist for end-of life care, it is not clear how these recommendations are measured and if they are fully achieved in acute care without supportive guidelines or protocols.

WHAT DOES THIS PAPER CONTRIBUTE TO THE WIDER COMMUNITY?

- Understanding bereavement care roles of nurses’ can influence the provision and quality of bereavement care provided within acute care.
- Acute care nurses’ need to receive appropriate professional development and training to support their role and ensure quality bereavement care.
- Although national practice recommendations exist for end-of-life care it is not clear how these recommendations are measured and if they are fully achieved in acute care hospitals. The development of clearer clinical policy and directive guidelines can support this process.
REFERENCES:


Appendix 1 PRISMA 2009 Bereavement search flow diagram

Records identified through database searching (CINAHL Plus, Embase, Ovid MEDLINE, PsychINFO, Scopus) (n=344)

Additional records identified through other sources (CareSearch, Google Scholar) (n=8)

Records after duplicates removed (n=183)

Records screened (n=183)

Records excluded (n=157)

Full-text articles assessed for eligibility (n=27)

Full-text articles excluded due to;
- nursing data not reported separately (n=16)
- data reported not concerning nursing bereavement roles (n=3)

Critical appraisal of 8 studies

Records excluded (n=1) on basis of appraisal score

Studies included in quantitative synthesis (n=3)

Studies included in qualitative synthesis (n=4)
## Appendix 2: Overview of selected studies

<table>
<thead>
<tr>
<th>Authors (Year) Country</th>
<th>Aims</th>
<th>Sample/Setting</th>
<th>Method</th>
<th>Results</th>
<th>Appraisal Score</th>
<th>Appraisor 1 (A1)</th>
<th>Appraisor 2 (A2)</th>
<th>Appraisor 3 (A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nelson et al (2006) Canada</td>
<td>Aim: To identify the Barriers to improved end-of-life care in the intensive care Unit. Strategies likely to improve end-of-life care.</td>
<td>Sample of nursing and physician directors of 600 Adult ICUs.</td>
<td>Self-Administered Mail Survey</td>
<td>Nursing only data barriers: No.(%) rating  (1) Competing demands for clinician time 80 (14.2)  (2) Inadequate communication between ICU team and other clinicians about patient prognosis 89 (15.8)  (3) Psychological/Emotional stress of providing care to dying patients 87 (15.4)  (4) Insufficient attention to diverse cultural norms and customs with respect to dying, death and grief  (5) Insufficient training in communication about end-of-life 83 (14.7)</td>
<td>A1= 6/7</td>
<td>A2 = 6/7</td>
<td>A3= 6/7</td>
<td></td>
</tr>
<tr>
<td>Wah Mak et al (2013) Hong Kong</td>
<td>Aim: Explore the experiences and perceptions of nurses caring for dying patients and their families in the acute medical admission setting.</td>
<td>15 nurses</td>
<td>Semi-Structured Interview</td>
<td>Four themes:  (1) Lack of preparedness for patients deaths,  (2) Reflecting on their own nursing roles for dying patients,  (3) Reflecting on the meaning of death and their personal experiences of the death of their own family member  (4) Coping with caring for dying patients</td>
<td>A1= 8/10</td>
<td>A2 = 8/10</td>
<td>A3=8/10</td>
<td></td>
</tr>
<tr>
<td>Popejoy et al (2009) Columbia</td>
<td>To identify intensive care nurse perceptions of caring for the dying.</td>
<td>365 bed community hospital 22 participants</td>
<td>Focus Groups</td>
<td>Five themes:  (1) Helping the patient through,  (2) Telling bad news  (3) Grieving as a process  (4) Family as the patient  (5) The dying patients effect on the nurse</td>
<td>A =8/10</td>
<td>A2 =7/10</td>
<td>A3=8/10</td>
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</tr>
<tr>
<td>Kurian et al</td>
<td>To ascertain ICU’s</td>
<td>Intensive Care RNs</td>
<td>Post-test-only survey</td>
<td>No.(%) rating</td>
<td>A1=5/7</td>
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</table>
### (2014) USA

<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Sample</th>
<th>Findings</th>
</tr>
</thead>
</table>
| **nurses’ current practice and beliefs about bereavement care, their role in bereavement support and their interest related to bereavement.**
| Quantitative | 110 participants | design using a convenience sample
| 1) ICU nurses have an important role to play in helping bereaved patients come to terms with their grief 80 (73)
| 2) Bereavement support to relatives of those patients who were under my care should be routine work 75 (68)
| 3) Bereavement support to relatives other than those patients who were under my care should be routine work 57 (52)
| 4) Visiting newly bereaved patients is intrusive to grief 44 (42)
| 5) ICU nurses should maintain contact with newly bereaved patients (e.g. letter, phone calls) |

### Hansen et al (2009) USA

<table>
<thead>
<tr>
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<th>Methodology</th>
<th>Sample</th>
<th>Findings</th>
</tr>
</thead>
</table>
| **To describe nurses perceptions of (1) knowledge and ability (2) work environment (3) support for staff (4) support for patients and families and (5) stress related to specific work situations in the context of end-of-life care**
| Quantitative | Intensive Care RN’s at a University Medical Centre 91 participants phase 1 127 participants phase 2 | 5 subscale tools consisting of a 30 items scored on a 4-point Likert scale. Written comments analysed from qualitative description.
| 1) More education and training necessary to support staff with bereavement care
| 2) Work stress related to end-of-life care
| 3) Nurses increased confidence with experience in providing end-of-life nursing care and accessing resources necessary for effective end-of-life care.
| 4) Improvements needed for communication between healthcare team and with patients’ families. |

### Arbour & Weigand (2013) USA

<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Sample</th>
<th>Findings</th>
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</thead>
</table>
| **Understand experiences of critical care nurses & perceptions of activities that they perform while caring for patients and families**
| Quantitative | 19 Critical Care Nurses Hospital Setting | Descriptive – phenomenological study Interviews
| 1) Educating the family
| 2) Advocating for the patient
| 3) Encouraging & supporting family presence
| 4) Managing symptoms
| 5) Protecting families and creating positive memories
| 6) Family Support
| 7) Mentoring & teaching |

### Chan & Chan (2013) Hong Kong

<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Sample</th>
<th>Findings</th>
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</thead>
</table>
| **Explore the perceptions and experiences of bereavement care among nurses and the bereaved family members**
| Qualitative | 15 Nurses 15 Bereaved family members Oncology Unit – Hospital Setting | Semi-structured interviews
| Nursing only data:
| 1) Promoting comfort to dying patient and care to families
| 2) Physical environment may hinder quality bereavement care
| 3) Providing bereavement care is emotionally taxing on the RN’s
| 4) Education needs – RN’s inadequately prepared to provide bereavement care. |
## Appendix 3: Synthesised findings table

<table>
<thead>
<tr>
<th>Synthesised theme</th>
<th>Subthemes</th>
<th>Mak et al., 2013</th>
<th>Chan et al., 2013</th>
<th>Popejoy et al., 2009</th>
<th>Arbour &amp; Wiegand, 2013</th>
<th>Hansen et al., 2009</th>
<th>Kurian et al., 2014</th>
<th>Nelson et al., 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient-Centered Care</strong></td>
<td>A: Physical Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>B: Emotional Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
<td>C: Clinical workload</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td></td>
<td>D: Physical Environment</td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Family-Centered Care</strong></td>
<td>A: Facilitating family presence</td>
<td>X</td>
<td></td>
<td>X</td>
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<td></td>
<td>B: Spending time &amp; supporting families</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
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<td><strong>Advocacy</strong></td>
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<tr>
<td><strong>Professional Development</strong></td>
<td>A: Seeking further education &amp; training in bereavement care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>B: Reflective Practice</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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