

**Registered Nurses' Responses to Resident Death in Residential
Aged Care Facilities:
A Qualitative Descriptive Study**

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Date

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Cecily E. Walley

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'To those whom I love and those who love me'.
When I am gone, release me let me go –
I have so many things to see and do.
You must not tie yourself to me with tears,
Be happy that we had so many years.
I gave you my love, you can only guess
How much you gave me in happiness.
I thank you for the love you each have shown,
But now it is time I traveled on alone.
So grieve a while for me, if grieve you must –
Then let your grief be comforted by trust.
It is only for a while that we must part
So bless the memories within your heart.
I will not be far away, for life goes on -
So if you need me, call and I will come.
Though you cannot see or touch me, I will be near,
And if you listen with your heart, you will hear
All of my love around you soft and clear.
Then when you must come this way alone,
I will greet you with a smile and a 'Welcome Home'

Mary Alice Ramisht 2010 [online]

ABSTRACT

Registered Nurses (RNs), working in residential aged care facilities, care for residents who may have reached the palliative stage of their lives and who have complex health issues. In addition, to attending to their extensive duties in the wards, the RNs also care for dying residents, and at the end of the residents' lives, endeavour to ensure that they experience a 'good death.' The aim of this study was to explore the responses of RNs when residents died. This qualitative descriptive study included interviews with 10 RNs who had worked in aged care facilities for at least two years.

Data were analysed using thematic analysis. The research began with an assumption that frequent resident deaths affected the RNs caring for the residents in aged care facilities. The purpose of the study was to raise awareness of the RNs' role when residents died and to establish how the RNs responded to the deaths of the residents in their care.

The research findings in this thesis reports four main themes: the different cultural perspectives on dying, RNs' grief, experiencing a sudden death, and the level of support available for RNs when the residents died. The research findings supported the assumption that RNs were affected by residents' deaths. The study's findings recommend that management teams in care facilities have clear processes of support for their nursing staff when there are deaths in their facilities.

The significance of this study is that it provides awareness of how very stressful managing frequent deaths was for the RNs concerned. Findings indicate that stress was increased when there was a close relationship between the RN and the resident. It is recommended that future research be conducted in this subject area.

CHAPTER ONE: INTRODUCTION

One aspect covered in this chapter is the acknowledgement that the population of older people, as a percentage of the total population, is predicted to increase in New Zealand (NZ). Secondly, as the increased older population will be more ethnically diverse, health systems may need to be modified to accommodate this divergence. This may result in the numbers of medical and nursing staff needing to be proportionally increased. The influence of the Treaty of Waitangi and Māori and Pacific Island end of life care, are discussed. The difficulties that immigrant Registered Nurses may encounter in their new country is also mentioned. Finally, the concepts of palliative care nursing are considered.

This qualitative descriptive study was focused on understanding RNs' responses when residents in aged care facilities died. My assumption was that RNs were affected by the deaths of the residents under their care and that the effects could be significant. I assumed that grief was of more significance when the RNs had a longstanding relationship with the residents. I also assumed that when a death occurred; the RNs required robust support systems to enable them to deal with the resulting grief.

Research Question

The research question for this study: "What are RNs' responses when the residents in aged care facilities die?"

The Focus of the Study

The focus of this study was determining the responses RNs have when residents die. As reported by the Ministry of Health (MOH, 2013) in New Zealand, in both 2013 and currently, older adults with health issues are provided with support which enables them to remain in their current residence within the community (MOH, 2013). Consequently, when older people are admitted to long term care facilities, they are usually extremely frail, have co-morbidities and require hospital-level twenty-four hour care. For these reasons deaths occur frequently in residential aged care facilities (Flicker, 2002; Miller, Tino & Mor, 2004, MOH, 2004). In this respect New Zealand follows international

trends, with results similar to those found in Australia and the USA. In New Zealand, long term care means live-in care, in an aged care facility. Residents are assessed to establish the level of care most appropriate for them. The choices of care facilities available at the present time are rest-homes, assisted living suites, private hospitals, specialist dementia units or psycho-geriatric units (MOH, 2013).

My aim was to establish how RNs responded to the deaths of the residents they cared for. I have often thought about this issue as I have observed that some RNs were very upset when residents' died. At times, the RNs had become the resident's 'substitute' family and on other occasions the family of the resident had become very close to the staff. For these reasons, when the resident died some RNs grieved both for the loss of the resident and also the loss of the extended family relationship. By way of contrast, other RNs appeared to just 'carry on' when deaths occurred, even when those RNs had cared for the particular resident for several years.

Purpose of the Study

This study was undertaken to describe how RNs, employed in residential care facilities, responded to residents' deaths. The purpose of this study was to raise awareness of the possible effect frequent deaths had on the RN participants

Method of Inquiry

A qualitative descriptive methodology was the study design used to answer the question, 'How do RNs respond when the residents die'? A qualitative descriptive study was chosen because it is the most popular method when straight descriptions of phenomena are desired (Sandelowski, 2000).

Significance of the Study

This research has potential benefits for the participants of this study and for other RNs working in aged care facilities. It provides an opportunity to raise awareness of how stressful managing frequent deaths may be for RNs. This was a small study, but in the future it may lead to other studies that could examine this subject area in depth.

Background of the Study

Statistics

Globally the number of people aged 60 years and older, by 2050, is estimated to be two billion. The greatest rise in population growth is expected to be people aged 80 years and older. The estimated resident population in New Zealand on the 31st March 2013 was 4,464,000 people. Between 2011 and 2021 the New Zealand population of older people is expected to grow by about 200,000 and in the following 10 years by 230,000. By 2030, the population of older adults will double to approximately 22% of all New Zealanders (Statistics New Zealand, 2010).

By 2051 there are projected to be at least 60% more elderly than children; and half of all New Zealanders will be older than 46 years by 2051. Those 85 years and older are expected to increase six-fold during the projected period (Statistics New Zealand, 2010). It is predicted that by the year 2051 there will be over 1.14 million people in New Zealand aged 65 years and over and it is estimated that they will be one in every four of the total population. This will have implications for health expenditure because as people age there is an increased need for health facilities and social services (Statistics New Zealand, 2010). Shaw (2002) disagrees with the view that old age automatically means poor health. Shaw argues that many older people do not have health issues.

In New Zealand the current older population, people aged 65 years and over, has increased by 45% during the last 20 years; while the number of residential care beds has only had a 3% increase. Therefore the proportion of older people in residential aged care has decreased from 74 to 53 persons per 1000 people aged 65 years and over. However, the level of dependency of those who are in care has significantly increased (Statistics New Zealand, 2010).

The ethnic diversity of New Zealand's population will continue to increase according to the population projections for the period 2006-2026, released in 2010 (Statistics New Zealand, 2010). European and adjacent countries share of the population is projected to fall from 77% in 2006 to 70% in 2026. Pacific, Asian and Māori ethnic groups will

increase their share of the New Zealand population. For Māori, the increase is predicted to rise from 15% in 2006 to 16% in 2026.

The Asian population is predicted to rise from 10% in 2006 to 16% in 2026. People from Pacific Island countries are projected to increase from 7% of the population in 2006 to 10% in 2026. Since 1991, people of these ethnicities have grown in number faster than any other major ethnic group. Lower fertility rates, an older age structure and a high Asian migration over this projected period are responsible for the slow growth of the European population (Statistics New Zealand, 2010).

Internationally over the next 40 years an increase in the number of deaths is predicted. According to the MOH, (2013) by approximately 2021 it is predicted that there will be more people over the age of 65 than under the age of 15. The largest increase will be in the over 85 age group. This will be due to increased longevity and the World War 11 'baby boomer' generation being part of this age group. This increase is expected to occur from about 2035. A large number of these deaths are predicted to be residents in residential care facilities. The ageing population may place increasing demands on health and disability support services. It is estimated that the 1.3% of the population currently 85 and over, use 10% of the health budget (MOH, 2013).

Currently older people 65+ constitute 12.4% of the population. This is anticipated to rise to 25% by 2050. By 2021 around 2.3% of the population will be 85+ (MOH, 2013). The older population is expected to be more diverse, with an increasing proportion of Māori, Pacific Island and Asian people reaching 65 and over. Since the 1980s the life expectancy for Māori and Pacific people has increased. Actual population figures in the future will depend on many factors that are difficult to accurately predict. Among these are mortality numbers and migration decisions. These can change at any time (MOH 2013).

In New Zealand, the ageing population is ethnically and culturally diverse. An analysis of this population reported in 2010 found that 67.6% self-identified as European, Māori 14.6%, Asian 9.2% and Pacific Islanders 6.9% (Statistics New Zealand, 2010). People who identify as non-European are predicted to increase in numbers markedly over the

next 20 years, especially in the older age group. This will occur as the result of increased migration (Statistics New Zealand, 2010).

Nursing Workforce

New Zealand has an ageing workforce. On 31st March 2013 there were 44,782 RNs in the New Zealand workforce. This equates to one RN for every 100 New Zealanders. Of these RNs, 44% were aged 50 or over and only 8% were male. The most common ethnicity in the New Zealand RN workforce was New Zealand European/Pakeha 67%. The next most common ethnic identifications were other Europeans (16%) New Zealand Māori (7%) followed by Filipino and Indian (6%). At least one Pacific ethnic group was identified by 3% of RNs, and 12% of RNs had multiple ethnic identifications. It is predicted that over the next 25 years about half (23,000) of our nursing RNs will retire (Nursing Council of New Zealand, 2013).

Since 2010, the rate that nurses enter and leave the workforce has not changed (Nursing Council of New Zealand, 2013). The current number of overseas trained nurses is adequate for the present time but inadequate to allow for a marked increase in the ageing population. By 2035, it is predicted that there will be 5.26 million people living in New Zealand, and that the number of people over 65 will increase from 600,000 in 2010 to 1.2 million in 2035. By 2035 it is estimated that there will be a nursing shortfall of 15,000 nurses (Nursing Council of New Zealand, 2013).

It is presumed that the supply of nurses will need to steadily increase if future care needs are to be met at their current levels of professionalism (Nursing Council of New Zealand, 2013). Judging by current trends, this increase in supply will come from immigrant RNs with a breakdown of ethnicity similar to that shown below. On the 31st March 2013 there were 11,415 practicing internationally qualified nurses on the nursing register. The largest groups were other Europeans 42%, Filipino 19% and Indian 17% (The Nursing Council of New Zealand, 2014).

This increase in the ageing population may in the future, necessitate different models of RN clinical education. Changes in the health budget, technology and models of care may also impact on the number of nurses needed in the future (Nursing Council of New Zealand 2013). There has been some debate about possible funding available for

more Enrolled Nurses. Enrolled Nurses have a slightly different focus to RNs. An increased number of immigrant RNs may assist to manage the anticipated shortfall of RNs. However in contrast, at the present time there are new graduates unable to obtain employment. Hopefully this be resolved in the future.

A competent nursing workforce is recognised as essential for providing quality healthcare for older people. Co-operation between aged care providers and District Health Boards (DHBs) is aiding this process (MOH, 2013). In order to deliver effective care, there is a need for healthcare staff to familiarise themselves with the residents and their families' goals. Clark and Phillips (2010) suggested that regardless of cultural heritage or age, effective end of life care is a fundamental right for all people. Registered Nurses need to strive to be sensitive to an individual's values and beliefs and also those of the family and Whānau. These authors discussed the barriers to end of life care among different ethnic and cultural groups. Robinson and Ingleton, (2011) stated that at times it may be challenging to deliver healthcare that is acceptable in terms of different cultural expectations.

It is not only important that staff have sufficient knowledge regarding the resident's values and beliefs but also the provision of sensitive end of life care requires staff to develop an awareness of how values and norms can shape beliefs. Only then can appropriate care be provided. Being culturally aware acknowledges that the person receiving the care is different in ethnicity, age, disability, spiritual belief, sexual orientation, and occupation (Nursing Council of New Zealand, 2012). It is the resident who defines whether he/she has received culturally safe care, not the staff providing that care (Crawley, Marshall, & Koenig, 2002; Kirkham, 2006).

The dependency level of those in care is also rising and this is expected to continue (Boyd, Broad, Kerse et al., 2011). The present healthcare system may need to be modified to ensure it will be a system that more effectively manages issues that affect the quality of life of older adults. There may be a need for an extension of effective support services to minimise hospital admissions. Improved quality of care could possibly result from increases in the availability, and more flexible utilisation of gerontological nurses (MOH, 2004)

If the health systems are to cope with the increased population of older people, there may need to be more medical practitioners available. There will possibly be greater use of specialist services to manage specific conditions associated with ageing, for example, cataracts and hip replacements (MOH, 2004). The increasing prevalence of chronic conditions emphasises that there is an expanding need for more expertise and resources to manage these problems. For a considerable time New Zealand has capped entry to medical school but not to nursing courses. Already there is a need to adjust medical and nursing school intakes to meet current demands (MOH, 2004).

Treaty of Waitangi

Within New Zealand the Treaty of Waitangi is considered to be the founding document setting out the relationship between the original Māori inhabitants and the newly arriving settlers or British immigrants. The Treaty of Waitangi was signed on the 6th February 1840, at Waitangi in the Bay of Islands which is located in the north of New Zealand. The Treaty is a statement of principles upon which the British and Māori agreed to establish a nation state and form a New Zealand Government. The first article covers sovereignty. The second mainly concerns the protection of property rights and the third article promises Māori the same citizen rights as the British people (MOH, 2006). These principles apply to all immigrants to New Zealand.

In terms of the Treaty of Waitangi it is important to work in partnership with family members to ensure culturally safe palliative and end of life care is given. Beauchamp and Childress (1994) and the Palliative Care Council of New Zealand (2011) suggested that it is important in Western culture, to impart full disclosure of health information to patients to enable individuals to make an informed decision about treatment options and future care needs. The challenge is to be able to balance end of life care, which ideally should reflect personal beliefs and values, with the increase in numbers of older people from different cultural and ethnic groups. A second challenge is the increase in staff with diverse cultural backgrounds. Ethnicity refers to the cultural practices and vision of a specific community, which then sets them apart from others." Often members of ethnic groups see themselves as culturally different from all other groups within the community, and the other groups agree" (Giddens, 1997, p.210).

Residential Care

In New Zealand, there are several different types of residential care available. Residents are assessed for level of professional health care. Those who qualify for rest home care require some RN input, while those assessed at private hospital level of care require RN input over 24 hours. Registered Nurse input into specialised care for those with dementia or those with mental health conditions usually require staff specifically educated in caring for people with these conditions. Additionally, there is respite or convalescent care available within facilities in order to provide informal carers with rest and support.

To qualify for Government subsidies, a financial means assessment is conducted by health professionals called Needs Assessors. They examine the income, gifting and the assets of the person, to determine if he or she is eligible for the residential care subsidy. This assessment is determined by Work and Income New Zealand. Only rest homes or hospitals that have achieved 'Certification' can have a funding contract with the District Health Boards (DHBs). District Health Boards are responsible for funding the residential care services for older people.

Residents admitted to residential aged care facilities will often have co-morbidities (Flicker, 2002; Miller et al., 2004, Palliative Care Guidelines, 2006). Resulting from this, these residents have complex health issues and require a high level of care. They may have a combination of medical and psychological problems. These residents are also at risk of progressive disability and psychosocial decline. Residents who have been living in a residential care setting for some time have a lower mortality rate than residents who have been in care for a short duration (Mitchell, Millar, Teno, Kiely, Davis & Shaffer, 2010). Mortality is increased for residents who have complex medical and nursing needs or those experiencing frequent hospital admissions (Magaziner, Zimmerman et al., 2005).

Māori and Pacific Island End of Life Care

Māori and Pacific Islanders' belief system views dying, death and bereavement as a central part of life (MacLeod, 2008). When providing end of life care for Māori, it is necessary for RNs to understand the cultural influences on the way to death,

appreciate what is important to the patient, and acknowledge the resources and strengths of Whānau (MacLeod, 2008). Whānau is the extended family group and forms the basic unit of Māori society. This group can span three to four generations (MOH, 2006). Perceptions of illness, grieving, death, and healing are centered on the ideas of harmony, unity, and balance (MacLeod, 2008). Māori and Pacific Island families usually prefer to provide 'hands on care' to their relative. In many instances the family find this preferable, to observing the end of life care given by staff, when the resident reaches the final stages of his/her life. When this is the case, nursing staff need to relinquish their role as being the 'main provider' of care and work as part of the team delivering patient centered care to the resident, in partnership with the family.

Research studies of Māori and Pacific populations have noted a preference for end of life care to be given by family members at home rather than in a hospital (Lawrenson, Smyth, Kara, & Thomson, 2010; Little, 2009; Mann et al., 2004; Ryder-Lewis, 2005). However, this is not always possible and, at times, the relative is admitted to a residential care facility. Effective communication skills are important for clinicians especially when dealing with large extended family groups. Both Māori and Pacific Island families prefer to have all of their Whānau present when they are dying (Lawrenson et al., 2010; MOH, 2003).

A discussion with family members, at the time of the admission of their relative, would hopefully ensure that care would be given as determined by the family. Māori protocol is very important. Māori believe that the deceased should be kept comfortable and warm. This is believed to assist the soul on the journey to the spirit world (Schwass, 2005).

Culturally Appropriate End of Life Care

There are different expectations in all ethnic groups. In the case of Chinese residents and those of some other ethnic groupings, including Māori, patient information needs to be channeled through a family member, acting as an intermediary (Bowman & Singer, 2001; McGrath, Vun, & McLeod, 2001). This practice is different from the Western model of patient autonomy and may create challenges for care staff. Most Chinese families prefer a public hospital death (Hathaway, 2009; McGrath et al., 2001,

Seymour, Payne, Chapman, & Holloway, 2007). However, this is not always possible, and a rest home or private hospital may be the only alternatives if residential care is preferred.

The reason for most Chinese families preferring a hospital death is because it is easier to maintain feelings of hope of recovery from illness. Furthermore, nursing staff are available, and the family does not have the responsibility of caring for the dying person. (Seymour et al. 2007). These families prefer not to have a death at home (McGrath et al., 2001; Seymour et al., 2007). Dying in a hospice is not considered desirable as the family feels that their relative would lose hope and could be influenced by the spirits of those who have already died at that site (Bennett, 2008; Hathaway, 2009; Seymour et al., 2007). Many families appear to prefer nurses from their own cultural background and this challenge is partially addressed with the presence of immigrant nursing staff. Protocols around dying vary with different ethnic groups and this subject should always be discussed and resident and family requests implemented.

Challenges Facing Immigrant Registered Nurses

There is quite a focus on immigrant RNs in this thesis as the participants that I interviewed were all immigrant RNs and it is therefore appropriate to consider the context of immigrant RNs. Thousands of RNs emigrate from their country of origin, to a wide variety of locations, for a multiplicity of reasons (Zlotnik, 2003). These reasons may include, searching for improved living conditions, a more satisfying life, professional development, a safer environment or a sense of adventure (Kingma, 2006). However, several field studies demonstrate that the majority of people would prefer not to emigrate. It appears, that if there was a financial incentive to remain in their own country most nurses would stay there (International Organisation of Migration (IOM), 2003). A research study finding suggests that immigration is influenced by the relative income of RNs in their home countries (Brown & Connell, 2004).

It is difficult to measure the magnitude of nurse migration but it has increased as a result of globalisation (International Organisation for Migration,2003).International

migration is a symptom of the larger systemic problems that encourage nurses to leave their home countries. It can often be advantageous to have global nursing standards uniform as there are difficulties with the differences in educational needs (Blythe & Baumann, 2009). The majority of countries do not collect data on migrating RNs, their motives, or their length of stay overseas (International Organisation for Migration, 2003). The absence of reliable data on these RNs' movements constitutes a significant limitation. Some evidence suggests that 50% of RN immigrants return to their home countries after five years (Lowell & Findlay, 2002). Zimmerman (2008) goes further and argues that eventually the majority of immigrants appear to return to their source country. The emigration of RNs also has an economic impact on their countries of origin. Many immigrant RNs send money back to their families. This then becomes an economic incentive for countries to encourage their people to emigrate. Nevertheless, there are many challenges that immigrating RNs face.

Language, diverse cultures and nursing practice are identified as the key challenges faced by immigrant RNs (Chandra and Willis 2005; Kingma 2006). It takes both time and emotional energy for immigrants to feel settled (Williams, 2012). Williams published an article about the challenges women face when coming alone to New Zealand. Loneliness was related to the settling down period following immigration to a new country. A further issue was the lack of support from family or friends.

Communication

One of the most difficult aspects of migration is communication. The fact that many older residents have defective hearing is a complication, as this makes deciphering accents a further challenge for the residents. Residents describe their pain, various problems and also discuss their health issues with the RNs. To ensure professional quality care is delivered the RNs need to be able to understand and communicate well with the residents. It is, of course, necessary for the RNs to be able to communicate effectively with other members of the healthcare team. This ensures that there is an accurate transfer of information between the staff (Maltby, 1999).

The nurses need fluency of language to ensure that they feel confident whilst carrying out their daily tasks. For all of these reasons, effective communication skills are always

essential. Even when there is proficiency in the English language, cultural norms in communication can lead to misunderstandings and can result in adverse outcomes. Culturally, nurses are challenged to meet the different linguistic and diverse cultural requirements of their residents (Maltby, 1999). The Registered Nurses require good communication skills to ensure that the residents feel supported when discussing their end of life plans.

Competency Assessment Programme

While it is reported in local news that some RNs are unable to obtain employment in New Zealand, it is difficult to determine if this is due to economic conditions or an oversupply of RNs. In the recent past and from projected population trends New Zealand has, and presumably will in the future, rely on overseas nurses to increase the nursing workforce. One reason, in addition to the population projections is that New Zealand trained nurses are internationally mobile and choose to travel to gain international experience thereby, leaving a gap in this country. Both women and men immigrant RNs from many different countries and cultures are involved in Competency Assessment Programmes (CAP). The Nursing Council of New Zealand (NCNZ) has approved this programme. The nurses that apply are RNs in their own countries who wish to practice in New Zealand. The CAP course is of six weeks duration and initially comprises up-to-date information on culture, legislation and the RN requirements to practice in New Zealand. Twenty days of clinical experience at an audited hospital site is included, in order to familiarise overseas RNs with New Zealand clinical practices.

At the respective sites they are placed with a trained RN preceptor whose role is to educate, and supervise their experience while they are in the facility. A clinical tutor visits regularly and manages any problems that may arise. Once completing the course, the RNs apply to register with the New Zealand Nursing Council. When their practicing certificate is granted, they are then entitled to practice as an RN in New Zealand. Six weeks however, is not a long time for immigrant RNs to become familiar with New Zealand's approach to end of life care, particularly when still trying to understand New Zealand's way of life. Some students have commenced the course after being in New Zealand for a very short time. It is important therefore, for this

literature review to include the principles of end of life care, and to consider how these immigrant RNs are required to practice within the NZ context.

New Life in a Foreign Country

Adjusting to a different environment and culture is usually both stressful and complex. Immigrant RNs are often women alone without family support (Timur, 2000). There is also international migration of doctors. In 2003 40% of New Zealand registered doctors were trained overseas. The international migration of health workers means that health care numbers are depleted in poorer countries. Staff will often seek career or personal growth opportunities overseas. To provide medical care for the older adult in 2030, it has been estimated that the number of physicians will possibly need to treble from current levels (MOH, 2013).

Culture can be described as a person's way of life, which includes his/her education, ethnicity, traditions, upbringing and customs. Culture also includes values, behaviours and beliefs. Koffmann (2011) asserted that it is essential to acknowledge cultural values as well as focusing on the care preferences of the individual and his/her family. Although people have a definite culture, they also have specific, individual differences.

Stereotyping can then give a false impression and this has the potential to create a discriminatory atmosphere for individuals and families. One of the greatest barriers to emigration is choosing to leave one's family and friends to begin a new life in a foreign country. Registered Nurses may suffer uncertainty and anxiety (Timur, 2000). It is stressful applying for work permits, permit renewals and residency.

Cultural differences can be complex and challenging. There are cultural differences in the way women are treated in some countries in comparison with New Zealand's approach to women's rights. On occasions, immigrants are misunderstood and may be viewed negatively when attempting to converse in English (Kingma, 2006). To be able to integrate into the New Zealand lifestyle immigrants strive to build rapport and trust with their associates. The citizens of New Zealand need to play their part also, and be welcoming to immigrants and endeavour to appreciate the richness they bring to the country (Williams, 2012).

Immigrant RNs.

Various codes of practice have been introduced for the purpose of monitoring immigration but none appear to be very effective, e.g. U.K. Code of Practice, Commonwealth Code of Practice (World Health Organisation, 2006). However, monitoring of immigration or emigration in many cases appears to be non-existent. These codes addressing ethical issues and international migration have been introduced at both international and national levels (World Health Organisation, (WHO) 2006). As noted previously, it appears that many immigrant RNs would not leave their original country if employment conditions were optimal there (WHO, 2006). Kingma (2006) agreed and suggested that migration usually only occurs when factors encourage people to leave the source country. Registered nurses emigrating from developing countries may leave behind a disadvantaged system. The RNs who remain, find they need to maintain even heavier workloads, covering for the RNs who have left their country seeking other opportunities (Dovlo, 2005).

Migration is increasingly seen as a means for personal development (IOM, 2003). If this statement is correct, then attention needs to be given to retention strategies for the current RNs. When RNs have mastered the skills available in their initial position, they often decide to move elsewhere seeking further development opportunities. New Zealand needs a diverse ethnic nursing workforce to provide quality healthcare for our multicultural residents as an ethnically diverse community now exists in this bicultural country. In addition, global populations require health systems with strong infrastructures and workforces that deliver equitable care (Kingma, 2006).

There is a need for increased education about different ethnic groups so that all healthcare staff are adequately educated in this field. As nursing organisations are experiencing a global shortage of nurses, the volume of immigrant nurses to New Zealand is expected to increase in the future. These nurses will need to be supported to ensure their professional success (Palliative Care Council of New Zealand, 2011). The diverse ethnic mix needs to be taken into account when planning and developing palliative care services, to ensure that the needs of all individuals, families and staff are met, regardless of their cultural differences.

Lack of Support for Immigrant RNs

In the workplace, RNs from another culture can sometimes be treated differently due to intolerance from RN colleagues, residents and relatives. To discriminate against RNs of another ethnicity is not only to disregard professional responsibilities but it is culturally unsafe. Cultural safety encompasses interactions with the residents and colleagues, some who are similar to us and others who are different. Negative behaviour creates anxiety and a loss of confidence and all RNs deserve a chance to develop within their role and need to be supported in order to succeed. Registered Nurse are bound by the Code of Ethics and the Code of Conduct (Nursing Council of New Zealand, 2013). On some occasions, RNs have even left the workforce because of disempowerment by other RNs and this is completely unacceptable (Chandra & Willis, 2005).

Racism is one of the most serious problems that immigrant RNs can experience in the workplace (Chandra & Willis, 2005). According to some immigrant RNs, there have been occasions when colleagues or management have undermined their skills, even bullied them, and this has led to feelings of isolation (Allan & Larsen, 2003; Hawthorne, 2001; Kingma, 2006). The needs of immigrant RNs should be respected as they are a vital part of the work force. The International Council of Nurses (2001) reported that some immigrant RNs have been misled regarding working conditions and remuneration.

Some immigrant RNs have experienced racism and rejection from both peers and residents. At times, these RNs stated that they were given the worst shifts and the most challenging residents to manage, and they were also passed over for promotion (Omeri & Atkins, 2002). A study using a phenomenological research design was carried out in Australia. The participants were nurses (n=5) who originated from different countries. Among the conclusions of the study was the statement that the RNs' experience of life in Australia was mostly negative and unhappy (Omeri, et al., 2002).

One difference, which the immigrant RNs interviewed for this study noted, was that family participation in delivering care was considered normal practice in the RNs'

home countries but this practice rarely occurred in Australia or New Zealand (Allan & Larsen, 2003). Immigrant RNs successful adjustment to new workplace environments may enhance their work satisfaction (Kawi & Xu, 2009). In contrast, dissatisfaction with the work situation can lead to lowered performance, increased RNs' resignations, and absenteeism, all leading to organisational shortages. For these reasons immigrant RNs need to be supported in their work environment and provided with opportunities for advancement (Gurkova, Cap, Ziakova, & Duriskova, 2012; Kovner, 2006).

It would be interesting to compare the differences between immigrant and non-immigrant RNs perception of job satisfaction (Gurkova et al., 2012; Kovner, 2006). The majority of the RNs interviewed for this study were of Asian origin. Asians are very diverse in language, religions, beliefs and culture, even within the same ethnic group, which makes understanding their cultures more difficult. I have observed, in my nursing practice, that many immigrants engage in activities within their own cultural groups as this makes them feel comfortable and accepted.

Registered Nurses' Responsibilities

There are four domains of competence for the New Zealand RNs scope of practice. The reason that I have included the competencies is because my topic for this study encompasses respectful, effective resident care and the support of RNs. The Nursing Council of New Zealand's (2012) standards for competency express that RNs provide care and utilise their judgement and knowledge to support people to manage their own health requirements. Registered Nurses are accountable for ensuring that the health services they provide, meet legislative requirements. Each domain has its own competencies (Nursing Council of New Zealand, 2012).

The first domain denotes professional responsibility, which encompasses practice standards, legislative requirements and scopes of practice. Additionally, RN competencies in domain one require the ability to reflect and develop insight into their own cultural understanding together with an understanding of the implications of the bicultural agreement documented in the Treaty of Waitangi (Nursing Council of New Zealand, 2012).

The second domain is about the management of nursing care. This domain includes the requirement for the skills and knowledge to provide evidence based client centred care. In addition to the statutory requirements for documenting practice, this domain includes the notion of continuous professional development (Nursing Council of New Zealand, 2012).

The third domain concerns interpersonal relationships where RNs are required to demonstrate effective client/RN partnerships. Clients receive relevant information about their healthcare. Registered Nurses demonstrate empathy, respect and endeavour to establish rapport and trust with all health consumers. The fourth and final domain concerns collaboration with a focus toward inter-professional health care and quality improvement. A notion throughout these competency domains leads to a consideration that concepts within cultural safety are inherent in the RN competencies (Nursing Council of New Zealand, 2012).

Cultural safety emerged in New Zealand as a response to bicultural interactions between Māori¹ and other New Zealanders. The Treaty of Waitangi originally provided the essential framework. Cultural safety was originally limited to nursing (Kirkham, 2006; Nursing Council of New Zealand, 2005). Cultural safety emphasises moving the power from all health professionals to the people receiving the care. Health professionals who have cultural prejudices may seriously affect the quality of care given to the clients, even to the extent of compromising their clients' health (Kirkham, 2006; Nursing Council of New Zealand, 2005; Papps & Ramsden, 1996). Registered Nurses need to reflect on his / her cultural identity to determine how it affects his or her practice (Papps & Ramsden, 1996).

Cultural safety is the effective nursing practice of the RNs as perceived by the person or family, from another culture. Actions and interactions may be culturally safe or unsafe (Nursing Council of New Zealand, 2005). The recipients of care are considered to be empowered to define what they feel is culturally safe practice. The 'lived experience' of patients therefore, establishes if a nurse has the ability to meet their cultural needs (Wepa, 2005). The RN is required to protect the consumer's health and

¹ Maori refers to the indigenous people of New Zealand

wellbeing, and provide advocacy when prejudice is apparent (Nursing Council of New Zealand, 2012). It is in this way that Te Tiriti o Waitangi (The Treaty of Waitangi) protects all citizens in New Zealand.

After the arrival of the Pakeha², New Zealand became a bicultural country. Today, the country has become diverse in terms of ethnicity, language and religion. The relationship between Māori and Pakeha, as previously stated, is defined in Te Tiriti o Waitangi/The Treaty of Waitangi (De Souza, 2008). In order to understand the place of cultural safety in nursing education and practice, one should consider relationships between the Treaty of Waitangi, Māori health and Cultural Safety in New Zealand (Nursing Council of New Zealand, 2005).

Cultural safety involves four substantial principles. Principle one focuses on improving the health status of New Zealanders. This includes positive health outcomes for everyone. Principle two focuses on a culturally safe nursing workforce at all times. The third principle addresses social inequalities in health care interactions. The fourth principle focuses on the nurse and suggests that nurses examine their practice and recognise that consumers need to receive effective and efficient care. The nurses need to have adequate skills to work with people who are from different cultures (De Souza, 2008).

New Zealand cultural safety principles have raised the interest of international health researchers. An interpretive hermeneutic research study conducted in New Zealand by Doutrich, Arcus, Dekker, Spunk and Pollock-Robinson (2012) explored cultural safety within nursing in New Zealand. . The purpose of their research was to describe cultural safety as demonstrated by New Zealand RNs, and to encourage the same practice and education in the USA. The RNs were selected through snowball and purposive sampling. Interviews were audio taped and the researchers reported themes namely: "Reflection is the key, know where you come from, learn to walk alongside and change over time" (p.144). The authors concluded that by means of reflective practice, the RNs enhanced the likelihood of providing culturally safe care for the residents. These principles are congruent with quality care for all who require health care services and

² Pakeha refers to all those who are not Maori in New Zealand

immigrant RNs are required to learn and understand these principles and apply them in their daily practice.

Palliative Care Approach

The World Health Organisation (2006) states that the aim of a palliative care approach is to provide quality care for the patient and his or her family at the end of life. Quality care includes the identification of physical, psychosocial and spiritual problems, with the goal of relieving pain, if this is present. However, to achieve these aims and to enable effective palliative care systems to function, staff need support, palliative care training and adequate resources (Katz & Johnson, 2006). Palliative care is an approach that improves the quality of life of patients, and families facing the problems associated with life threatening illnesses. End of life is the part of life where a person is living with an eventually fatal condition, even if the prognosis is unknown (Palliative Care 2008). For this thesis, the terminology 'end of life' will be used the majority of the time.

An effective end of life approach for the residents when their condition is deteriorating, means improving the quality of their life by ensuring that they have adequate symptom control, are kept comfortable and pain free at all times. Discomfort may be reduced for both the resident and the family if early identification and assessment determines that the resident requires palliative measures to be undertaken (Kristjanson & Toye, 2005; Panke, 2002). However, as noted in the previous section, this is dependent on staff knowledge, skill and the availability of adequate resources. Additionally, a palliative approach requires a deliberate effort to be inclusive of family needs. Many family caregivers are unprepared for the death of their loved one. It is therefore important that the family is well prepared and that channels of communication are effective (Hebert, Schulz, Copland & Arnold, 2008). This could indeed be a challenge for RNs whose cultural perspectives about death and dying are different to those of New Zealand.

Traditionally, aged care facilities have not been recognised as ideal places for either palliative or end of life care (Froggatt, 2000). Even in countries where the numbers of residents in care has decreased, absolute numbers are rising because of demographic ageing (Broad, Boyd, Kerse et al, 2011). In May 2014, the Last Days of Life Working

Group was established. The goal of this group was to develop principles to guide staff caring for patients in their last days and hours of life (Grundy & Sawyer, 2014).

At the present time, some facilities use the Liverpool Care Pathway as the model of care when patients are dying. The Liverpool Care Pathway (LCP) is an integrated pathway based on goals of care. It provides an evidence based care guide that supports health professionals in caring for people, when they are dying. The Liverpool Care Pathway was originally developed in Liverpool in the late 1990's. Although this model has to some extent enhanced the standard of care there are indications that further improvements can be made especially in relation to cultural and spiritual aspects. It is expected that the final report from the Working Group will be available by November 2014 (Grundy & Sawyer, 2014).

To assist the families and the RNs, in managing grief issues there does not appear to be extensive, published research available discussing the grieving process. In fact, there appears to be a scarcity of relevant articles, concerning the influence residents' deaths have on the RNs who have been caring for them. For this reason, there was no limit placed on the year of publication when reviewing literature for this study .Although some of the publications are seminal I included them in this study as they are still relevant today.

If nurses are grieving for a deceased resident, then they may not be able to give optimal care to the other residents. Therefore, these nurses require considerable support. Brunelli (2005,) published a concept analysis of the grieving process for nurses and documented her concern about the welfare of the RN who lives through people's grief, week by week and day by day. Brunelli (2005) argued that there is very little support for the RN who knows that when someone dies nothing that he or she does will actually change the situation. Registered Nurses however, do have a part to play in ensuring the process towards death will have a positive though sad outcome for the resident and their family.

Understanding patient's needs and values, and being able to integrate family dynamics and palliative options, can be challenging (Oliver, Porock, Oliver, & Oliver, 2006). The nursing role is also challenging when one considers that the nurse is

expected, by grieving families, to accurately anticipate how and when a death will occur. I have observed that the dying process is often very stressful for families. In an end of life setting many nurses see their main role as facilitating a 'good death' for the resident (Steinhauser, et al., 2000).

However, ensuring a 'good death' is achieved for the resident, can be a challenging exercise (Steinhauser et al., 2000). This is particularly relevant when the resident refuses to acknowledge that he/she is actually dying. There can also be a problem if the family members do not wish to have the interventions that clinical staff associate with managing a 'good death'. Registered Nurses guidance is important to ensure that the family feels adequately supported. To ensure a 'good death' is achieved, ideally one needs to anticipate when death is near and to comprehend what may be expected. Dying residents are always entitled to be treated with dignity and privacy, and should be given access to any emotional or spiritual support that they may require (Palliative Care Council, 2011).

The understanding of what constitutes a 'good death' depends on each individual. Higginson (2004) considers that good symptom control, including psychological support, is important. The majority of people would probably agree that a 'good death' is one when symptoms and pain are controlled, and the person is given dignity and privacy. Ideally, a 'good death' is free from avoidable distress and is consistent with cultural, ethical and clinical standards (Higginson, 2004). It is ideal if the resident is able to have control and choice over where death occurs and to have access to any spiritual or emotional support desired. The person has a sense of completion of their life if they are able to have the death that someone might choose for him or herself, if that choice was available. It is reassuring for the residents if they have sufficient time to say goodbye to the people that are important to them. The RNs are in a position to facilitate this whenever possible.

When the resident's needs and their family expectations are very different, at times problems may occur. To ensure harmony, these problems need to be resolved as soon as possible (Randall & Downie, 2006; Steinhauser et al., 2000). The RN is in a position, to be an advocate for the resident, and then to provide all possible support for

the family. On occasions, when the resident or the family's expectations are beyond the organisational resources that are available, skillful negotiation is needed to find the best solution for all concerned.

Randall and Downie (2006) presented the argument that the palliative care approach has often become over-professionalised. Some weaknesses can then become apparent. These authors examined dignity, autonomy, patient centeredness, and the moral problems associated with implementing such a philosophy. They also recorded the positive aspects and presented the argument that the benefits of a palliative care approach have been overstated. They considered quality of life and personal dignity to be important and discussed alternate philosophies.

I have worked in aged care facilities for 20 years and the following is one of my observations. One difficult challenge facing RNs is that families, at times, consider that extraordinary means should be adopted to treat their family member when they are seriously unwell. This may be despite the fact that the doctor has explained to the family that there is little likelihood for improvement in the resident's condition. Registered Nurses often find this situation stressful. Nurses consider end of life measures need to be implemented for the resident at the end of their life and the family do not always want such measures.

Mitchell et al., (2010) agree with a end of life approach and suggest that futile, unnecessary treatments should be avoided. The RN is the team leader as well as the frontline professional and, as such, is ideally suited to implement and co-ordinate end of life interventions. This will only happen however, if the RNs have the ability and knowledge to carry out this function and the resident and family are in agreement. This is one reason why end of life care education for RNs is so vitally important.

Residents who have been in the facility for a long time will have had the opportunity to decide their preference for end of life care. It may be a different situation for residents who are entering a facility for a short time of weeks or possibly only days at the end of their life. Short stay residents create additional challenges for care staff and necessitate a greater intensity of resources. It is challenging to predict end-of- life in residential care facilities. Porock, Oliver, Zweik and Rantz, (2005), state that at times,

it is only obvious that someone is dying for a very short time before their death actually occurs.

When a sudden deterioration in a resident's condition occurs it is often difficult to instigate effective end of life care measures. Experienced RNs are rarely surprised by the death of a resident, but they sometimes have difficulty explaining how they knew a resident was approaching his/her death. Although family members expect the doctor to tell them when their family member is dying, some physicians also find it difficult to recognise the dying trajectory (Porock et al., 2005).

As a resident's life comes to an end, the RNs manage individualised care for the resident, as well as organisational issues that impact on their nursing practice. The psychosocial task for the dying resident is to review his/her life's accomplishments, deal with his/her loss, and then prepare for death. It is a continuing process to find final meaning. In my experience, the thought of dying is a traumatic experience for many people. The RN competencies suggest that RNs require the skills to listen attentively; and to be open, honest and supportive to the dying resident at all times, while also being sensitive to the cultural diversity of the resident (Nursing Council of New Zealand, 2012).

Residents' Deaths in the Future

Registered Nurses in the future will be exposed to increasing numbers of residents' deaths. The main reason for this occurrence will be the increased number of people that were born in the 'baby boomers' generation and who will be senior citizens before the end of the decade. I assume that effective coping mechanisms for RNs, within the working environment, will need to be developed further, to assist RNs to cope with the increased number of dying people. There may also need to be a greater understanding about the heavier workload that RNs will have to face when they experience a marked increase in the frequency of deaths. My aim, when I commenced this study, was to establish how RNs respond to resident deaths.

Structure of the Study

This study consists of five chapters. A brief outline of each chapter is given.

Chapter one introduces the study. This includes; the research question, focus of the study, purpose of the study, focus of inquiry, significance of the study, background to the study and structure of the study.

Chapter two is a critical review of the literature and addresses issues such as loss and grieving, relationships with residents and families and challenges for immigrant RNs. It provides the reader with an overview of some of the literature that is available relating to RNs' responses when the residents die.

Chapter three discusses the qualitative, descriptive research design used in this study. This chapter includes participant selection, data collection, data analysis and ethical considerations. All of the participants in this study were immigrant nurses.

Chapter four presents the research findings. Four themes were identified in this study. These were; the different cultural perspectives of dying, experiencing residents' sudden deaths; nurses' grief and the support available to nurses when residents die. .

Chapter five provides a discussion on the findings of the study and also suggests some recommendations for future nursing practices, education and research. The participant RNs found the dying process in New Zealand was quite different from their previous experiences and they found communication and the differences in medications and procedures challenging.

Summary

In this chapter, the end of life approach to terminally ill residents has been considered. End of life strategies are important if they are adopted and applied effectively. They may ensure quality care is given to the residents at the end of their lives. When residents die the nurses grieve and this is also briefly discussed. Brunelli (2005) asked the question 'Who looks after the nurses when the residents die?' The ultimate aim of end of life care is to ensure that the resident has a 'good death.' However, it is also important to support the RNs who are involved in the resident's death. As the RNs' role is challenging when residents die, it is essential that nurses have the knowledge and skills to ensure that whenever possible, the resident has a 'good death'. New Zealand is now a country comprising of many different ethnic groups, hence

discussions about cultural sensitivity are important for all staff. As a result of these discussions, it is hoped that the residents will be given improved quality of care, and care that is relevant to their different cultures, while at the same time assisting the RNs to increase their knowledge and confidence.

CHAPTER TWO: LITERATURE REVIEW

“The grieving process is a concept that all nurses need to examine, because grief is a phenomenon that every human being will eventually experience” (Brunelli, 2005).

Introduction

The purpose of this chapter is to provide the reader with a critical review of the literature relating to the responses nurses have when the residents they have been caring for, die. The following themes have been critically reviewed: the concepts of loss; ensuring a good death; relationships with residents and some of the most important challenges facing immigrant RNs. With advances in medical care more people are living longer lives and the number of older people is increasing as a proportion of the total population (Wagner & Groves, 2002). Therefore, one can assume from this statement that there will be fewer young people to care for the increase in growth of the older population.

”Search strategy”

The initial abstract search was via the CINAHL data base using the key words, nurses, grief and death. Limits were applied for full text and peer reviewed. The search yielded seven results of which three were retained and four discarded as not meeting the search criteria. I then conducted an abstract search using the AUT library Summons database using the key words nurses’ grief. Limits were applied to full text online only. When the subject terms death and dying and culture were searched within the results, the yield was 610 articles. A filter for ‘nursing’ was then applied within the 610 articles which yielded 170 articles. From these 170 publications, articles related to suicide, individual stories, case studies focusing on individual clients and student nurses experiences were discarded. Finally 20 articles were retained for further analysis and consideration. A second abstract search for well-known grief theorists for example, Freud was undertaken using CINAHL and the key words, grief and theory or theorists as I wished to access early as well as contemporary approaches to grief. As a result

there are some earlier articles related to death and dying cited in this study. These were retained as they related to theoretical perspectives on death and dying and could be considered seminal work in the area of grief. A third abstract search was related to immigrant registered nurses due to the workforce statistics related to the number of immigrant nurses employed in residential care in New Zealand. Finally, I searched New Zealand and International policy documents and reports regarding approaches to nurses' grief, immigrant nurses, death and dying, family grief, end of life care and palliative care as related to Aged Residential Care.

Palliative Approach

A palliative approach aims to improve the quality of life for people, with a terminal illness, and also their families. This is achieved by accurate and early assessment, effective pain control and meeting their social, spiritual, physical, cultural and psychological needs (Palliative Care Guidelines, 2006). Underlying the philosophy of end of life care is an open attitude towards death and dying. A palliative approach provides a focus for quality care with the aim of reducing a person's adverse symptoms, while at all times supporting the family. Residents in residential aged care facilities may also require a end of life approach when they are dying, not perhaps because of any specific illness but simply due to the fact that their life is ending. This end of life care may only be necessary for a short time, possibly only several days, but there is a need for a sensitive palliative approach (Palliative Care Guidelines, 2006).

Symptom management rather than cure is the aim of an end of life care approach. In the future an increasing proportion of residents will require palliative care. In the United States, researchers have reported the many challenges associated with palliative care (Kayser-Jones, Chan, & Kris, 2005), Millar et al., 2004). It is also expected that New Zealand will experience very similar challenges. Among these challenges are ensuring symptom management and working to meet the expectations of relative's care requirements. Cultural aspects of care are given consideration at all times (Palliative Care Guidelines, 2006). Avis et al., (1999) and Cooper and Glaetzer (2004) suggested that RNs need to be competent in end of life care management in order to be effective

in ensuring quality care is delivered to residents. It would seem from some research reports that this is not always the case.

Reynolds, Henderson, Schulman, and Hanson (2002) suggested that end of life care needs to be improved in nursing homes. They considered that combining traditional end of life care with increased attention to emotional symptoms and physical care would be beneficial. Many of these end of life residents are in a residential aged care facility for a relatively short time before they die. As a result of this, deaths occur frequently (Parker et al., 2005; Porock et al., 2005). Cooper and Glaetzer (2004) suggested residential aged care facilities can now be considered to be de-facto hospices, whereas previously their main purpose was to provide rehabilitation centers for the residents. This is also the situation in New Zealand and therefore, it is becoming increasingly important that all staff are well versed in end of life care management.

One reason that this subtle change has occurred is because the majority of older people stay in their own homes for a longer time than previously, as there are many essential services available in the community. However, Oliver et al. (2006) argued that aged care facilities are still viewed by many people as places of rehabilitation and maintenance of function. Residents' mobility should be maintained whenever possible. Regardless of the stage of their life, the main goal of residential care facilities should be to give residents the best quality of life possible, for the remainder of their lives.

In residential aged care facilities it is preferable for the resident if end of life care can be provided in the resident's familiar environment and by a multidisciplinary team. A sense of control and the ability to communicate with familiar people gives the person a sense of dignity. Advanced care planning ensures that the doctor, resident and family, agree with the goals for care. Comprehensive advance care plans and ongoing assessments which note changes in the residents' health status ensure family members feel confident about the delivery of care and are congruent with a palliative care approach (Palliative Care Guidelines, 2006).

Nursing staff would prefer to provide optimal end of life care for residents, who are obviously deteriorating with their level of comfort being the primary aim (Porock &

Oliver, 2005). Older people are often very frail and unwell when they ultimately enter residential care. For these reasons deaths are a frequent event in aged care facilities as noted previously. Cooper and Glaetzer (2004) suggested that the palliative needs of residents and their families/Whānau are not always acknowledged by staff. They considered that the nursing staff are not always aware that a resident is deteriorating and therefore, has a need for end of life care intervention. They also suggested that there is a need for end of life care management to be developed further in aged care facilities and for better systems to be established to care for people when they are dying.

Without excellent end of life knowledge many RNs find it challenging to be an effective advocate for the residents (Bjornsdottir, 2000; Porock et al., 2005). Registered Nurses have reported that there are often deficits in the delivery of care when education about death, dying and bereavement is inadequate (Medland et al., 2004; Redinbaugh, Schuerger; Weiss, Brufsky, & Arnold, 2001; Saunders & Valente, 1994). These authors reported that mishandled treatments can cause grief because these deaths indicate fault. Registered Nurses consider deaths on a continuum of positive and negative. Coady and Wynne (2001) recommended that Nurse Specialists with expertise in both palliative and geriatric medicine be employed to oversee protocols and guidelines in care facilities. Currently in some New Zealand DHBs, Gerontology Nurse Specialists are employed in this capacity. More recently, others have reinforced the importance of staff being encouraged to increase their skill, confidence and knowledge of end of life care nursing (Phillips, Davidson et al., 2006).

It has been previously suggested that in residential aged care facilities, a large amount of time is expended because of the volume of compulsory regulation documentation that is required for auditing purposes. Registered Nurses spend more time dealing with documentation, than they spend with the residents and their families (Jeong & McMillian, 2003). Many RNs agree with this assertion and consider that a large amount of documentation is repetitive and unnecessary. However, this is part of the regulation of facilities so is therefore not negotiable. One approach, perhaps open to consideration, could be the restructuring of the RN work flow. Unfortunately an in depth critique of this is outside the remit for this literature review. The increased

workload often prevents the nursing staff from spending optimal time with a dying resident. This can cause the RNs to feel that they have not given adequate personal care, when this situation arises (Jeong & McMillian, 2003).

Nursing staff aim to provide optimal end of life care for dying residents (Avis et al 1999; Porock & Oliver, 2007) and for this very reason RNs endeavour to ensure that residents do not die alone (Phillips et al., 2006 Touhy et al., 2005). Following on from this idea, it appears that nurses consider that it is ideal to be with a resident at the end of their life and many RNs see this as 'their duty of care,' to meet the resident's needs. It is considered a matter of high importance to RNs that their residents are kept comfortable. When the end of the resident's life is approaching, RNs feel that they need to be present at that time to ensure that both the resident and his/her family have all their needs met and any concerns are able to be addressed promptly (Phillips et al., 2006).

This is another reason why it is so important that staff are given current information about end of life care in order to accomplish this well (Hill, Ginburg, Citko, & Cadogan 2005). There are substantial challenges for the RNs who endeavour to balance regulatory requirements, staff shortages and diverse skill mix. To ensure that residents receive optimal care an adequate volume of competent staff should be available at all times. A study on end of life care, nurses (n=14) and caregivers (cg=8) found that additional education and support would enhance end of life care (Goodridge, Bond, Cameron, & McKean, 2005).

The very wide disparity in the ability of nursing staff, both novice and experienced, is challenging to manage. The varied cultures that exist in New Zealand healthcare teams, add to the complexities. A further challenge is the inadequate staffing levels, and the high turnover of both residents and staff in aged care facilities.

Additionally, a number of authors have indicated that conflicts with families and physicians, as well as a shortage of time, are hindrances when it becomes necessary to provide excellent end of life care to residents (Ersek et al., 2003; Zimmerman, Sloane, Hanson, Mitchell, & Shy, 2003). Today it is possible to have medical interventions available almost to the point of death. Although this may not be medically

advisable, some families insist on the utilisation of extraordinary means to keep their relative alive. This attitude encourages death denial and impacts on the family's ability to cope with death (Stevens, McFarlane, & Stirling, 2000).

Unbelievable as it may be, according to Johnstone and Smith (2006), very few patients have been asked for their views on end of life care. Their research study was a phenomenological study consisting of in-depth interviews and thematic analysis. The research consisting of nurses (n=22), dying patients (pts=22), found that patients wished to maintain their independence for as long as possible and remain in control of their own decisions. It was also stated that ideally RNs needed to be interpersonally skilled and have the ability to build positive relationships with the residents. They are then able to encourage and assist the residents to have the best quality of life available to them for the time they have left before dying. Both patients and nurses agreed that compassion and kindness were vitally important qualities.

Concepts of Loss

The concept of loss has been examined for many decades (Bowlby, 1997; Kubler-Ross, 1969; Lindemann, 1979; Pilkington, 2006; Robinson & McKenna, 1998). Kubler-Ross (1969) developed a well-known model of five definitive stages of grief. They are denial and isolation, anger, bargaining, depression and acceptance. Within Kubler-Ross's (1973) model of the stages of death, people would initially disbelieve they were dying, then fight the concept of death and eventually accept the inevitable. Kubler-Ross identified 'hope' as the one concept that persisted through all of the stages of grief (Schina, 2002).

Hope is the ability to find continued meaning in one's life. There is hope to be listened to and to be understood, hope for relief of pain and symptoms, hope to maintain respect and dignity, hope to see another sunrise and always the hope for experiencing a 'good death'. Other writers suggest that Kubler-Ross' (1973) model only explains external processes and does not examine the problem of loss or unresolved grief in any depth (Schina, 2002). Following the publication of Kubler-Ross's model (1973), other researchers who worked with the bereaved, began to look at the processes and experiences that many seemed to share.

Bowlby (1997) wrote about shock, numbness, yearning and searching. Other tasks, considered by Noppe (2000) were reorganisation, which is the assimilation of the loss, and then at a later time, redefining life and meaning without the deceased. Cultural context, social environment, gender and the type of death, determines the experience of loss. Noppe acknowledged that the disruption of attachment bonds can result in both loss and grief. Noppe also presented a developmental model integrating the attachment theory and cognitive development approaches to increase knowledge about grief and loss.

Loss and grief are interchangeable terms and loss is one of the primary antecedents of grief (Reed, 2003). This also applies to the nurses caring for the residents. Although not all loss results in grief, RNs are expected to cope with grief and loss as they are part of the RNs' work. The fact that not all loss results in grief is illustrated in a descriptive study of 16 paediatric oncology RNs. The RNs reported that they had developed close relationships with the families therefore, creating meaning related to the loss and they did not report feelings of loss or grief (Papadatou et al., 2002). Similarly, at times in residential care facilities, loss may result in relief for the family because the stressful situation of their relative dying has resolved itself and the resident is now at peace.

Aspects of Grief

Just as the dead do not reawake
grief never fully ends.
Shuchter and Zisook (1993)

Grief is mentioned frequently in my study and is examined at some depth as it was the main response shared by the RNs in their interviews. Therefore, it is relevant to my study. Grief is a normal, natural, and necessary process that occurs after the loss of a loved one and refers to the emotional distress associated with that loss. Grief is not always present and grief is never completely absent. It is always an individual process. Grief is affected by the individual's perception of the loss and the physical, emotional, spiritual and social consequences that flow from that sense of loss (Keene -Reder, 2003; Zang, El-Jawahri, & Prigerson, 2006).

Grief is not something that can be fixed. Grieving is healthy and it is usually not an illness; however at times it may intensify and people may experience complicated grief. This grief is sometimes referred to as traumatic or complex grief. It is a form of grief that is extreme or prolonged. Other types of grief are, anticipatory grief refers to a grief that occurs before an impending loss. Disenfranchised grief is not acknowledged by society. Delayed grief is reaction to the loss, postponed to a later time. Unresolved grief is any aspect of grief still to be resolved. Abandonment grief was described in 2000 and features five phases of abandonment, grief and recovery. Anticipatory mourning describes the process of grieving, adapting and coping that a person experiences when their loved one is reaching the end of their life.

Family members often try to imagine their life without the person. Anticipatory grief leads to feelings of concern for the dying person, feelings of loss and preparing for the death of the loved one. At times, as previously mentioned, complicated grief occurs. Complicated grief is intense grief that requires professional support to enable the person to function at their previous level.

Other researchers suggest that grief is a response to a significant loss (Viorst, 1998). Viorst felt that losses are our greatest source of growth. Bereavement is an event; grief is the emotional response, whilst mourning is the cultural process. Often the terms grieving and mourning are used interchangeably. Mourning has been defined traditionally as the public display of grief.

Mourning usually happens in the presence of others (Hagman, 2003; Schina, 2002). Death is the most dramatic example of loss (Parkes, 1996). Grief is experienced in accordance with cultural norms, belief systems, faith systems, spirituality, and family and life experiences. It is only after the actual death that the full intensity of grief occurs, and this seems to be regardless of how much preparation has been done beforehand.

Altig (1996) suggested that the way people die remains in the memories of those who live on. We have to learn to accept the pain that is part of loss as this is part of the grieving process. Grieving involves relearning the world (Altig, 1996). It is also suggested that grief gives rise to emotional feelings of frustration, guilt or anger related

to the loss. Freud provided the first notion about grief in 1917 and his idea was initially adopted by many. Freud (1925) suggested that when grieving, the person needs to break the bonds that connect the grieving person to the deceased.

Freud (1925) also suggested that expressions of anger and guilt should be permitted. He believed that if the bereaved did not complete the grief process, complications were likely to occur. These could even manifest in physical and mental illnesses. Freud was very aware of the long term nature of grief as he had lost a daughter whom he loved dearly. Freud felt that an individual will forgo reality and believe that the loved one is not really dead, rather than acknowledge the reality. He suggested that it would be harmful to interfere with this belief.

Freud (1925) further suggested that when a loved person is lost through death, the grieving energy of the person left behind, remains attached to memories of the deceased. In order for the surviving person to regain their previous energy, the emotions attached to the deceased have to be severed. This is to enable new relationships to be established. He called this process 'grief work'. Grief work allows the bereaved person to acknowledge that the loss is inevitable (Bowlby, 1981; Parkes, 1996).

Because people form emotional bonds with both people and possessions, when a loss occurs the individual grieves the loss. In contrast to Freud's (1925) notions, Klass, Silverman and Nickman (1996) suggested that individuals do not need to sever bonds with the deceased. On the contrary, it appears that there is value in maintaining bonds with the deceased person, and although death has occurred, that does not mean that the relationship needs to end.

Neimeyer (2003) agreed that although death ends a life, it does not end a relationship, and the deceased may be seen as a role model. The bereaved may even turn to the deceased for guidance. A number of studies have found that approximately half of the bereaved experience the sense of the presence of the deceased. After a significant loss the bonds continue and remain significant in people's lives (Klass et al., 1996). There is, however, some evidence that a sudden death increases the likelihood of prolonged grief. When a sudden death occurs, person's coping mechanisms are

overtaxed by the unexpected death. The person often feels overwhelmed or unable to function.

There seems to be general agreement that people find ways to stay connected to the deceased. This occurs even when it means the individual's quality of life is diminished as there often remains a gap left by the deceased (Neimeyer, 2003; Worden, 2002). Neimeyer (2003) considered that it was fundamental to the grieving process to have oscillation between avoiding and engaging in grief work. Grieving is a process of reconstructing meaning. In order to react in an acceptable manner, when people are bereaved, society expects them to display signs of grief and sadness (Hagman, 2003).

However, as stated earlier, Freud (1925) suggested that people needed to break the connecting bonds to the deceased in order to move forward. As the mourning process became more clearly understood, the Kubler-Ross' (1973) findings that mourning unfolds in stages has been criticised because it does not recognise the uniqueness of each experience (Hagman, 2003). Kubler-Ross did not intend her model of grief to be interpreted the way it has been by her critics. She formulated the stages of grief after speaking to dying patients in hospices. She suggested that grief was best dealt with in stages that the bereaved person was able work through at their own pace, in order to be eventually reconciled with the death of their loved one.

Grief theorists, including Bowlby (1981) and Parkes and Weiss, (1983) considered that grief manifested itself in predictable tasks. Some individuals may experience grief intensely at the time of loss, whilst for others it is a delayed experience (Hagman, 2003; Linehan, 1993). For some people grief lasts a short time and for others it is a long drawn out process (Worden, 2002). Bonanno et al. (2002) suggested that people often miss their deceased loved one for a longer period than the suggested time of weeks or months. Similarities have been identified that have prompted a variety of theories about the grief process (Worden, 2002).

Worden (2002) considered that people need to work through their reactions in order to adjust. The bereaved person also had to work through the emotional pain of the loss and adjust to the changes in his/her life. Tasks are completed when the loss is integrated into the person's life. Feelings of loss usually decrease in intensity as time

passes (Love, 2007). Anderson (2010) suggested that the complexity of the grieving process, or the intensity of the grief, depended on the circumstances of the loss or the death.

There is an awareness that there is disagreement amongst writers when it comes to a discussion about the appropriate duration of grieving. The ideas of writers range from the acute stage of grief lasting a few years to the grief process continuing throughout the remainder of life (Hentz, 2002; Worden, 2002; Wortman & Silver, 1989). Current thinking allows for the individual to grieve the loss of a loved one for a lifetime (Hentz, 2002). Subsequent surges of grief may occur at times (Hentz, 2002; Rando, 1993). Being able to accept the reality of a personal loss takes time, as grieving involves the intellectual and emotional acceptance of that loss.

Grieving is unique to each individual and each bereaved person will deal with the loss in their own way. Bonanno et al. (2002) found that people, who have had a caregiver role, or have had a poor relationship with their spouse, actually functioned at a higher cognitive level following the death of their spouse. The reason given for this statement is that the amount of stress, worry and responsibility that the caregiver had when their spouse was alive, has now dissipated due to the fact that their spouse's death has occurred. This can be related to another grief theory, that of the dual-process model developed by Stroebe and Schut (1999). The purpose of this model is to assist the individual to cope with the loss of a person.

Coping is the process of tolerating the situation in which bereavement leaves the person. Freud (1917/1957) originally instigated grief work followed by the phase theory of Parkes (1996) and Bowlby (1980). Bowlby's model was fundamental to the attachment theory and this was followed by Worden's task model (2002). Parkes' phase theory suggested that the bereaved return to feelings of security again as their grief resolves.

According to Parkes (1996) a person comes to terms with the reality of the loss. Parkes stated that there were four phases of grief before realisation is complete. The first phase is shock and numbness, second phase is yearning and searching, the third

phase is disorganisation and despair and the fourth is reorganisation and recovery. Not all people move through all phases or in this sequence.

Stroebe and Schut (1999) developed the dual purpose model to describe how people alternated between grieving behaviour and behaviour where they made adjustments to their life so that they could carry on to live without the deceased person. The dual process model described grief as a process swinging between problem focused coping and emotion focused coping. The aim of problem focused coping was to eliminate the source of stress by finding information to solve the problem. Emotional focused strategies involved releasing emotions and managing the emotions that accompany stress.

This model suggested that the coping focus could change from one moment to another or from one person to another. The bereaved demonstrated their grief assuming that there was an acknowledgement of the loss to the individual and that they had a right to grieve. This desired right to grieve was validated by the cultural norms of their society (Stroebe & Schut, 1999).

Stroebe and Schut (1999) suggested that avoiding grief could be both helpful and unhelpful depending on the particular situation. This dual process model recognised that feelings were important. The dual process model of coping with bereavement identified two changing coping processes, loss orientation and restoration orientation. Loss orientation is about grief work and is concerned with managing emotions. Restoration orientation involves secondary losses. These are the life changes associated with the bereavement and which occur because of the person's death (Stroebe & Schut, 1999).

The results demonstrated that the people coping well used new identities whereas, the people not coping well were found to avoid change. The emphasis on each approach depended on the cultural background and the circumstances of the death. Previous models centered on the loss, however, the dual purpose model recognised that both expressing and controlling feelings was important. This model illustrated the need to deal with both the primary loss and the stressors that followed (Stroebe & Schut, 1999).

Following on from this, Richardson and Balaswamy (2001) demonstrated Stroebe and Schut's model with older widowed men during the second year of their bereavement. They found that loss variables such as death influenced negative feelings, especially during the early stages of bereavement, while restoration-orientated factors, such as dating other people, had a positive effect and were relevant later. This study however, selected a limited sample of people and they were also a self-selected group. More recently Richardson (2007) argued that it is important to distinguish between constructive and destructive grief work. Constructive grief means releasing something that is no longer in our lives so that we are able to move on to new opportunities. Grief makes us aware that we will die some day and this thought can compel us to evaluate our values. Destructive grief is painful as having lost someone we love, that flow of love has nowhere left to go.

Failure to complete the grief process may leave the bereaved person with feelings of anger, resentment, or even guilt. Worden (2008) suggested that grieving is an active process. In the past, people were encouraged to 'let go' of the deceased but now there has been a move towards maintaining bonds with the deceased person instead. There has been an increased level of understanding that there is no 'either/or' rule to be applied. It is neither generally adaptive for bereaved people to continue their bonds with deceased loved ones, nor to relinquish them (Field, 2006; Stroebe & Schut, 1999). It is a personal choice.

Making Sense of the Loss

Possibly the most critical issue of all, for the majority of people, is making 'sense' of the loss or 'finding meaning' for its occurrence (Neimeyer & Sands, 2011). Being able to find meaning is important for people when they are grieving. There are two processes that form important roles in the adaptation of loss. These are to be able to make sense of the loss and at a later stage to identify the benefits. The finding of benefit to the person after bereavement appears to grow stronger with time (Davis, Nolan-Hoeksema, & Larson, 1998). The way that we adapt to the changes in personal growth that can occur following experiences of loss, determines the person we become.

At times, individuals find it difficult to integrate the loss (Field, 2006). Field identified a type of continuing bonds expression due to the failure to integrate the loss because of avoidance in processing the implications of the loss. For these individuals there is always disbelief that the person has actually died. When people experience insecure attachments they are more prone to chronic grief trajectories (Bonanno, Wortman, & Nesse, 2004; Neimeyer, 2003).

The wavering between engaging with, and the avoidance of grief work, is fundamental to grieving. The 'making sense' of the death is often linked to more intense grief symptoms. The research that does exist on this topic has shown that coping with traumatic events and finding meaning for that event is important (Affleck & Tennem, 1996; Folkman, 2001). Neimeyer (2001) agreed and suggested that unexpected deaths usually lead to a protracted search for meaning. Folkman (2001) suggested that the death of a loved one is likely to challenge worldview beliefs. The validity of these beliefs can be reaffirmed by strategies such as spiritual reframing or benefit finding. The purpose of these strategies is to allow people to reconstruct their understanding of the death in a way that is acceptable to their worldview.

Folkman (2001) also discussed the process of bereavement and then adopted the cognitive stress theory. This problem focused coping method, manages and changes the problem causing the distress. Most individuals search for meaning especially if a death is unexpected, and there is empirical evidence supporting this assumption (Davis et al., 1998). The support of families and friends appears to be a very positive aspect when people suffer bereavement. However there is little evidence that social support makes much difference as bereavement results in an emotional loneliness (Stroebe & Schut, 1999).

Nurses' Grief

Anything that you have, you can lose,
anything that you are attached to, you can be separated from,
anything you love can be taken away from you.
yet, if you really have nothing to lose, you have nothing.
Kalish, R (1985. p.181).

My aim when commencing this study was to determine how nurses' respond when the residents die. The literature gathered in this study suggests that grief is the main response. Residents' deaths occur frequently in aged care facilities, therefore for the RNs it is a major aspect of their working life. As noted previously, research has expanded our understanding of grief and the risk factors, the associated symptoms and the outcomes.

Registered Nurses wish to build good relationships with both the residents and their families. When the resident dies this bond is broken and the nurse grieves for both the resident and the loss of the relationship with the family. This is especially poignant if the relationship was close and long-term. Managing residents and families' grief is part of the RNs' work. It is vitally important that RNs are aware of their own grief responses. There is a need for grieving nurses to be offered emotional support (Lee & Dupree 2008; Macpherson, 2008). As well as the RNs' own grief, the RNs also experience a number of other peoples' grief as they endeavour to comfort bereaved relatives at what is often one of the most traumatic times of the relatives' lives.

De-briefing sessions seem to be useful for staff especially following either the death of a resident with whom they have had a long term relationship, or when a sudden death of a resident occurs (Papadatou, 2000). Papadatou noted that RNs tend to use informal conversations with colleagues as a means of coping with grief. Papadatou also proposed a model showing how health professionals grieve and suggested approaches to support RNs. These recommendations included, clinical and emotional support, giving information and making meaning of residents' deaths.

Coping with death is important for all health professionals (Fee, 2001) and RNs may develop an emotional attachment to a dying resident. Registered Nurses place a high value on their relationship with residents and often cite this as an integral part of nursing practice and job satisfaction. However, when the resident dies the closure of this relationship can cause a considerable amount of grief. The research that exists has shown that attachments between nurses and residents contributed to nurses' feelings of loss when residents died (Gerow et al., 2010; Touhy et al., 2005).

Residents value close reciprocal relationships with staff (Pilkington, 2005). However, it has been reported that a particular resident may be avoided when the RN feels emotionally involved and considers he/she may not cope when that resident dies (Davies, 1996; Rashotte, Fothergil-Bouibonnais, & Chamberlain 1997). It has been suggested that it is of the utmost importance that RNs learn to manage their grief responses when their residents die. If not, they may experience physical, emotional or spiritual distress, and this may have negative consequences on their professional practice (Behnke, Reiss, Nermeyer, & Bandstra, 1987; Davies, 1996; Papadatou, 2000). A possible consequence of this may be the deliverance of inferior care to the residents (International Work Group on Death, Dying & Bereavement, 2006).

Papadatou (2000) is among the researchers who consider emotional support to be an effective intervention to assist nurses to manage their responses to grief. McCoyd et al. (2007) however, reported that being able to measure responses to residents' deaths does not often happen. Very little attention has been given to the emotional needs of the RN when a resident dies in an aged care facility (Brunelli, 2005; Brosche, 2003). Brunelli suggested that nurses require a considerable amount of education about the concepts of love and grief.

Brunelli (2005) also argued that RNs do not grieve because they do not know how to grieve and therefore, require education in this matter. Understanding the emotional reaction of grief is very important as it can affect the RNs' experience of grief and loss (Gerow et al., 2010). In Gerow et al's., study, a qualitative phenomenological approach was used for interviewing and analysis. The purpose of this study was to describe the experiences of nurses following the death of the patients. Using semi-structured interviews and phenomenological concepts, four themes were identified.

Firstly, that a reciprocal relationship transcends a professional relationship; secondly, that initial patient's death events are formative; thirdly, that nurses have rituals and spiritual views of the world; and fourthly, acting in a professional manner requires compartmentalising experience. Eleven Registered Nurses were interviewed for this study and the conclusion reached, was that nurses protect themselves from the grieving process with a curtain of protection, which then allows them to continue to

provide supportive nursing care to residents. The relevance of this research is that nursing facilities could provide more supportive environments for staff. If staff felt valued and supported they would be able to grieve and this would be optimal for their wellbeing (Gerow et al, 2010).

Suppression of Nurses' Feelings

At times, because of staff shortages, the RNs suppress their feelings because they do not have sufficient time to reflect and grieve (Savett 2000). Some research suggests that constant suppression of feelings may lead to workplace burnout (Brosche, 2003). It has also been suggested that a high level of work related stress also contributes to RN's burnout (Saunders & Valente, 1994). Yang and Mcilpatrick (2001) considered that RNs who experience frequent deaths often complain of increased levels of stress. Another researcher agreeing with this statement, Brosche (2003), suggested that moral distress is anxiety, stress or burnout that may occur following frequent loss. Moral distress can be a very distressing experience and can cause RNs to leave their nursing positions.

Registered Nurses also experience varying degrees of emotional turmoil when faced with ethical problems in the workplace. Currently, this phenomenon is known as 'moral distress.' Not all researchers agree with this statement however. Johnston (2013) queried the credibility of moral distress within nursing. She considered RNs in general know what the correct procedure is in particular circumstances due to their training or professional guidelines. In reality, they are not always able to follow the best practice procedure.

Woods (2013) outlined a range of usual responses to moral distress. These included sleeplessness, exhaustion, confusion and dissatisfaction with their nursing position. Woods stated that cooperative workplaces and adequate staffing were essential to prevent moral distress. This research was taken from a sample of experienced nurses (n=412), 30% of whom had more than 30 years nursing experience; 48% had considered leaving their current position and 16% currently were considering leaving nursing altogether due to moral distress.

Other studies have identified that RNs suppress their feelings of grief in the presence of families and residents (Boyle, 2000; Feldstein & Gemma, 1995). Registered Nurses believe that it is more professional to repress their feelings (Papadatou et al., 2002). They also feel that if they show emotion, this may demonstrate that they are too involved with the resident and their family (Feldstein & Gemma, 1995; Saunders & Valente, 1994).

Ensuring a Good Death

It has been argued that all residents need to have access to an effective end of life care approach and a 'good death' (Froggatt, 2000). The understanding of what constitutes a 'good death' varies (Steinhauser et al., 2000). Norton and Bowers (2001) reported that healthcare providers characterised a 'good death' as one that allows the resident time to resolve personal business, time to forgive and to be forgiven and time to say goodbye to loved ones. Additionally, it is important the staff at all times need to ensure good symptom control is being delivered. Effective pain management is always vitally important (Copp, 2006). However, Kayser-Jones et al. (2005) and Millar et al. (2004) suggested that inadequately treated pain in older people is a common problem that needs to be addressed.

Studies in the United States have examined the difficulties in delivering good end of life care to residents and have investigated the quality of care in residential aged care facilities. Wasserman (2008) suggested that a 'good death' is one that is expected, well managed, and one where optimal nursing care is given. Costello (2006) considered that a 'good death' was one that was expected and one where the RNs were able to exert an influence over the dying process. Values and personal experiences, beliefs and education all encourage people to define the difference between a 'good' and a 'bad' death experience (Lazarus, 1991).

Some deaths are more challenging than others (Rando, 1993; Stowers, 1983). Rando's text is focused on complicated mourning or abnormal grief. It provides therapeutic strategies for cases where counselling is not adequate. 'Good deaths' have been described in the literature as deaths where optimal care has been given to

the resident and when the family has accepted the fact that their loved one is going to die (Reynolds, Henderson, Schulman, & Hansen, 2002).

Papadatou (2000) considered a 'good death' was one free from avoidable distress and reasonably consistent with ethical, clinical and cultural standards. Many people talk about dying in language such as letting go of the person or passing away. They feel it does not seem as harsh as saying the actual word death. Usually death is quietly hidden away (Griffen, 2000). Death does not disrupt mainstream life for most people (Stevens, McFarlane, & Stirling, 2000).

Until they are personally affected, most people prefer not to dwell upon the concept of death and few people wish to think about what the reality of dying actually means. Adams (2005) goes further. He suggested that because our psyche is directed towards life, humans live in such a way as to be in death avoidance mode. People often question their spiritual beliefs and values when a death occurs (Love, 2007). As death has now been removed from everyday life, many people tend to only think about death and dying when someone they know personally, dies (Stevens et al., 2000). Doctors, nurses and others that deal with death frequently are, however, very aware of death and dying.

In one study 58% of families suggested that their loved ones experienced a 'good death' (Reynolds, Henderson, Schulman, & Hansen, 2002). However, in another study 49% had negative comments about the dying process (Hanson, Danis, & Garrett 1997). The findings noted, poorly trained staff, remoteness of the general practitioners and quality of care issues. They suggested that in view of their findings, advanced planning for end of life care was a critical need and should increase the likelihood of the resident having a 'good death'.

The concept of dying well, for the majority of people, involves the support of family and friends and having positive involvement with the RNs and the caregivers. Skilled RNs usually deal more effectively with grief issues than their newly qualified colleagues. They are more familiar with the death process and often have greater rapport with grieving relatives. Ensuring a 'good death' amid the activity of everyday life in residential care facilities produces many challenges. These arise from the RN/resident

ratios, the complexity of care and the high dependency level of residents with multiple co-morbidities. Despite these less than ideal circumstances, the majority of RNs find caring for the older dying adults satisfying and rewarding (Lee & Dupree, 2008; Macpherson, 2008).

Relationships with Residents

The third theme acknowledged that the death of a resident, who is known to a person, will have an impact on that same person (Kubler-Ross, 1973; Parkes 1975). It has been highlighted that RNs have been identified as having a closer relationship with dying residents than any other health professional (Costello, 2001). The aim of Costello's study was to explore the experience of dying patients. An ethnographic research design was chosen for the study. The participants were doctors (drs =8), patients (pts=74) and nurses (n =29).

Data collection consisted of semi-structured interviews and participants' observations. The findings of the study raised issues concerning the lack of effective communication regarding the disclosure of information about death and dying. The conclusion reached was that terminal care for some elderly patients is inadequate because some doctors and nurses do not communicate well when discussing death and the process of dying with the resident and their family.

Johnson and Lorraine (2006) explored RNs' perceptions of expert end of life care and revealed that nurses value close nurse-resident relationships. These relationships are viewed as part of their nursing expertise in the care of the dying. The quality and closeness of the relationship between the dying resident and the RN seems to affect the intensity and the length of time the RN grieves for the resident. The findings support an earlier study by Rittman et al., (1997). In this hermeneutic study, oncology nurses felt that an engaging relationship with a resident was a vital factor in ensuring quality care of the dying.

The quality and closeness of the relationship between the RN and dying residents appears to affect the intensity and duration of RNs' grief. The RNs reported that where there was a close bond with residents and their families, the RNs experienced a very deep sense of grief (Johnston & Lorraine, 2006; Rashotte et al., 1997; Rittman et al.,

1997). Furthermore, family involvement in residents' care and especially end of life care helps the family to grieve (Gerow et al., 2010; Touhy et al., 2005).

As these research studies show, close attachments between residents and nurses increase the feelings of loss and sadness on the death of a resident (Gerow et al., 2010; Holman et al., 2006; Johnson & Smith, 2006). Yang and Meilpatrick (2001) suggested that respecting a resident's wishes and providing physical comfort may ensure that the reaction to the death is positive. Nurses like to empathise and build relationships with residents. This has both positive and negative results. The positive result being, that if a close relationship has been established between the resident and the RN, then the resident's quality of life has been enhanced. The negative result is that the RN may be traumatised by the death of the resident.

The research that does exist on this topic has shown that the kindness of nurses and reciprocal relationships with residents and their families contributed to good end of life care (Papadatou et al., 2002; Phillips et al., 2006). Stayt (2007) even suggested that some deaths are more significant than others and when a strong attachment is developed with a dying resident, the nurse may feel that it is like losing a member of his/her own family.

A qualitative study of 203 staff working in six residential aged care facilities in the United States concluded that the staff that had worked in the facilities the longest and who had the closest relationships with the residents, were the staff that presented with the strongest grief related symptoms. The most common symptoms reported were crying, dwelling on thoughts about death, and feeling sad and upset. As such, the competence of the staff was affected negatively both at work and at home as the staff found it difficult to concentrate and move forward (Rickerson et al., 2005).

The purpose of Rickerson's (2005) research was to define the prevalence of grief related symptoms, among long-term staff caring for end of life patients. A cross-sectional survey was carried out at six organisations. All staff were asked to complete a survey to assess sources of bereavement support and establish if people used the sources available. Surveys were completed by 203/236 staff (86%) who described a wide selection of grief symptoms. Most staff (72%) reported at least one symptom.

Oberle and Hughes's (2001) findings from a qualitative descriptive study of doctors (drs=7) and nurses (n=14) indicated that caring for dying residents can be very stressful for both medical and nursing staff. They considered that both doctors and nurses are affected by observing residents' suffering at the end of life and they reported that they have a moral obligation to alleviate this suffering. A literature review by Georges and Grypdonck (2002) indicated that RNs caring for dying residents often fail to recognise the moral dimensions of the situations they experience.

Nursing, considered by some to be a moral practice, has different elements, and these usually include caring behaviours and the delivery of expert care and close relationships. These can lead to the delivery of excellent individualised care, which is the ultimate goal of good nursing practice. Georges and Grypdonck (2002) suggested that it is necessary for RNs to be supported not only to develop their end of life approach, but also to be assisted to reflect on their practice. These authors demonstrated the extent that loss and grief affected the RNs. The RNs felt that they lacked the power to solve conflict among family members. If the RNs were empowered to do this there could be more effective interventions resulting in a better quality of life for the residents.

Registered Nurses experience death in their everyday work and are often exposed to the emotional, intellectual and physical repercussions of grief (Rashotte et al., 1997). Yam et al., (2001) suggested that RNs often protect themselves from the effects of grief by engaging in physical care only and Stayt (2007) agreed. In Yam's study, 10 RNs were interviewed to determine their experience and views in caring for infants whose disease was not responsive to curative treatment. The RNs minimised their social interaction with the parents to avoid close relationships developing.

By disassociating themselves from dying residents, RNs may have an impact on the quality of the care delivered. Stayt (2007) reported that RNs sought protection by avoiding discussing sensitive issues as well as distancing themselves emotionally from dying residents. Stayt attributed the need for such a conscious 'grief avoidance' strategy to some RNs great difficulty or apparent inability to confront their own specific vulnerability and mortality. Stayt also noted that RNs distanced themselves from

families in the intensive care unit (ICU). This area has a high number of deaths, so from this point of view, has similarities with aged care facilities.

The dying process is usually experienced as a loss which begins the grieving process. This loss is perceived quite uniquely by individual RNs. Katz and Johnson (2006) suggested that some RNs work with people at the end of their life because they have experienced loss in their lives as well as deaths and other traumas. Even if a team is grieving over a given resident, in reality each RN will be grieving over a different aspect of the loss.

Registered Nurses' grief is a dynamic, intrapersonal and interpersonal process. Roos (2002) acknowledged that the loss of a significant person with whom there was a deep attachment, results in recurring grief and that RNs would benefit from becoming aware of their grief related feelings after resident loss. Because RNs build relationships with the residents as part of their working life, nurses occupy a unique position within the death process. Roos also wrote about chronic grief. This grief is sometimes called a 'living loss' because it does not go away. It is a pervasive and profound sadness. RNs frequently need support and encouragement in order to be able to deal competently with their challenging work as grief is a multifaceted response to a loss (Feldstein & Gemma, 1995).

Disenfranchised Grief

Registered Nurses, in residential aged care experience the reality of the dying process and the death of their residents as part of their professional practice. However as RNs are not related to their residents by family ties, they are not recognised as legitimate grievers, even though they may have been caring for the resident for several years. Doka (2002) called this 'disenfranchised grief'. He used this term to describe the process where RNs and others in a similar position are unable to openly grieve for a resident because this is not considered acceptable by society.

It seems to be believed by society that the relationship should not cause a RN a grief response. The RN needs to support the family in their loss but there is not always acknowledgement by the resident's family that the death is a loss for the RN as well. However, from my personal experience, very often the family is willing to allow the

nursing staff to grieve with them, and in fact appear to be comforted by this practice. Kaplan (2000) agreed with Doka (2002) and even went a step further by suggesting that losses that society consider insignificant, deny the bereaved the means to express their grief, thereby stagnating the grief process. Societal norms dictate who, when, where, how long, and for whom, it is acceptable for people to grieve over a death.

Doka (2002) suggested that there are three main categories of disenfranchised grief. The first occurs when the relationship between the deceased and the bereaved is not acknowledged. The second example of disenfranchised grief is where the actual loss is not recognised. A third category is when the person grieving is excluded from any involvement in the death, funeral or memorial activities.

Hospice staff found that increased workloads were making it very difficult for them to effectively grieve for residents (Stephany, 1989). Stowers (1983) noted that nurses exhibited sleep problems and irritability towards their own families because they had unresolved grief issues. Since this idea was suggested many years ago, the RNs' workload of dying residents has increased even further so this is a problem of even greater proportions today. Fee (2001) stated that it was beneficial for RNs to acknowledge feelings of grief, following the death of a resident, and that all health professionals need to learn how to competently manage a resident's death.

Empirical research has shown that chronic exposure to residents' deaths can be physically and emotionally harmful to RNs and can lead to cumulative grief (Cranswick, 1997; Hinds, 2000; Marino, 1998). Regular exposure to death means it becomes part of an RN's day and can impact on his/her work. Many RNs appear to accept grief as part of their role. Multiple encounters with death may mean there is no opportunity to grieve for each patient who has died. Because unresolved grief accumulates, this may have professional or personal ramifications.

Frequent exposure to death can lead to a profound sense of grief (Redinbaugh et al., 2001). Registered Nurses regularly exposed to grief were more likely to suffer despair and socially isolate themselves (Feldstein & Gemma, 1995; Rashotte et al., 1997; Yang & McIlpatrick, 2001). Marino (1998) described the effects of accumulated grief as including decreased professional competency and a pre-occupation with death. There

is also the aspect of complicated grief. There is considerable controversy about what might constitute complicated grief.

Generally, complicated grief appears to be when grief symptoms, similar to those seen in the first few months, are observed beyond the first year after a loss or bereavement (Rando, 1993). Registered Nurses are reluctant to seek formal support for grief issues but value talking with colleagues. Strong peer support was identified as enhancing the ability of RNs to cope with grief (Stayt, 2007). Some of the effects of grief for RNs can be alleviated through adequate support and intervention.

Nurses' Dissatisfaction

The literature suggests that some RNs are dissatisfied with their jobs and are emotionally exhausted (Backer, Hannon, & Russell 1994). Nursing research has linked chronic exposure to deaths to the prevalence of RNs leaving their profession (Backer, Hannon, & Russell 1994; Feldstein & Gemma, 1995). To minimise this adverse effect, and as the shortage of RNs is expected to increase in the near future, research examining RNs' grief experiences is essential (Buerhaus, Staiger, & Auerbach, 2000). For the sustainability of the service, obstacles to retaining experienced RNs should be minimised or preferably removed. Due to the trauma of frequent residents' deaths, some RNs chose to seek employment in other fields of nursing where deaths occur infrequently.

Registered Nurses can often recall the deaths of particular residents even after a lengthy period of time (Lapum, 2006; Savett, 2000; Stephany, 1989; Stowers, 1983). Lapum (2006) argued that the majority of RNs were able to recall their first death experience regardless of the amount of time that had elapsed since that event occurred. Demmer (1999) found that RNs were able to recall exact details about the dying residents who had been in their care. In many cases RNs could recall the actual number of resident deaths they had experienced.

To confront impending separation from loved ones, dying persons should be able to reflect on their life lived and to make meaning of it. They need to be assured of privacy, dignity, and access to any spiritual or emotional support desired. The dying person ideally needs to have time to say goodbye to their loved ones. Good palliative

care serves to relieve symptoms, enhance the quality of life and provide bereavement support, even as the resident is actually dying (Papadatou, 2000). When this situation is negative there is an additional impact on RNs.

The way the nurses expressed their grief can be influenced by the way the resident died. Ufema (2000) argued that RNs' grief was more intense if the resident's death lacked dignity. There is only one opportunity to ensure that residents die with dignity on life's final journey and nurses need to ensure that this happens. Registered Nurses obtain satisfaction when they feel that this is achieved.

Residents' Deaths

We all bring our traumas and experiences with us through life and we cannot predict how a death may trigger our emotions, thereby, potentially increasing the grief response. Nursing staff need encouragement to explore both their attitudes and values with regard to ethical, legal and moral issues surrounding 'end of life care'. End of life decisions are difficult to make. This was the conclusion of a grounded theory study of nurses (n=10), doctors (drs=5), and family members (Norton & Bowers, 2001). The conclusion reached was that the transition from unrealistic curative goals to realistic palliative goals needs to be made when residents are dying. This can be best made when RNs are insightful about their own perspectives on death and dying.

It is desirable that nurses do not merely copy the behaviour of their co-workers (Copp, 2006). In order to demonstrate effective palliative care practice, nurses require adequate education, support and resources (Katz et al., 2006). Katz concluded that inexperienced staff require a large amount of support when a resident dies and also need to be assisted in accepting a new resident entering the facility and taking the place of the deceased. Ongoing relevant education dealing with grief and loss issues is important for both new and experienced staff members. The development of support systems is valuable as studies show that grieving RNs need to have meaning for their resident's death (Lee & Dupree, 2008; Macpherson, 2008). Rickerson et al. (2005) stated that over 80% of staff used informal support mechanisms to cope with residents' deaths. These were mainly finding support by attending support groups or talking with colleagues.

Rickerson et al., (2005) published a research article about a quantitative study involving 203 staff working in six residential care facilities in the United States. They concluded that the staff who had worked for a longer time in the facilities experienced the most grief when the residents died. The majority of workers suffered feelings of sadness, constant thoughts about death and had frequent episodes of anxiety and crying. These symptoms impacted negatively on their well-being and their ability to perform well at both work and at home and their relationships with others were affected. In other words, their grief related symptoms affected their relationships, both professionally and personally. The study determined that 80% of the staff talked to their colleagues and friends to assist them to cope with the residents' deaths. In addition, some of the staff requested counselling services.

Cultural values

When a resident is dying it is important that they feel that their values and cultural needs are accommodated. The cultural values and beliefs of the resident and his/her family determine the expectations of quality care. Caring has spiritual, social and psychological elements as well as physical elements (Schwass, 2005).

Summary

In this literature review, a range of topics have been critiqued. The main topics included the concept of loss, aspects of grief, nurses' grief, ensuring a good death, and disenfranchised grief. The population of older people in New Zealand is estimated to increase markedly in the future. Therefore, it is essential that RNs are competent to deliver quality nursing care to residents in aged care facilities. As the older population increases, the requirements for both residential beds and nursing staff will presumably also grow and an increasing volume of residents will become palliative.

Registered Nurses experience grief when residents with whom they have established a relationship, die. When deaths occur the nurses need support and this is especially important when the death is unexpected. It is essential that people can make sense of the loss. Grief is the main response that nurses experience when the residents die. The level of grief is usually greater when a close relationship has occurred. The cultural values of the residents and their families need to be taken into consideration

when delivering care to the residents. The cultural differences among the staff should also be taken into account. A great deal of support needs to be given to immigrant nurses who decide to make New Zealand their new home. The following chapter will outline the methodology and the methods of data collection and data analysis within this study.

CHAPTER THREE: METHODOLOGY

Introduction

In this chapter I present the research design and discuss the methods used for this study. First, I will explain the rationale for the methodology chosen. Second, I will discuss the methods adopted for participant selection, data collection and data analysis. Third, the ethical considerations pertaining to this study will be considered. Finally, the process of establishing and maintaining rigour and trustworthiness will be discussed.

Overall Approach and Rationale

Qualitative research is a broad term and is useful in this context as it is both meaningful and important in the development of nursing knowledge (Streubert-Speziale & Carpenter, 2003). Qualitative descriptive research is a method of investigation (Sandelowski, 2000). The goal of qualitative descriptive studies is a comprehensive summary of events in the everyday terms of those events (Sandelowski, 2000).

The description in qualitative descriptive studies contains the presentation of the facts of the situation in everyday language. When producing qualitative descriptive studies the researcher stays close to the data and to the surface of events and words (Sandelowski, 2000). Descriptive research is a combination of sampling, data collection and analysis. Qualitative descriptive researchers “collect as much data as they can that will allow them to capture all of the elements of an event, to make it the event that it is” (Sandelowski, 2000, p. 336). Descriptive research is one of the most frequently used methodological approaches in the health disciplines (Sandelowski, 2000).

Methodology refers to the “plan of action, the design or process found behind the choice and the use of methods to achieve the wanted outcome” (Crotty, 1998, p 3). There are several qualitative methodologies available but the one chosen has to be an appropriate methodology for the research question. A qualitative descriptive

methodology was found to be a good fit for this study as a description of the nurses' experiences was one of the desired outcomes.

Qualitative descriptive research is the methodology of choice when descriptions of phenomena are desired and it is a valuable method in itself (Polit & Tatano-Beck, 2006; Sandelowski, 2000). This methodology is considered a valuable way to explore human behaviour (Sandelowski, 2000). Qualitative researchers collect data from the original source and then collect observations from those who have experienced the event. The researcher then makes interpretations of the meaning of the data (Sandelowski, 2000).

Qualitative descriptive research is a methodology that is more concerned with description than testing hypotheses. It does not require the researcher to move far from the data. It has been suggested that when descriptions of circumstances are required, a qualitative descriptive study is the best choice (Polit & Tatano Beck, 2006; Sandelowski, 2000). Sandelowski (2000) suggested that although qualitative descriptive research is used frequently it is not well described. It is argued that qualitative descriptive studies are based on the assumption that there is no one universal truth (Denzin & Lincoln, 1998; Schneider, Elliot, Lo Binodo-Wood, & Haber, 2003).

Sandelowski (2000) stated that the researcher is the essential person to enable the participants' experiences of phenomena to be shared. A qualitative researcher cannot be separated from the topic in question as he/she is influenced by previous experiences. Qualitative descriptive research is suitable for 'how' 'why' and 'what' questions about behaviour, motives and views. Qualitative description depends on the perceptions of the describer and the descriptions should show valid interview data (Sandelowski, 2000).

Methods

Methods have been suggested to be the procedures or strategies for gathering and analysing data in research (Polit & Hungler, 1997). The methods used in this study were purposeful sampling and semi-structured interviews followed by thematic analysis of the data. I used these methods as I considered they were appropriate for

this study. This section of the thesis will describe the participant selection method, the data gathering method, and data analysis procedures.

Participant Selection

Purposeful sampling was the method used to select participants for this study and was used to obtain in-depth knowledge about the phenomenon in question, namely RNs' responses when the residents died. The purpose was to obtain rich, detailed data. Streubert-Speziale and Carpenter (2003) defined purposeful sampling as choosing participants specifically because of their experience and their knowledge of the subject for the study. For these reasons this method permitted me to become familiar with the nurses' responses when the residents died. Purposeful sampling was an ideal method of selection for this study as the goal was to obtain an information rich sample of nurses who could provide a variety of perspectives on dealing with their responses when the residents died.

Sample selection needs to focus on what the researcher wishes to determine and the purpose of the research (Patton, 2002). The quality and the amount of data extracted during the interviews, not the number of participants interviewed for the study, determines the size of a purposeful sample (Patton, 2002). However the sample size in qualitative descriptive studies is normally small as the study involves in-depth interviews (Patton, 1990).

According to Burns and Grove (2001) the quality of the participants interviewed is the most important aspect of a sample collection for a qualitative study. The usefulness of the data and the reason for the research are also important (Patton, 2002). The interviews are completed when data saturation occurs. This means that no new information is forthcoming (Polit & Tatano- Beck, 2006). A total of 10 RNs were sought for this study. The particular participants were chosen because they met the inclusion criteria which stated that they had to be RNs who had worked in an aged care facility for a minimum of two years and had a current practicing certificate. The identity of the participants was not disclosed in the study and the participants were given a number.

The RNs were keen to be part of the study and they also had experience in their field of gerontological nursing. When I commenced the study I did not set out to recruit

immigrant nurses particularly, but these were the RNs who chose to take part in the study. The participants reflect the staffing mix in residential care facilities today. Recruiting these RNs from overseas countries was a positive move as it provided an important insight into the difference in cultural perspectives towards death and dying. The table presents participant's ethnicity, age and qualifications. All the participants in the study, were female.

Table 1

Registered Nurse Participants in Research Study

Ethnicity	Age	Qualifications
Chinese	2	20-30 years: 4
Indian	2	NZ Registered: 9
Filipino	5	30-40 years: 3
Zimbabwean	1	40 plus years:3
		Overseas Registered 1

Data Collection

The data for the study was collected by means of semi structured in-depth interviews. The purpose of an interview is to collect data which is suitable for analysing at a later stage (Patton, 2000). The ability to develop good interviewing techniques is very important, because the depth and the quality of the data will depend to a large extent on the researcher's skill and competence in drawing out information from the participants (Patton, 2002).

It is important to be sensitive during the interview process (Polit & Hungler, 1997). It is also important that the participant's right to confidentiality and privacy occurs during all study procedures (Polit & Tatano-Beck, 2006). Confidentiality and privacy were met by providing personal, private interviews, giving the participants a participant number and assuring them of data confidentiality. Qualitative description depends on the perceptions of the describer and the descriptions needed to illustrate valid interview data (Sandelowski, 2000). The participants for this study were invited to choose the location where they wished to have their interviews. The nurses requested that the interviews be conducted in their own homes. The individual interviews were semi-structured and the questions were open-ended.

Open-ended questions are used to encourage the person being interviewed to answer the questions in their own words (Polit et al., 2001). (See Appendix 4). For this study the open-ended questions were decided in advance. These questions were available to guide the conversation and a second purpose was to encourage the participants to share their experiences. The questions were not strictly adhered to in the interviews but merely used as a guide. The questions were constructed to keep the participants focused on the topic whilst not moving them in any particular direction.

It is important to keep the discussion on relevant topics (Langridge, 2007; Smith et al., 2009). An inferior quality transcription and subsequent analysis is the end result if an interview is inadequate. Open ended questions enable a researcher to understand the participant's world. There are, however, some limitations with regard to how much knowledge can be gained by what people say in conversation. The researcher needs to get close enough to the person being interviewed and the situation being studied, to enable him/her to understand all the details.

At the commencement of the interview there was some informal discussion to ease any anxiety the participant may have felt. It was explained to the nurses that any identifying material in the writing up of the study would be disguised so that there was no possibility that the individual participants could be identified. In the interviews the participant RNs were encouraged to describe, with as much detail as they were able to contribute, how the deaths of the residents affected them. The interviews were held face to face. This method of interviewing has the advantage that the researcher is able to observe the body language of the participant during the interview.

Davidson and Tolich (2003) suggested that the greatest value of this method is that the interviewer is likely to obtain more relevant and in-depth information when using this approach. Berg (2001) stated that interviewing may be defined as a conversation, the primary purpose being to collect information. The interview should be reflective and provide a degree of insight into a life event. Berg suggested semi-structured interviews facilitate the sharing of information, guided by a particular focus. The interviewer is then able to delve beyond the obvious answers to the suggested question.

As suggested by Hsieh & Shannon (2005), all of the interviews were audio-taped and transcribed verbatim by the researcher. This was a useful exercise as the researcher then became very familiar with the data. The audio-tapes and transcripts were reviewed and replayed and the information was accurately documented. Participants' consent was previously obtained for this procedure. Each transcript was read carefully identifying how the participants answered the questions. The purpose of this was to find similar characteristics from the participants' experiences, as described by (Ulin, Robinson & Tolley, 2005). I transcribed the audio-tapes and ensured that the context could not be related to any particular participant. Data saturation is essentially sampling until no new information is available (Polit & Tatano -Beck, 2006). In this study, saturation was reached as the RNs' responses to the deaths of their residents became similar, from one interview to the next. Ten interviews with RNs working in residential aged care facilities yielded sufficient data to reach saturation.

Data analysis

The interviews yielded direct quotations from RNs about their knowledge, feelings, opinions and experiences. The raw data was then organised into major themes and categories. Examples were extracted through analysis. The themes and patterns then become obvious. The themes were analysed until only a small number of core themes remained.

Thematic analysis was the method of analysis used for this study, and is possibly the most commonly used form of analysis (Braun & Clarke, 2013). Braun and Clarke's (2006) version of thematic analysis was used for this study. Thematic analysis is really 'just a method' (Braun & Clarke, 2013). It can be used to analyse almost any kind of data and can be applied to the data in various ways from experimental to critical analysis and is a useful tool for novice researchers. It can answer almost any question and it is flexible in terms of framework, research questions, methods of data collection and sample size. According to Braun and Clarke (2013) despite these qualities, however, some qualitative researchers consider that it lacks substance, definite guidance and the method does not provide continuity.

Thematic analysis is a commonly used qualitative analytic method (Boyatzis, 1998; Roulston, 2010). It involves the collection, coding and the analysis of data (Denzin & Lincoln, 1998). Ryan and Bernard (2000) consider that thematic coding is a process found within other methodologies rather than a specific approach in its own right. Despite this, thematic analysis can produce detail rich data. The process of analysis for this study was to record the data and listen to it many times to familiarise myself with the information. Coding across the dataset searching for specific themes, reviewing, defining and naming these themes, then writing and finalising data. This immersion in the data assisted me to become familiar with participant's stories.

Thematic analysis is useful for identifying, analysing and reporting themes and patterns within the data (Boyatzis, 1998). However, although it is a frequently used method there is little information about its use (Boyatzis, 1998; Tuckett, 2005). All theoretical frameworks carry assumptions about the data. The description of the phenomenon provides the framework for the analysis that the researcher interprets (Merriam, 2009).

The analysis of the data commences when the researcher is first looking for ideas about the study topic. The analysis continues whilst the participants are interviewed. The verbal cues were observed and noted. Schneider et al. (2003) suggests that in the interviewing process non-verbal cues are not always acted upon and it is important that they are recorded as soon as possible after the interview. The non-verbal cues were recorded as soon as possible after each interview while they were fresh in the researcher's mind and they could be recalled readily. The researcher was conscious of her own assumptions, presuppositions and biases.

Thematic analysis is grounded within the data and this leads to the development and refinement of the themes. Recognising themes from the interviews is an important part of the data analysis. The analysis of the transcribed interviews uncovered a number of common themes. It is difficult to evaluate research if it is unclear how the data was analysed (Altride-Stirling, 2001). The analysis procedure includes verification.

The researcher looked for patterns in the data and then confirmed them. The diagram following illustrates these patterns. Berg (2001) described verification as a process

containing two sections. The first makes conclusions from the obvious patterns in the data and the second is the confirmation of those patterns. Lincoln and Guba (1985) suggested that data analysis is a process where the researcher makes sense from the data. The volume of data has to be reduced to a manageable amount (Neuman, 2003). Data is required to be subjected to analysis to ensure that the richness of the data is not reduced (Schneider et al., 2003).

Table 2

Methods Used for Processing the Data

Step	Process
1	Interview = observation of non-verbal data
2	Listening to audio-tape + writing a summary of the interview
3	Transcribing the tape
4	Listening to the tape = reading the transcript
5	Focusing on the research question
6	Beginning the analysis = highlighting the key points
7	Reading the data
8	Analysing the data = identifying initial codes
9	Analysing the data = organising into clusters
10	Analysing the data = identifying themes
11	Analysing the data to further refine the themes = deciding on four main themes

Initial codes

Coding is a part of analysis (Miles & Huberman, 1994). Coding is the process of identifying aspects of the data that relate to the research question. Codes that appeared in the study were grouped with the corresponding stories. The stories described aspects of the participant's experience of the phenomenon. The codes were placed into categories. Categories of responses and emerging patterns were then coded from the data. The reason for this was to obtain a sense of the participants' experiences. Concepts were put together to demonstrate core categories of responses. Combining categories into groups that can capture the codes is recommended by Hsieh and Shannon (2005). General themes in the data were identified and integrated by the researcher.

Themes

A theme captures something important in relation to the research question. Themes are broader than codes. Developing themes from coded data is an active process. The researcher examines the codes and the coded data and creates patterns (Taylor & Ussher, 2001). In order to identify themes one needs to review the codes and the data related to the codes and identify similarities and overlap between codes. When developing themes, one needs to consider them on their own. Also themes need to fit together to form the overall analysis.

Codes were collated into themes and all data were organised so that it related to the potential theme. The themes developed from the meanings that the participants attributed to their experiences contained in the data. I analysed each transcript and highlighted key words. Many initial themes emerged from the participants' statements and among them were; stressful situations, physical and emotional support, pain free residents, peaceful deaths, peer support and different cultures. By examining how frequently the same theme was mentioned in the interviews demonstrated how important that issue was to the participants.

A number of common themes were discovered in the study. The researcher reviewed the themes and looked at where they appeared to be best placed along with the other extracts. Data was reconsidered for relevance to the themes (Hsieh & Shannon, 2005). Defining each theme involved identifying it by name, by using a process of ongoing analysis and by clarifying each theme. I decided that there were four main themes: the different cultural perspectives of dying, experiencing a sudden death, nurses' grief, and the support available to nurses when residents die.

Table 3**Example of Analytic Path: Theme: Different Cultural Perspectives of Dying.**

Codes	Clusters	Theme
Dying at home Constant flow of visitors Saying goodbye Prolonging life Wanting loved ones around you Telling traditional stories Paying what it costs	What's it like at home.	Different cultural perspectives of dying
Relatives/family present Ensuring person's comfort Being there day and night	Caring for the dying person	

Ethical Considerations

To ensure a high level of ethical conduct in the research the ethical principles developed by the Auckland University of Technology Ethics Committee (AUTEC) were considered and applied throughout the research design. As the researcher, I acknowledged that I would adhere to the ethical principles as they related to the research integrity and to the participants taking part in the study. A comprehensive range of ethical issues were integrated into the study design. Approval for the research study was gained from AUTEC (refer Appendix 1). All participants were able to view this documentation.

Participation in this study was voluntary. Once the participants acknowledged that they were interested in the research, a participant information sheet (Appendix 2) and a consent form (Appendix 3) were given to the participants and the consent form was signed. The information included the phone numbers of a designated person at AUTEC and the participants were able to contact this person if they had any concerns about the study. Participants who volunteered to take part in the study were also informed that they could withdraw from the study at any time without repercussion, if they wished, and their data would be destroyed.

The identity of the participants was not disclosed in the study and the participants were given a participant number. I transcribed the audio-tapes and ensured that the context could not be related to any particular participant. Whilst the goal of the research was to advance knowledge it was also important that the rights of the participants in the study were ethically protected. The participants consented to participate without any coercion. They were assured of data confidentiality and also confidentiality in the reporting of the research.

A requirement of confidentiality is that the identity of the participants should not be connected to the information they provide for the study (LoBiondo-Wood & Haber, 1994). The information sheet provided for the participants ensured that they were well informed about the benefits and the risks that could occur as participants in the study. The RNs were offered the opportunity to ask questions and to discuss any issues and concerns they might have regarding the study. The interviews were carried out with enthusiasm as the nurses were keen to share their thoughts and feelings about death and also to discuss the dying experience as it occurred in their facilities.

They were asked to give specific examples of responses that had particular significance for them and to recall incidents and particular residents that had made a lasting impression on them. The nurses said they felt being able to talk about their responses when their residents died was beneficial to them and they appreciated their input being included in the study. The ethical principles itemised below were part of the ethical preparation for the research.

Beneficence

This principle includes freedom from harm and exploitation (Polit & Hungler, 1999). Beneficence means that the researcher should ensure that the participant is treated with respect and in an ethical manner (LoBiondo-Wood & Haber, 1994). The participants' right to privacy and confidentiality should be maintained during all study procedures (Polit & Tatano-Beck, 2006). The ethical principles were integrated into the study design and no physical harm came to the participants.

The participants were able to discuss any aspects of the research they wished and were able to contact me, by telephone as they were given my contact details.

According to the principle of beneficence the participants not only need to be protected from harm and discomfort but should be given as many benefits as possible (Burns & Grove, 2001). Each participant in the study was treated with respect and dignity.

Justice

This ethical principle is regarding the participant's right to be treated equally and fairly (LoBiondo-Wood & Haber, 1994). All 10 RN participants were treated fairly, and each was given the same rights and information about the research study, including the option to withdraw without negative consequences.

Do No Harm

Participants were informed at the beginning of the interview that a counsellor from Auckland University of Technology was available, at no cost, if required. The venue for the interview was at a place of the participant's choice. The participants were informed at the beginning of the interview that if they felt uncomfortable at any time, the interview would immediately cease. Research processes need to ensure that they do not cause psychological or physical harm to the participants. As this research concerned a sensitive subject the effects of both recalling and then sharing emotional experiences was unpredictable.

Human Rights

Another ethical principle was maintaining the human rights of the participants. This includes the right to full disclosure (Polit & Hungler, 1999). This was demonstrated as the participants were able to decide whether or not to participate in the study. The participants were protected by ensuring that the right to anonymity and confidentiality was followed.

Maintaining the anonymity of the participants was assured by initially referring to the participants by numbers. As a means of further protection and to prevent identification of any participant, direct quotes were not identified when the tapes were transcribed. Research interview notes were only available to the supervisor and the researcher and the consent forms were stored in a locked file in the supervisor's office. Data stored on the computer were secured with an electronic password. All data pertaining to the

study will be stored for a period of six years in the supervisor's office. Documents will then be shredded, by the supervisor, to maintain long term confidentiality of the participants.

Informed Consent

Informed consent is possible when the participants have sufficient information about the research. The participants are able to understand the information given and are enabled to either participate or decline participation in the study, according to Polit and Hungler (1997). The participants in this research study felt that they were given adequate information about the study. Questions were encouraged and all the participants gave written consent prior to data collection.

Rigour and Trustworthiness

Rigour is the means by which the researcher is able to demonstrate competence and integrity in the research process (Tobin & Begley, 2004). It is very important to establish and maintain rigour and trustworthiness in any research. Qualitative researchers should present results that are both valid and reliable. This is to illustrate the trustworthiness of the research. Trustworthiness is the name used when qualitative data is evaluated and assessed by the standard of credibility. Data analysis included categorisation and the themes were classified. Finally patterns were identified and the research question was revisited (Davidson & Tolich, 2003).

Credibility

Credibility relates to the trustworthiness of the findings and is the "overarching goal of qualitative research"(Polit & Beck,2010,p.492). Research is considered trustworthy if the results are credible. Credibility refers to the truth of findings as judged by the participants and others. According to Lincoln and Guba (1985) credibility can be established when participants can recognise that the experiences being described are in fact the participants' own experiences. The contribution from all the nurses was included in the study. Their thoughts and concerns were listened to attentively and respectfully and were also included in the study. I asked the participants to contact me if they had any issues about the study.

Transferability

Transferability affects trustworthiness and refers to the generalisability of inquiry. It concerns whether or not the findings of the study can be transferred or generalised from a sample to the whole group (Holloway & Wheeler, 2000). For this reason, the researcher should detail adequate information about the study setting, the participants and the procedures. This enables the reader to decide whether or not the study can be applied to a different context. The sample group was purposeful. As the researcher, I selected participants for this study on the basis that they fulfilled the requirements of the research with regard to experience and qualifications. Transferability is closely connected to dependability.

Dependability

Dependability relates to trustworthiness. It is another way of demonstrating rigour in the study. It is attained through the process of auditing. Dependability occurs when the researcher provides an adequate amount of information, which enables others to follow the decisions made in the data analysis process. In this study, there is a step by step process determining the initial reason for commencing the study, establishing a research question, choosing the methodology to be adopted and collecting, analysing and processing the data. The researcher's risk of bias during the data analysis stage would be minimised if this process was carried out through external checks to allow the process to be transparent. Holloway and Wheeler (2000) suggested that if acceptable standards are followed then the study will be found to be dependable.

Confirmability

Confirmability relates to trust and means that the data is linked so that people can determine that the interpretations and the conclusions are established (Holloway & Wheeler, 2000). It ensures that the researcher has not misrepresented the findings (Polit & Beck, 2010). Confirmability relates to the objectivity and evaluation of the data. Sandelowski (2000) and Polit and Hungler (1997) suggested that confirmability focuses on the characteristics of the data. A useful audit trail can demonstrate the confirmability of the data if evidence is provided for an inquirer to follow the procedures

made during the inquiry. Rigour was also recognised by confirmability. All data and analytic notes have been kept in a password protected computer file.

Cultural Sensitivity

As this research is taking place in New Zealand, the implications of the key principles of the Treaty of Waitangi should be considered. The conduct of this study was guided by the principle of partnership (which is working together with iwi, hapu, Whānau and all Māori communities) together to provide care for older persons. Partnership and participation is the involvement of Māori in all levels of care. Protection is supporting cultural differences and respecting cultural ways. Protection was ensured in this study by the signing of informed consent.

Although this study does not directly involve Māori participants, the principles of the Treaty of Waitangi are relevant as the treaty does not only apply to Māori/Pakeha relationships. It also applies to relationships with all immigrant groups. Except for the Māori, all people in New Zealand, or their ancestors, are immigrants. This particular study involved participants from different cultures.

Auditability

The concept of auditability is closely related to dependability and pursues a consistent trail of data collection, data coding and data analysis as outlined previously. This simple procedure ensures consistency in the researcher's approach (Burnard, 2004; Patton, 2002; Sandelowski, 2000).

Summary

In this chapter, a discussion of the methodology and the method employed in the study and its relation to the research question have been presented. Qualitative description was the methodology chosen for this study. Qualitative description research is the method of choice when descriptions of phenomena are desired (Polit & Beck, 2001, Sandelowski, 2000). The qualitative descriptive research methodology has been explored. Issues regarding ethics, sampling, selection of participants, data collection, data analysis and the rigour of the study have been presented. The ethical principles

developed by AUTECH were considered and applied throughout the research design. The following chapter presents the findings of the study.

CHAPTER FOUR: FINDINGS

Introduction

This chapter presents the research findings of the study reported in this thesis concerning the responses of RNs when the residents die. In data analysis, I identified four main themes; namely 1) different cultural perspectives of dying, 2) experiencing a sudden death, 3) nurses' grief, and 4) the support available to nurses when the residents die. Themes that were analysed are reported, together with the words the nurses used to communicate their experiences. The 10 RNs interviewed were from different ethnic groups and had been working in residential aged care facilities for at least two years. For the purposes of maintaining confidentiality, the participants were given a number from 1-10. For example, (P 9).

Theme 1: The Different Cultural Perspectives of Dying

“How you think about death depends on your culture and your religion” (P10). All of the participants in this study were of diverse cultural backgrounds. In comparison with their home countries, these nurses found several aspects of death to be quite different in New Zealand. In their home countries, people generally died in their own homes or in the homes of their families but not in residential care facilities. Participants' stories point to a somewhat difficult journey of getting to know the differences between their experiences at home and those in New Zealand. These included learning that in NZ we allow people to die peacefully, finding the aloneness of some deaths difficult, taking in cues of imminent death, experiencing not knowing how to talk to resident's families at the time of the resident's death and learning skills by watching their colleagues.

“In my country we look after our elderly at home. Hospitals are used for acute care not for long term continuous care” (P5). The participants noted the difference in collective family cultures and individualised Western family cultures. The notion of separation from family was an unusual concept for them.

“In my country the extended family would support someone that was unmarried. They would be taken in and cared for. It is different here” (P5). This participant also thought it was very unusual for someone not to have any family support. “I never thought that

anyone would say they didn't have any family and thought that was very strange. Wondered what would be going on in that family" (P5). In some of the participants' countries if people were acutely or chronically ill they would always be admitted to a public hospital for treatment. The reason for this was the fact that families wanted their relative to live as long as possible and, in their view, the more treatment available the more positive the outcome.

In their own countries not only family members, but even slight acquaintances would visit the dying person to pay their respects. The person dying would have many more visitors in their own country than they would be likely to have in New Zealand. "I've noticed that here, it is not like at home where lots of people come to visit 24/7, as much as possible" (P6).

Cultural Differences and Similarities

From a cultural perspective the nurses reported that ideally the family would be at the bedside to give comfort to the dying person, as the nurses considered this was an important aspect of providing quality care. The attitude towards death and dying of many of the residents and their relatives in New Zealand was different from the attitude the participants had previously experienced in their home countries. In their home countries even when death was imminent, extraordinary measures were often taken in an endeavour to keep the dying person alive for as long a time as possible.

The findings here point to cultural differences and similarities. The participant is comparing the norms of her new country to the cultural norms she grew up with. "In my country people do everything possible, even sell the house, to have enough money to do everything possible to keep the dying person alive" (P10). This participant explained that in her own country it was considered preferable to prolong life for as long as possible regardless of the quality of the life. Participants compared their home country experience with the New Zealand approach and perceived, as they gained experience, that this might just be a better way to consider dying. This development however did not appear to be easy and they viewed this approach with some trepidation and difficulty.

Biggest difference between here and my country
is here, we let them go. In my country we don't

want to let them go as we want to prolong life. The main objective is to try to keep people alive as long as possible. Here in New Zealand I think it is better. There are lots of issues surrounding death. In my country it was all about saving lives, here it is about letting go. Now I really realise that death is part of life. I really understand that now. I found the first few deaths really hard, now I am used to it. We just have to make people comfortable. (P6)

A participant gave this example. She is talking about relationships with residents and the memories in relation to some residents. This resident had left a lasting impression on this RN. Significant here was the close relationship and the 'knowing' of each other. Significant also were what was noticed for example, 'death' eyes.

One lady was smiling in the morning. You could see though that she would die soon by her sparkling 'death' eyes. I often think of her. You know how the 'death' eyes are? She passed away in the night. She knew my name and she loved me. I'll always remember this lady. (P6)

Points of Difference

In New Zealand, the process of death and dying was different from that to which the nurses were accustomed. Because it was a different experience for these RNs they initially found it challenging to discover how 'end of life care' was managed in New Zealand. They were accustomed to a considerable amount of family involvement when people were dying. This participant educated herself by watching other staff to see how they dealt with the deaths of their residents. This was not an ideal way for her to be educated. It would have been more effective if she had worked alongside another RN. She wanted to learn how to deal with deaths in New Zealand.

When I first came to New Zealand I did not know what to say to families. I was watching other staff so that I could learn how to manage deaths. I was scared when I experienced my first death in New Zealand. In my home country I worked in a

medical ward and saw many deaths but that was in an acute care setting. (P3)

Most of the RNs reported they felt more comfortable if the family was present when their relative was dying. Having the family present reassured the RNs as it was a practice familiar to them. The presence and the support of the family was seen as both therapeutic for the family and essential for the majority of the residents. The RNs reported that they liked to have reassurance from the family that the care provided was exactly the care that the family wished their relative to receive. They also reported they preferred that decisions were made with the resident and the family whenever possible, to eliminate regrets at a later stage.

I feel uncomfortable if the family is not there when the resident is dying. I think this is to do with my culture or my beliefs or my personal preference. When I am on my deathbed I would want the people I love there. So I feel sad when someone is dying and there is no-one there. I'm not saying my culture is different but when you contact their daughter, or their son, the family often do not come and they don't actually care and we can't contact them at night, they just say to ring them in the morning. I feel really bad about this. My dad if he was dying, well I would be there day and night so I feel really, really sad. There are those families that we only see when their mother or father is dying or is dead, and that really bothers me. I feel awful... It is my personal belief. I suppose there could be some reason that I am not aware of, but yeah. (P7)

I consider that the provision of appropriate end of life care for people of different cultural groups means that RNs always need to be sensitive and caring when dealing with another person's beliefs and/or values. Several of the RNs were scared when they witnessed their first deaths in New Zealand. One RN stated that she did not know what to say to the family members when their relative was in the process of dying. Nor did she feel competent to manage a death. Another RN found the first deaths emotionally difficult but in time and with more experience had become accustomed to

the reality that people were going to die. The RNs realised that their main aim was to ensure that the residents' journey towards their death was made as peaceful and as comfortable as possible.

Some of the residents in residential care facilities had different cultural backgrounds from New Zealanders so the immigrant RN had not only to be integrated into their new country and its culture, but at times they also provided care for residents from other ethnic backgrounds. The RNs managed this challenge by communicating with the families and asking them what they ideally wanted to happen when their relative was dying. From the RNs' perspective it was important that the family was satisfied with the care given to their relative. "As we have residents from many different cultures we check with the relatives on admission as to what they wish to happen when their relative is dying or dies" (P1).

In general, the immigrant RNs felt that the New Zealand culture was more accepting of death, when it was inevitable. A discussion about death is taboo in some cultures. The participants reported that some staff members endeavoured to distance themselves from people when they were dying. A fear of death was talked about by one of the RNs. For this RN, death was based on traditional stories that she had heard while she was growing up and she was still affected by them. The stories had made her quite anxious about people dying.

When someone dies, some of the caregivers won't touch a dead person. They have different cultural beliefs. Some even distance themselves when the resident is dying. In my country, in my nursing, I never had a death on my shift. I'm scared of the morgue, I'm scared of coffins but then I think that when my grandmother died in front of me then that was it really for me. We see a lot of family deaths in my country because when someone is dying the family members all gather around. You can remember what it was like when you were a new graduate. It was really scary. We tell a lot of ghost stories in my culture. That is part of death for us. Maybe that's why I found it so scary. A lot of our traditional stories have people coming back from death. My fear came with me due to the scary

stories I heard. Death is a taboo subject to discuss in a lot of cultures. (P9)

Theme 2: Experiencing a Sudden Death

The nurses who participated in this study reported that they found a sudden death traumatic. The loss experienced by nurses when a resident died suddenly, can often be emotive. The nurses felt more comfortable when they knew that someone was dying and the death then followed a predictable pathway. They knew what to expect. They reported that a sudden death was always difficult to manage because it was always unexpected.

In several instances, the resident had appeared well, had just finished a meal, talked with the staff, then suddenly collapsed and died. The nurses stated that they felt both sad and shocked. They experienced sadness in the examples they gave because they had built relationships with the residents and had not expected them to die. One nurse gave the example that she went in to check on a resident only to find he had died. She said she was extremely shocked.

Last week we had a resident who died suddenly. He appeared well, ate his lunch and chattered to the staff. He asked to go to the toilet and when he was there, he collapsed and died. The resident was a new admission. We were shocked. As a team we work really well together. If you think that you might have made a mistake and you talk with your colleagues and they say "That's ok, don't worry" you feel better. (P4)

The RNs were more comfortable when an expected death was imminent because they anticipated what was going to happen. They could then put suitable measures in place to successfully deal with the anticipated situation. They felt happy when they could communicate with the family and carry out the family's wishes competently.

Well um, if it is an unexpected death it is worse it is always hard when someone dies. I pray for them if it is expected but if it is an unexpected one it is really difficult. "For me you see someone deteriorating you do your best."

It was important to the nurses that the resident had what they termed a 'good death'. This was unable to occur when the death was unexpected and sudden as the nurses were not prepared for the event. "A resident of mine, a really nice person, collapsed. She seemed ok but she suddenly died. I don't think she even knew it was happening. It was hard to believe she had gone" (P5). When it was suggested to a nurse, that a certain resident's sudden death was a relief because the resident was now at peace, the nurse did not really agree.

Actually I am not upset normally, but it is a sudden death that is upsetting, you are not expecting the person to die. Some people would say that it is good that as they have died there is no more suffering. They are at peace. I witnessed a death in Australia. This lady was breathing normally but then she just died. (P10)

Every death is a different experience - not the same. Especially if you have got to know them for a long time I feel sad. Just recently we had a resident who came into the facility and was just here for a day when she passed away. So there was no chance of getting to know her or her family. So yes there is no chance. You feel sad, just the fact that you lost the resident. Of course it is different if they are in a lot of pain because we want them to die with dignity. So we give them as much comfort even when they are dying. The caregivers are sad as well. (P7)

The RNs were obviously affected by sudden deaths and talked about them at length. Because the deaths were not anticipated the nurses were unprepared for their resident to die and the death seemed to affect the participants more deeply.

Sudden deaths, as previously mentioned, had the greatest impact on the RNs. They recalled these deaths with clarity even when the resident had died many years earlier. Deaths affected the staff differently when the resident had been in the facility for a long time or if the staff was emotionally involved with the resident. The RNs often found these deaths distressing.

Not Doing It Right – Reflecting on care

When a sudden death occurred the nurses felt guilty. On reflection, they wondered if they had missed something. They felt that their assessment of the patient was perhaps inadequate. Perhaps they may have been responsible for the resident's death as they had not noticed any problems and therefore did not seek medical intervention.

“The sudden death that I experienced happened so fast, but it gave me an opportunity for a discussion with other staff and now I feel stronger and more competent” (P4). I think you maybe need someone to talk to, if someone passes away unexpectedly you feel guilty. What else could I have done? It is nice, as well as a bad feeling when they die” (P6). They felt that they had not done things right. Even when the RNs were reassured that the death was not their fault some of the RNs were not convinced that this was correct. Several participants said they reflected on their practice and their level of competency especially after a sudden death.

The nurses found reflection practice gave them reassurance. After a sudden death, when the RNs discussed the death with their peers, the discussion enabled them to feel stronger and more competent, according to their feedback. Some of the RNs commented that communicating with each other was always beneficial. When death is talked about in honest open communication, fear and anxiety are replaced by understanding and acceptance. One RN actually called in her manager, seeking support, as she was very upset when her resident died suddenly.

I went into the room to check on this man and I found that he had died. It was such a shock. I rang my manager straight away and she came in to see me. I was very upset. She made me feel really supported. I think that if ever you feel that you just cannot manage you should talk to someone (P.8).

Although some nurses stated how useful it was to communicate with each other following the death of a resident, not all of the staff chose to do this. It was reported by some participants that some of the staff preferred to just carry on with their work when the resident died, and they acted as if nothing untoward had happened.

Theme 3: Nurses' Grief

The RNs often felt sadness and distress when the residents died, especially if a close relationship had developed between them, as good relationships were very important to the RNs. "When our residents' die I feel very sad although I feel more distressed when I have built a good relationship with the resident. I talk with colleagues and the family of the deceased resident. The caregivers need support as well" (P1). Therefore, when the relationship was close, a death was a sad experience for all the staff concerned.

It depends. Sometimes if you see them suffering you wish you could do something but sometimes you can't. You wish you could breathe for them. It is different for long term residents. I've been working here so long, maybe for too long. After you walk past the room you think of them for a while, but then you forget. (P1)

It is important to the nurses that the residents are kept comfortable and without pain and as noted in this participant's story the opportunity to have time with the resident and their family was satisfying. "I like this work because you have more time to spend with the residents and their families" (P2). In contrast however, another participant reported limited time and indicated the task oriented focus of her work. "Sometimes I forget when I am so busy but most of the time I pray for them when they are dying. Sometimes I think we are too 'task' orientated. Better to spend more time with the residents" (P8). Regardless of the comparisons, the RNs reported the value of spending time with residents. Losing a resident causes grief for the RNs but if the resident has been in pain the RNs find the death easier to accept and at times are even relieved that the resident is now pain free and at peace. "Sometimes they still have discomfort. I am always relieved when the resident has died pain free" (P.2). Participants also reported praying for residents who were dying. "I actually pray for my residents when they are going down" (P10).

...most of the time you build a good relationship with the residents. Losing them is not easy to deal with. It's sad but if they have been suffering it is

also a relief. It is quite different if you have bonded with them. Know the families, know everybody. When they die it is quite dramatic and traumatic. If someone is only there for two or three days you feel sad but it is not the same. (P5)

Generally speaking, long term residents' deaths lead to the most grief for the RNs. The participants reported quite deep sadness and the loss of the relationship not only with the resident but with the family. They also reported the longevity of that grief. It was really sad and it took me a long time to get over that. It was about a year ago. I still think about it" (P8). Currently, the majority of residents are quite unwell when they come into care and they are often in the facility for a relatively short time. As a consequence of this there is a constant movement of residents within aged care facilities. Therefore, the RNs are constantly building new relationships with residents and their families.

You work with residents maybe for a year, you get involved then the person dies. The staff will talk about the person for maybe two days after they die because you are attached to the resident. "It is different if someone just comes and goes. You are not attached and not really close to the resident." (P3)

We had an incident when a lady got very sick and the family wanted her to go to the hospital. She didn't want to go. She wanted to stay with us. She soon died in the hospital. The family told us that she was begging to come back to us but it was too late. (P8)

I feel sad because you are attached to them for a long time, they are with you every day, they have a routine and then they die. I feel sad and sometimes I get emotional as well. I don't like to feel emotional. It's not like I'm ashamed but I don't like it. Sometimes the family is so close to you it is so sad. But the family sometimes you just want to give them that moment. Tell them good memories 'Your mother was a good lady'. 'Your father was a good man'. After I talk to them I give them space. (P6)

While there is sadness at the loss of the relationship and the presence of death, participants also reported relief, particularly when pain was not relieved. Participant (4) reported many emotions. This participant also alluded to the notion that unrelieved pain and discomfort was not an isolated situation in the facility where she worked. On the whole however, the participants indicated that they came to accept the presence of death in their work life.

I get fond of them like part of your family. They are always there, but most of them take a few days to die and they suffer and have pain, but when they pass away I have a sense of relief. When the families are there and they are crying I feel sad. There is also relief that it is all over. I comfort the family and tell them when you are ready I'll talk with you about the funeral arrangements. (P4)

When I was a new graduate I used to feel really sad and get attached to the residents. When you have experience it's not like you don't care, you just learn to cope, I think. I also think it is best to leave the family to grieve together. Sometimes I feel overwhelmed when the family is very upset. I just feel like I want to comfort them to take their pain away. (P4)

On some occasions the nurses' grief was deeper. When a resident had no family or no contact with their own family, the nurses become the 'family'. This magnified the nurse's sense of loss that was experienced when the resident died.

First Experiences of Death

The first death that the nurses experienced was a traumatic event for most of the participants who were interviewed for this study. The fact that death was viewed differently in the home countries of the RNs compounded this issue. Inexperienced nurses reported feeling scared and overwhelmed when they were new to the experience of people dying in New Zealand. This was largely because the systems in New Zealand were different from the systems they were familiar with in their own countries. It was a learning curve for them.

When I saw my first person die in New Zealand I didn't know what to do. I was scared. New Zealand culture is quite different. All of the family members were there and it was difficult to support them. Don't know what to say. In my own country people die at home. All of the family helps so it is quite different. Now it is usual for me. I know what to do. Know the procedure. (P3)

In time, they became more confident as they watched and listened to other nurses speaking with relatives. The nurses preferred to receive support from their peers rather than seek assistance from their management team as they felt able to confide in their colleagues without feeling that they were being judged or criticised.

The nurses tended to manage residents' deaths competently when they became familiar with the death process in New Zealand. There was often a feeling of relief when the resident died especially if pain had been difficult to control. However, all of the nurses expressed feelings of sadness when the residents' died. This RN discussed her experiences when residents were dying.

Actually we see the signs of death approaching, you know the death visions. I myself, I sit down with the resident and hold their hand and sort of reassure them. If the person is afraid you see that in their eyes. They wonder 'Where am I going?' I think at a certain time they accept that they are going to die. You can see it and sometimes they ask me my belief and it goes back to religion. I've been asked if I think something happens after death. I tell them that I think they will be going to a very nice place so that they are not afraid. I try to reassure them. I tell them I'll stay with them and I stay until they go. Usually they die on the afternoon or night shift and you have time to sit with them especially the ones with no family... (P9)

Replacement of Residents

One nurse found it difficult to acknowledge a new resident in the room where a resident had died a short time before. The deceased resident had been in the facility for a considerable length of time and the staff had a congenial relationship with her. Some residents leave a lasting impression on nurses and it is difficult for the staff to accept change when residents die. The void is not filled with the admission of a new person, because memories live on after a person has died. “You get to know the residents, they are in their room for some time, they deteriorate, then they die and shortly afterwards someone else is in their room. That is hard, a new person in that room” (P4).

Disenfranchised Grief

Another nurse mentioned ‘disenfranchised grief’. Disenfranchised grief is understood to mean that because nurses are not related to their residents by family ties, they are not recognised by society as legitimate grievers when the resident dies (Doka,2002).On some occasions the nurses may have been caring for the resident for several years. If the nurse has had a close relationship with the resident, she/he may become upset when the resident dies and this grief may not be acknowledged by the family.

The other thing that upsets me is the fact that the nurse has no place. Us nurses are an outsider. We may have cared for the patient for a year or maybe more but when they die we are not part of the family. And when they go you are just pushed in one corner and you don't know what to do. It happens to the care givers as well. Yeah. Even yet it is true. (P9)

Pain-free Deaths

The participants also spoke about trying to ensure that pain management was optimal for their residents. Several of the participants mentioned that the residents were in pain before dying and that they found this distressing. One nurse spoke about a

resident who died in considerable pain despite the fact that there was a lot of input concerning her care from both the medical team and the hospice.

It would depend how long the resident has been with us. You would be upset. For me it doesn't affect me personally as it is a progression and if the person has had a lot of pain I see it as a relief for them. I have probably seen about 60 deaths so I am used to it now. It upsets me because I won't be able to be with that person anymore. Sometimes I get upset with the way the family reacts. A lot of families don't really care. But I try to think that maybe there is a reason. (P9)

Theme 4: The Support Nurses have when the Residents Die

In this study the RNs used a range of strategies to meet the needs of their staff, thereby encouraging them to share their feelings and concerns. Talking in a group setting appeared to be a worthwhile support strategy. "Sometimes all of the team sits and talks. At times you can see that the team want to talk although some staff members just want to carry on with their work. When the staff members are obviously upset I talk with them" (P2).

The participants in this study communicated that the majority of the support that they received came from their peers. Several of the RNs mentioned the caregivers. They are often very upset as they are more involved in personal care. Caring teamwork is also mentioned. "The caregivers are usually more upset than the RNs as they are more directly involved with the residents. Sometimes they cry" (P3). "We support and talk about the death with any staff member who is upset" (P4). The staff felt comfortable talking and sharing both their thoughts and their anxieties with the other RNs. Talking with other nurses also assisted them to grieve over the death of their residents and they felt supported by their colleagues. "If my resident dies my colleagues help with everything. They help emotionally and I get their support. We ask each other if we are ok. I feel they care" (P5).

The nurses found communication was of the utmost importance. It did not appear to matter whether the communication occurred individually or collectively. "When a

resident dies we talk about the person and their death in a group setting. This seems to be a helpful exercise for everyone” (P6). Communication was a very important component as some of the nurses wanted to talk about their feelings when their residents died. “When a resident dies I tend to talk about the resident’s death. You want to vent your feelings especially if you feel really sad or frustrated. You feel bad if you haven’t done everything very well” (P4). Sharing thoughts about the deceased is very therapeutic for the staff. “After the death usually everyone talks about the person for a day or two” (P3). At times, the resident’s death is significant and the grieving process is shared over a lengthy period as reported by participant 5.

A resident of mine, a really nice person, collapsed. She seemed ok but she suddenly died. I don’t think she even knew it was happening. It was hard to believe she had gone. It was a while ago but I still talk about her to my colleagues. I am still upset about it. For some deaths it is really sad when you know them well. When they have to go they have to go. You just have to accept it. (P5)

The nurses were anxious to ensure they did everything correctly. If they made a mistake or had a problem about some care aspect, they wanted the reassurance of their colleagues or, in one instance, a manager was asked for support.

When the RNs felt that they had done everything that they could to assist both the resident and their family they achieved a sense of satisfaction. It was important to the nurses that they were acknowledged for giving good care to their residents. “Families often give us a photo or a card which helps to make us feel part of the family” (P5).

It was clear from the participant interviews that aged care facilities have different methods of debriefing after residents have died and use a range of strategies to meet staff needs. “The RNs ensure that the caregivers are aware that the resident is dying” (P3). “We pay our respects to the resident when they have died. We would like more time to sit with the resident” (P6).

Once the resident dies we all take part like in the cleaning and dressing up. Most of the time, the family is there so we all say how sorry we are that the resident has died. It is nice. We give comfort to family who have just lost their loved one. We pay our respect to the resident in our own way. (P7)

Debriefing

Some RNs gathered their staff together and talked about the deceased resident. When a staff member had been particularly close to a resident that person was often upset and the rest of the team gave them support. Some facilities offered professional counselling when requested.

Remembering Residents

Other participants mentioned that they had memorial services on a regular basis in their facilities. The nurses endeavoured to keep memories of deceased residents alive by attending remembrance services. These services assisted the RNs and caregivers to place the loss in the context of acknowledgment of the person's life. Other facilities placed a photograph of the resident on a wall or on a table with a light, to alert staff and the other residents that a resident had died. A book was placed there so that people could write their thoughts about the deceased person if they wished. Some staff ensured that the caregivers, not on duty when the resident died, were informed about the circumstances surrounding the resident's death, on their return to their workplace.

Resourcing Extra Staff

One nurse suggested that an extra staff member needed to be resourced when a resident was dying to ensure that the resident's needs were adequately met. If family members were not available to be with their relative an additional staff member would mean that the dying person was not left alone.

When people are dying and other residents require attention, we need an extra staff member to ensure that everyone's needs are being adequately met. Normal staffing levels do not allow for sufficient time to provide excellent care when a resident is dying. (P1)

The nurses considered that the family should be with the dying person to give their relative personal comfort when the resident was near to death. This was a normal expectation of the participants interviewed.

Leadership

RNs need to be prepared to accept the leadership role, especially when a death occurs. Leadership involves both a leader and a follower in a special setting. When a death occurs, competent leadership is very important as the family often waits to see what the nurse requires of them. The caregivers also look to the RN for support and guidance and they expect the nurse to be a role model for them to follow. This fact is illustrated in the following excerpt. "We had a resident and a caregiver who had been in our hospital for 15 years. When the resident died, the caregiver was very upset and I looked after her. The RN needs to be the leader, the strong person in the care-giving group" (P9).

Summary

Data analysis identified four main themes. These were 1) the different cultural perspectives of dying, 2) experiencing a sudden death, 3) nurses' grief, 4) the support that is available to nurses when the residents die. The RNs were from different ethnic groups. One marked difference they found was that, in their home countries, older people normally either died at home or in the home of a family member. In New Zealand however, they observed that a number of people died in residential aged care facilities. The RNs preferred to have family members present when a resident was dying. This was mainly to ensure that the family was satisfied with the measures used to nurse their loved one.

Another difference was the fact that in their home countries it is considered preferable to prolong life for as long a time as possible. However, in New Zealand keeping a

resident comfortable until death occurs, is thought to be more appropriate. In general, the immigrant nurses felt that the New Zealand culture was more accepting of death when this was inevitable. The RNs found sudden deaths traumatic. They were more at ease when they knew that a resident was dying as the death then followed a predictable pathway. A 'good death' was thought to be the ideal death, with the resident pain free, and both the resident and the family accepting of the outcome.

The RNs felt comfortable sharing their problems and anxieties with their colleagues. These discussions enabled them to feel supported and part of the team. Teamwork was essential for building morale. Memorial services and debriefing sessions were also considered beneficial to assist the grieving process. It is apparent from the research findings that nurses are affected by the death of their residents. This is especially relevant when the resident has been in the facility for a considerable time and the nurses have built a relationship with him/her. When the resident has only been in the facility for a short length of time the level of RN grief, generally speaking, is less.

There is evidence to suggest that RNs require support when their residents die, as it can be a traumatic, emotional experience. This support is especially important if the relationship is close and when the death is sudden and unexpected. Registered Nurses seek support from their peers when their residents die. However, findings suggest that management teams in aged care facilities are not considered to be as supportive of the RNs as are their peers.

The purpose of this chapter has been to describe the research findings. In their interviews, the RNs expressed similar views about most aspects of the discussions. This chapter raises areas for consideration especially when dealing with nurse's grief and the need for support when residents die in residential aged care facilities.

The following chapter discusses all of these findings and then makes some recommendations for nursing practice, education, study and research.

CHAPTER FIVE: DISCUSSION OF THE FINDINGS

Introduction

The previous chapter has presented the research findings of this study concerning the responses of 10 RNs when their residents in aged care facilities die. The purpose of this chapter is to bring together the findings of this study and make recommendations. I intend that the knowledge gained will be utilised to enable RNs to feel more valued and supported whenever the residents die. The limitations of this study and the recommendation for practice, education and research will also be presented. From the results of the findings there are several areas requiring further research.

In this chapter the most important findings are drawn together to answer the research question: 'What are Registered Nurses' responses when the residents die?' Nurses can recall the first death they experienced and some nurses can recall all the deaths they have witnessed. Registered Nurses wish the resident to die with dignity, pain free and at peace. Several RNs expressed how some residents become like 'part of their family'. Registered Nurses feel relieved when residents who have been in pain or discomfort die, because they see it as a failure on their part, if dying residents' symptoms are not managed well.

Ensuring that families are happy with the level of care and interventions utilised is vitally important to the nurses as is the reassurance from the family that the care being delivered is satisfactory. The RNs are then able to feel a sense of achievement. The RNs felt sad and upset when the residents died and they were able to recollect deaths that had made a strong impression on them even after a considerable time lapse. Grief is universal and will be experienced by almost everyone at some point in their life.

The replacement of a resident following a death is difficult for some staff to accept. This is especially so when the previous resident has been in the facility for some considerable time and has built a strong relationship with the nurses. Studies illustrate that it is quite essential that grieving nurses make meaning of the residents' deaths (Desbiens & Fillion, 2007; Lee & Dupree, 2008; Macpherson, 2008; Saunders & Valente, 1994).

Some RN participants mentioned being afraid of dead people and shared different ideas about death. Others said that they felt overwhelmed when the family is very upset, and at times, knowing what to say to the grieving families is very difficult. Registered Nurse participants in general, felt that the family needed to be present when their family member was dying. When this does not happen the RNs feel anxious as it appears to them that the family does not care about their dying family member. The RNs could not comprehend this concept.

One RN mentioned 'disenfranchised grief' and she felt that the families just push the RNs and the caregivers' aside as though they are of no consequence even when the relationship has been a long-term friendship. Anderson and Gaugler (2006) agreed with this concept. Their study involved 136 nursing assistants working in 12 different facilities. As mentioned previously, all the RNs could recall their first death which had obviously left a strong impression with them. Several RNs said that with time they learnt to cope with managing deaths. There were four main findings from the interviews.

The First Finding was: The Different Cultural Perspectives of Dying

The most prominent statement that the participants, who were immigrant RNs working in aged care facilities shared, was that the dying process in New Zealand was totally different from their previous experiences. A number of participants mentioned this during their interviews. The procedures, the medication methods, the attitudes of staff and even the way of looking at the dying process was very different from the model of dying that they had previously accepted in their own countries.

It was a huge cultural shift coming to work in a New Zealand facility. Firstly, in their home countries, the dying person is given nursing care in either, their own home, in the home of a family member or in an acute care hospital, but not in a care facility. Should a person have no family, someone in the community will take the un-well person into their home and take care of him/her. Generally people are only admitted to hospital when they are requiring acute nursing care.

The RNs confirmed that when someone, in their home countries, is dying, many people, even slight acquaintances, pay their respects to the dying person, so this means that they have a flow of visitors. This does not happen generally to the same extent in New Zealand, as often only close family and friends visit when a person is dying. However there are exceptions to this. Māori and Pacific Islanders often visit their dying relative, in large numbers as this is part of their culture.

In New Zealand, the RNs considered that their first priority was to keep the resident pain-free and comfortable. However, had the participants been in their own country, their main priority would have been to ensure the dying person was kept alive as long as possible, even when this caused financial hardship for the family. Several of the RNs interviewed for this study expressed the thought that when people are actually dying, 'letting people go' or giving them permission to die, was a better option than endeavouring to extend their life span when the inevitable was going to happen in any case.

Some of the RNs said they did not know initially what to say to families when their relatives died. However, as they became more experienced this was no longer a problem as they learnt to cope with incidents of death. Some of the RNs expressed feeling frightened when they saw their first death. All of the RNs felt sad, uncomfortable and upset, if the family were not present and participating when their relative was dying. The RNs preferred to communicate with the family and wanted to have the reassurance that the way they were caring for the resident was exactly what the family desired.

When residents were from other cultures the RNs were keen to meet their needs also. The RNs appeared to relate well to anyone from another culture. This may have been because they understood how difficult it was to settle into new surroundings. Some cultures are afraid of death. The RNs explained how some cultures are anxious about managing people when they are dying or when they have died. Dealing with death issues is culturally inappropriate for some people.

Williams (2012) suggested that immigrants are here to improve society through the care that they provide to the residents. Among workplace challenges is the fact that

some facilities force RNs to sign contracts with penalty clauses applying if the RN leaves that site of employment. These contracts are often signed in the country of origin.

Often immigrant nurses speak amongst themselves in their own language so that they can communicate more effectively with their colleagues. This is usually not approved by management as English is the only language acceptable in many facilities. This is a difficult rule for the RNs to comply with, if their ability to speak English is not particularly fluent. If the RNs' English comprehension is not adequate it may be safer for that RN to speak to a colleague in their own language as it could lessen the likelihood of mistakes occurring because of a misunderstanding (Williams, 2012). However, only English should be spoken in the presence of the residents. Speaking in an unfamiliar language may make the residents feel uncomfortable. All staff need to consider that the care facility is the residents' home. The exception to this directive would be when the RN and the resident speak the same language and the resident prefers that they speak in their native tongue.

Williams (2012) argued that it is important that New Zealanders assist and support immigrants, and also be more accommodating at both an institutional and a human level to ensure nurses feel welcomed and understood. Williams suggested that people need to extend the hand of friendship more willingly to these valuable immigrant nurses. They face many difficulties including dealing with a different culture, knowing very few people to converse with in their own language, and they are often unaware of the indigenous culture and related issues.

They may also be exhibiting anxiety and uncertainty leading to a loss of confidence. They can be concerned about reprisals from employers. Williams (2012) suggested the New Zealand Nurses Organisation needs to reflect on the RNs' difficulties and find solutions so that these RNs will want to stay long term in New Zealand. New Zealand RNs need to appreciate that they can learn a great deal from nurses of other cultures and may need to be more open, generous and accepting of other ways of managing nursing issues. A diverse ethnic nursing workforce is required to meet the needs of the

multi-cultural community that now comprises New Zealand society. A potential problem that immigrant RNs may encounter, is discrimination.

Discrimination

The nursing workforce in New Zealand is 68% New Zealand European, 7% Māori and 4% Pacific. The remaining 21% consists of a variety of ethnicities (Nursing Council of New Zealand, 2011). As reported by Seccombe (2014) discrimination is evident in the workplace from New Zealand nurses towards nurses of other ethnicities practicing in New Zealand. This negative attitude creates not only a loss of confidence and fear, but it can cause mistakes to be made in practice and is extremely unprofessional. It can even be the cause of an RN leaving the nursing workforce. All nurses have a responsibility to support their colleagues and respect their cultural needs.

Discrimination includes the notion that immigrants are not entitled to the same rights as people born in this country. The experience of immigrating is a major adjustment and can cause psychological distress (Aroian, 1990). Immigrant nurses experience loss when they leave their families, friends and working environment behind. They have to overcome many obstacles to ensure that they are successful in their new countries (Aroian, 1990). According to immigrant nurses there is a high level of discrimination experienced by the RNs when English is not their first language. Some health consumers do not wish to be nursed by immigrant nurses and can be very vocal about this issue.

Another acknowledged problem is the fact that nurses employed in aged care facilities have a lack of recognition in the community, in their remuneration and in their role within healthcare. Gerontology does not have the same glamour appeal as emergency nursing, and the remuneration in the residential care sector does not equate with that of the public sector. These are some of the reasons why it is difficult to recruit nurses to work in this area of nursing, and for many it is a transitory occupation. As a result of these issues nursing staff are frequently being replaced. This does not auger well for quality or continuity of care.

The Second Finding was: Nurses' Grief.

At the present time, there is a lack of adequate training for nurses concerning the grief process. Most of the support systems currently available are mainly interventions for the resident and their family and do not cater for the needs of nurses in the majority of instances. The literature suggests that death and dying is stressful for nurses who encounter it on a frequent basis. However, much of the research concentrates on the residents and their respective families. When RNs refuse to acknowledge their grief it tends to isolate them from supportive colleagues. Anxiety overload may occur after frequent deaths. This can readily lead to a lack of confidence. Grieving is facilitated when RNs accept their own mortality and do not become defensive when people point out to them that they are displaying grief reactions. When the RNs allow themselves to work through their grief they often find the process beneficial. Support groups can provide therapeutic support and encourage staff to realise that grief is universal and a natural process.

The residents and their family live through the grieving process, for the family member. For the RN however, grieving can be a common occurrence when frequent deaths occur. Brunelli (2005) suggests a need for full recognition and acceptance that nursing will involve work with dying patients and therefore processes and structures need to be in place so that RNs can effectively work through grieving processes towards a resolution and acceptance of grief. Brunelli's aim was to "encourage further development of both research and education to assist RNs with their grieving process ultimately benefiting nursing practice and retention" (p.123).

The dying process is a frightening and anxious experience for some people and it is difficult for someone to die well without the recognition that they are dying. Both fear and anxiety need to be recognised, understood, and addressed. The RNs need to find ways to encourage people to talk about how they wish to live while they are dying. Not everyone will want to talk about how they want to die but everyone should be offered the opportunity to do so. The discussion needs to be low key, sensitive and friendly. It has been noted that at times, stress and anxiety may be a cause of anguish for health professionals working in palliative care areas. Several of the participants found working in New Zealand was initially stressful and that it took time to adjust.

Communication

Death of a family member is a moment in time that really matters. The RN is the facilitator to communicate with the family about death and dying. Clear communication with health professionals ensures the family is prepared for the end of a life journey (Hebert, Dang, & Schulz, 2006) There is some evidence that if communication is adequate and families are prepared for the end of life for their relative, they are unlikely to suffer adverse death responses (Hebert, et al., 2006). However, it is crucial to remain in close contact with the family after sensitively discussing care. This discussion should not be a 'one time only' conversation as a lot of information given about dying takes time for the family member to absorb. Often they do not really wish to hear that their relative is approaching death.

End of life conversations need to be addressed in stages. Keeping communication channels open with the family could avoid family members thinking that their loved one's death was due to inadequate care (Oliver et al., 2006). A paradigm shift has occurred. No longer does bereavement support have the same emphasis as it did previously. It is considered more important to support families as death approaches (Neimeyer, 2004).

At times RNs are tentative about giving information to families in case they are wrong about whether the resident is actually dying. Hebert et al. (2006) noted that withholding information is problematic and causes families distress. Information needs to be provided by the staff in a concise, clear manner. At times it is difficult for RNs to know exactly what the status of the dying person is but there is no problem in admitting uncertainty. Language and communication is of utmost importance. Speaking the same language does not necessarily guarantee effective communication between RNs of different cultures.

The Third Finding was: Experiencing a Sudden Death.

When sudden deaths occurred the RNs were shocked and traumatised. They could all recall the details of the sudden deaths they had experienced. When a sudden death occurred, the RNs felt they needed to talk to someone about the death. The preference was to talk to their colleagues, as they felt more supported by them than by

management. On one occasion the RN actually called in her manager as she was so traumatised by a sudden death.

A sudden death made the RNs feel guilty as they thought they might have missed some vital sign that could have alerted them to the resident's condition and they then would have obtained the doctor's input. The RNs felt they did not 'do it right' when a sudden death occurred and they found that extremely stressful. Although most of the RNs preferred to confide and communicate with their colleagues; some of the staff preferred to just carry on with their work when the resident died and they acted as though nothing untoward had happened. This appeared to be their way of coping with the incident. By not actually acknowledging the death meant they did not have to face up to the reality of the event.

Registered Nurses prefer deaths to be expected and organised. When this happens they feel they have control over the dying process and they can ensure the person dies well. An unexpected death does not follow the accepted path and causes trauma. Registered Nurses are anxious about speaking to the family when a sudden death occurs as they were the RN in charge at the time and did not notice any problems with the resident.

Some facilities have formal debriefing sessions following the death of a resident. This can be effective in dealing with staff grief, especially when the resident has been in the facility for a considerable time. However, there are controversies in the literature about debriefing. Tuckey (2007) considers that lack of empirical rigour in the majority of studies results in very little comparative value between debriefing sessions and non-intervention groups. However, a benefit of debriefing is that everyone learns the various, effective ways of relating to the resident, to each other and to the families.

**The Fourth Finding was:
The Support Available for RNs When the Residents Die.**

Registered Nurses looked for the support of their peers when the residents died. They found talking to each other helpful either individually or in a group. In the majority of the facilities there was usually very little management input when a person died. One RN who was distressed when a sudden death occurred asked her manager for

support, but other RNs talked to their colleagues only. Some of the RNs were concerned about the caregivers and their grief, as the caregivers are more personally involved with the residents. Several of the RNs mentioned teamwork and the support they gave each other when a death occurred.

All the RNs considered communication to be very important. Some were sad when reflecting about deaths they had experienced in the past, even when they occurred a long time ago. They mentioned how important it was for RNs to be acknowledged by the families.

One RN felt it would be helpful to have extra staff available when a resident was dying, to ensure that the dying resident was given excellent care and also that the other residents were not disadvantaged because the RN was busy. Another RN talked about leadership and how the RN needed to demonstrate leadership to both the relatives and the other team members. The RNs felt that they needed support when a resident died and they would also prefer to be acknowledged by the management team at that time.

New Zealand Nurses Organisation 2013 report demonstrates that there must be the correct number of skilled nursing staff on site at all times. When staff do not attend for their rostered duties, facilities have difficulties finding replacement staff at short notice. The RN at times has too many tasks to spend adequate time with dying residents and to supervise caregivers who are working with time restraints.

The RNs had some suggestions about the support staff required, when the residents died; 1) To remember to inform the other staff on the ward, and especially the staff on leave at the time of the death. 2) To share stories and thoughts about the deceased resident with the other members of the team. 3) To listen to appropriate music as it can be gently healing. 4) To set aside a time to contemplate, meditate, and to recall memories about the resident. 5) To cherish your memories, remembering that they are in your heart. 6) To help and encourage other team members while they are grieving for the deceased. 7) To discuss the death either individually or in a group discussion with other staff members. Teamwork and supporting each other is considered to be very important at this time. Good communication with others is essential.

RNs need reassurance that they have managed the death well. They need this reassurance from the family concerned, the management team and the other RNs. Debriefing sessions are helpful as are regular memorial services held to remember the residents. Staff who have been very close to the resident should be able to attend the funeral whenever this is practical. It is also therapeutic for the staff to wash and dress the deceased for the last time. Recognition from the family by means of a thank you card is always appreciated by the staff.

Support for Immigrant Nurses

To support immigrant RNs, regional forums could be held. The nurses could be informed about services available for them and they could also be given information on topics of interest. Mastering time management and pharmacology are challenges for these participant nurses because of differences in practice in New Zealand in comparison to the practice that is familiar to them. Difficulty with understanding the parameters of Western culture and inadequate communication skills may inhibit career advancement for immigrant nurses. It is reasonable to assume that all immigrants experience some level of immigration distress (Chandra & Willis, 2005). The orientation of RNs is inadequate in many instances. Immigrant RNs may actually only have a few days orientation to a facility and are then expected to manage independently. It is not only the residents who are unfamiliar to the RNs but policies and procedures, medications, documentation and staff.

Teamwork

Teamwork is an essential component of nursing care. Working together as part of a team is beneficial for both the resident and the staff. There is less risk of injury, when two staff members assist each other with a resident's care. Teamwork builds good staff morale and was mentioned in participants' interviews. Teamwork helps to empower those who may feel powerless or unimportant to the organisation.

Teamwork means working with others to achieve common goals and it is underpinned by a sense of shared destiny. It involves delegating authority, and developing, empowering, and enabling people to achieve. Martin and Henderson (2001) suggested that a good team has a shared goal or task. People will achieve maximum

performance in a positive, nurturing working environment. It would be beneficial for teams to be supported to encourage creativity and imagination (Martin & Henderson, 2001). As staff work as a team this ensures they have a supportive network available when there is a resident death.

Competent leaders create an atmosphere of trust. This encourages each person to feel capable and empowered. When the team members are aware of any organisational expectations and it is explained that they are expected to meet defined standards, then they are more likely to achieve pre-determined goals. If the leader delegates tasks, this enables others to develop their talents and abilities (Kouzes & Posner, 1998). The effective leader knows that the ultimate task of leadership is to create energies and vision (Drucker, 2006).

When speaking with the RN participants in my study however, I found they were reluctant to speak with their management leaders about their feelings when residents died. Usually they preferred to discuss their responses with their peers. I feel that with strong, effective leadership and a cohesive team atmosphere staff may feel confident to discuss their responses to the deaths, with their management team. . All appropriate support could then be effectively initiated.

Future directions

Future nursing research could be directed at the challenge of understanding cultural diversity in end of life care. This is necessary to ensure that RNs are competent in delivering quality culturally sensitive care. It is important to adapt leadership knowledge and behaviours to different cultural contexts. Registered Nurse leaders need to be knowledgeable and sufficiently experienced to be flexible in their thinking and leadership behaviour. They need to be wary about using labels like 'culture' to explain differences that may or may not be relevant.

Orientation is only of a few days duration in most facilities. Therefore, if the Immigrant RNs were offered the services of an experienced, competent mentor to assist them to put into practice the orientation learning, integration into the work force could be more effective. This may also be of considerable benefit to the residents as the new RNs may then quickly assimilate into current practices.

Limitations of the Study

Although this study provides some contribution to the literature, limitations should be noted and the results of this study need to be considered in the light of its limitations. A comparison with other populations of nurses is limited by the experience and perception of those who were interviewed. However, whilst the diverse cultural and educational background is typical of RNs in aged care today, conclusions cannot be drawn about how conditions such as culture, experience or education may influence a nurse's perception. Additional research is warranted to determine if nurses of different ethnic, educational, or cultural backgrounds have different responses and perceptions from those interviewed for this study.

Transferring the themes from this study may not be accurate because of the small sample. Because the majority of the participants were of Asian origin there would almost certainly have been a different cultural perspective apparent if nurses from a European cultural background had been interviewed. All participants were the same gender and that may also have made a difference to the eventual outcome and conclusions. Nevertheless, the participants reflect the cultural mix currently in the New Zealand residential aged care facilities.

A stipulation of the research stated that the Registered Nurses had to have the experience of at least two years, in their role as RNs, working in aged care facilities. However, it is feasible that if the research had included nurses with approximately 10 years or more nursing experience, the data may have been richer as those nurses would have had more experiences to discuss. They would possibly have been managing novice nurses and caregivers and may have had a broader knowledge base. It may be beneficial, in a future study, to include Nurse Managers as they may have a different perspective on RN's grief. Nurse Managers are responsible for the work structure in aged care facilities.

The lack of competence in the novice researcher's interviewing technique is also considered a limitation of this qualitative study. If the participants had been asked more persistent questions, for example, "How was that for you in retrospect?" or "Can you tell me more about that particular incident?" richer data may have resulted.

However, I was very aware that this was a very sensitive subject and it was my intention to avoid any distress to the participants. At times it was obvious that remembering special residents that had been close to the nurses, brought back memories for them. I was surprised at how willing the nurses were to share their personal thoughts and they stated that it had been a positive experience for them to be able to talk openly about their thoughts and feelings.

Recommendations

Senior management within organisations, need to acknowledge and support RNs grief. There is also a responsibility to ensure that RNs are supported in their role and are valued for their contribution to ensuring the residents are given optimal care. Staff are entitled to be given regular, constructive feedback when it is warranted. This could result in an enhanced quality of life for the residents in the facility, and this needs to be the main focus of all staff members and organisations in this sector.

Recommendations for Practice

The findings of this study provide insight into the way RNs respond when the residents die. While these findings may not apply to all RNs, they have raised questions that may enhance support for grieving staff. Grief counselling could be beneficial for staff grieving for deceased residents.

Recommendations for Research

Further research would be beneficial if a more diverse, group of participants was interviewed. It would be interesting to establish if richer data was obtained from a group of more experienced RNs or a group of caregivers who would present a different perspective. Further research is needed to identify the barriers that prevent RNs from accessing formal support and to evaluate the effectiveness of peer support in assisting nurses to cope with grief.

Recommendations for Education

Education and current resources are required to raise organisational awareness of the reasons for nurses' grief and to develop strategies to enable RNs to manage this issue. In addition, to maintaining both current knowledge and skills, RNs should be

encouraged to seek educational opportunities in personal and professional development. It would be ideal, if the management team encouraged staff to attend education sessions concerning grief and end of life care.

Conclusion

This study supports the limited amount of other research available about this topic. Other researchers came to similar conclusions when writing about nurses' grief and the effect that residents' deaths had on RNs. The purpose of this study was to describe the responses of RNs in New Zealand when the residents died and to establish if RNs required support when these deaths occurred. This study has shown that RNs, currently working and caring for residents in aged care facilities, require a high level of support when their residents die. The main purpose of this support is to enable staff to provide optimal end of life care to the growing number of residents, who require care.

All future predictions indicate that the number of residents in aged care facilities will increase. Therefore, this perceived need for support requires addressing with some urgency. The provision of enhanced educational opportunities for both RNs and caregivers, encouraged by a supportive organisational culture, would hopefully ensure that nursing staff felt valued and supported. As deaths of older adults increase in residential facilities, the staff who provide that care will increasingly face challenges in coping with residents' deaths. In some instances, grief counselling may be of benefit to the staff managing these deaths. In the future, it will be important to include RNs in the planning processes to ensure that their health and well-being receives the same consideration as the residents, for whom the long-term care is intended. This subject requires further investigation and hopefully this will occur in the near future.

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MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Barbara McKenzie-Green
 From: Rosemary Godbold, Executive Secretary, AUTEC
 Date: 3 July 2012
 Subject: Ethics Application Number **12/122 Registered nurses' responses to resident death in residential aged care facilities.**

Dear Barbara

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 28 May 2012 and that I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 25 July 2012.

Your ethics application is approved for a period of three years until 3 July 2015.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 3 July 2015;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 3 July 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary

to obtain this. Also, if your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. **Should** you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTECH Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at <http://www.aut.ac.nz/research/research-ethics/ethics>).

On behalf of AUTECH and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Cecily Walley cecily.walley@gmail.com

Participant Information Sheet



Date Information Sheet Produced:

21 April 2012

Project Title

Registered nurses' responses to resident death in residential aged care facilities.

Invitation

My name is Cecily Walley and I am a registered nurse. I am interested in the responses nurses have when their residents die. This research will contribute to my qualification of Master of Health Science (Nursing). I invite you to be part of this research study. Your participation is voluntary and you may withdraw from the research study at any time without adverse consequences.

What is the purpose of this research?

I am interested in finding out your perceptions and how you respond when a resident whom you have cared for dies, especially if the resident is special to you. One of my aims is to assist in developing effective staff support and where possible introduce some structural change within residential aged care facilities.

How was I identified and why am I being invited to participate in this research?

You have been invited because you are a registered nurse with at least two years experience working in a residential aged care facility.

What will happen in this research?

You will be asked to take part in an interview. This will be held at a time to suit you, either in an interview room at AUT Akoranga Campus or if you would prefer the interview could be held in your home. The interview will consist of an in-depth discussion that will last approximately an hour. With your permission, the interview will be audio-taped so that I can transcribe the information following our discussion. I will also take notes. If I require clarification about any of your responses when I am analysing the data, I will contact you if I have your permission to do this. It will be your choice whether or not you wish to respond.

What are the discomforts and risks?

You may feel some distress remembering incidents involving the death of a resident. **Should** you wish to stop the discussion at any stage, I am willing to do so.

How will these discomforts and risks be alleviated?

You may respond to questions as you choose. You do not have to respond to questions that make you feel uncomfortable. Any information you share at the interview will remain confidential and your privacy will be respected. If any adverse consequences occur as a result of the interview process, the AUT Health and Counselling service is available at no cost to you.

What are the benefits?

There are no personal benefits to you by your participation in the research however you may enjoy the opportunity to share your experiences. The knowledge gained from the study may also ensure that registered nurses receive the support they require when a resident they cared for dies in a residential aged care facility.

How will my privacy be protected?

To ensure your privacy is protected and the information you share remains confidential, the information gleaned from the interview will be transcribed by me. There will be no means of identifying you or your place of work. You will be asked to choose a pseudonym that will mask your identity. The information collected will remain confidential and the only people with access to the data will be myself, Cecily Walley the researcher, and my research supervisor, Dr. Barbara McKenzie-Green, at AUT University. Your consent form and the collected data will be stored securely for six years and then the information will be shredded.

What are the costs of participating in this research?

There is no financial cost to you. The interview will require approximately an hour of your time. If I require clarification about your responses it may be necessary to request a little more of your time if you are agreeable.

What opportunity do I have to consider this invitation?

Once you have read and understood the information, you have a week to consider if you would like to sign a consent form. I am available and willing to answer any questions raised during this time.

How do I agree to participate in this research?

You will need to sign and submit the consent form I will provide for you. I will answer any queries you have about the study.

Will I receive feedback on the results of this research?

Yes. A summary of the research study will be available to you upon request.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project **should** be notified to the Project Supervisor, *Dr. Barbara McKenzie -Green*; barbara.mckenzie-green@aut.ac.nz, telephone details: (09) 921-9999 ext.7352.

Concerns regarding the conduct of the research **should** be notified to the Executive Secretary, AUTEK, *Dr. Rosemary Godbold*, rosemary.godbold@aut.ac.nz, 921-9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:

Cecily Walley

E-mail cecily.walley@gmail.com Ph 09 4492727

Project Supervisor Contact Details:

Dr. B McKenzie-Green,
Senior Lecturer
Post graduate Head Health Care Practice
AUT University
Auckland NZ
barbara.mckenzie-green@aut.ac.nz

(09) 921-9999 ext.7352

Approved by the Auckland University of Technology Ethics Committee on 3rd July 2012. AUTEK

Reference number 12/122.



Consent Form

Project title: Registered nurses responses to resident’s deaths in residential care facilities.

Project Supervisor: Dr. Barbara McKenzie- Green.

Researcher: Cecily Walley.

- I have read and understood the information provided about this research project in the Information Sheet dated 24 March 2012.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research (please tick one): Yes No

Participants Signature:

Participants Name:

Participants Contact Details (if appropriate):
.....
.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 3rd July 2012.

AUTEC Reference number 12/122.

*Note: The Participant **should** retain a copy of this form.*

QUESTIONS ASKED OF THE PARTICIPANTS:

- 1) Tell me about your experiences when your residents have died.
How was that for you?
- 2) I have heard people say a resident had a 'good death'. What does that mean to you?
- 3) Tell me about the team that you are part of when a resident dies? I am wondering about levels of support that might be available.
Could you tell me something about that support?
- 4) Tell me about de-briefing with staff about the death of a resident?
- 5) What you are talking about tells me that you have gained useful knowledge and experience about how to respond when a resident dies. Where did you learn these skills?
- 6) Are there times when deaths are different?
- 7) Do you have an example of this that you could discuss?