IMPACT OF PATIENTS' DEATHS ON HEALTHCARE PROVIDERS' EMOTIONAL WELL-BEING AND THE ROLE OF SUPPORTIVE WORKPLACE STRATEGIES

Capstone project submitted in partial fulfillment of the requirements for the degree of
Masters of Public Health (Environmental and Occupational Health)

Supervisor: Bruce Lanphear
Co-supervisor: Agnes (Aggie) Black
Second reader: Patricia Rodney

Shazbeen Ali, MPH candidate
Simon Fraser University
Summer, 2017

Abstract:

Due to increasing trends in the aging population and high prevalence of chronic diseases, like cancer and heart disease, the burden on healthcare providers has been escalating. Healthcare providers are frequently exposed to physical and emotional stressors in their work environment. One of the well-established occupational risks among healthcare providers is their frequent exposure to death and the dying process of their patients. Death of a patient affect healthcare providers' emotional well-being, and can also impair their job performance. Therefore, providing a safe and supportive workplace environment for healthcare providers to deal with the death of their patients is critical to promote their emotional well-being and job satisfaction. From an organizational perspective, supportive workplace environments can ultimately lead to better quality of patient care and reduce high turnover rates, thus ameliorating staffing shortages in healthcare settings. Through a review of literature, this capstone project will describe the importance of providing adequate support for healthcare providers who deal frequently with patients' deaths. This paper will review some effective strategies, programs and interventions implemented in different healthcare settings around the world to lessen emotional stress faced by healthcare providers who are involved in caring for dying patients. The purpose of this paper is to: (1) describe the effects of patients' deaths on healthcare providers; (2) identify existing supportive workplace strategies in various healthcare settings around the world to help healthcare providers who care for dying patients; and (3) develop recommendations for healthcare organizations to support healthcare providers to effectively deal with patients' deaths.

Table of contents

Introduction

Topic relevance:

Public health advances and biomedical technologies have increased life expectancy and the ability to keep people who have serious chronic diseases alive longer. Approximately, 11.7% of Canadians aged 65 years and older are living with at least two of the four major chronic diseases, including cardiovascular diseases, chronic respiratory illnesses, diabetes and cancer (The Canadian Community health survey, 2014). Besides this, the number of seniors 65 years and older is estimated to double from 4.2 million to 9.8 million between 2005 and 2036 in Canada (Fowler & Hammer, 2013). Aging does not invariably equate with diseases and disabilities, but it does increase the risk of both (Canadian Medical Association, 2013). Thus, the rise in aging population and increasing trends of chronic disease exert dual stress on the healthcare system, leading to an increase in demand for health services.

Elderly people and people who have terminal illnesses or end-stage chronic diseases are likely to spend their last days of life in healthcare facilities, mostly in hospitals under the supervision of trained healthcare providers. In 2013, 158,584 deaths (approximately 63% of the total deaths) in Canada were in hospitals and 93,282 deaths (37% of the total deaths) were at non-hospital settings including homes, long-term/short term healthcare settings, nursing homes and other unlicensed healthcare facilities (Statistics Canada, 2017). The number of people who require end-of-life care in healthcare facilities –including hospitals, nursing homes and long-term/short-term hospice care facilities – has been rising, which increases the demand for healthcare providers required to care for those with terminal illnesses like heart disease, Parkinson's disease, dementia and cancer (Fowler & Hammer, 2013). This growing patient population, and the demand in end-of-life care, increases the importance of providing adequate education and

training, and supportive resources to healthcare providers who witness death as a part of their daily work. Throughout this paper, the term healthcare providers refer to healthcare staffs who are directly involved in caring for patient at different levels or who are expected to have one on one contact with patients and their families. Healthcare providers in this paper include nurses, healthcare aides, doctors, physiotherapists, speech therapists, occupational therapists, dietitians and other allied health professionals who interact directly with patients.

Caring for dying patients increases emotional labour among healthcare providers. According to Grandey (2000), "emotional labour is the process of regulating both feelings and expressions for the organizational goals" (p. 97). Emotional labour demands many professionals including healthcare providers to display emotions that are set by organizations and hide their true emotions (Bagdasarov & Connelly, 2013). Consequently, this emotional labour has a detrimental impact on work performance and overall well-being of healthcare providers if not addressed and supported in a timely manner (McVicar, 2003, Wilson & Kirshbaum, 2011 and Whitebird, Asche, Thompson, Rossom & Heinrich, 2013). Thus, providing safe and supportive workplace environment is critical for a healthy workforce and can help with retention of healthcare providers (Branch & Klinkenberg, 2015).

Capstone purpose and objectives:

This capstone project serves to highlight the importance of supportive workplace policies and suggest strategies that can enhance the emotional and psychological well-being and effectiveness of healthcare providers who care for dying patients. The purpose of the capstone project is to: (1) describe the effects of patients' deaths on healthcare providers; and (2) describe the role of existing workplace policies, frameworks or strategies for ensuring emotional and psychological well-being of healthcare providers. The specific objectives of this paper are as follows:

1. To identify patients' deaths and dying process as a stressor for healthcare providers.

2. To review evidence from the literature on the effects of patients' deaths on the emotional and psychological well-being of healthcare providers.

3. To review and identify existing strategies to promote resilience, provide grief support and reduce burnout among healthcare providers dealing with dying patients.

4. To develop recommendations for healthcare organizations to support healthcare providers dealing with dying patients in various healthcare settings.

Death and dying as a workplace stressor:

The healthcare profession is amongst the most stressful professions due to long working hours, frequently changing working conditions and dealing with patients who have unpredictable health conditions (O'Connor, O'Connor, White & Bundred, 2000). Caring for dying patients and critically ill patients is an integral part of many healthcare providers' daily work. Death of a patient is a well-established source of occupational stress among healthcare providers (McVicar, 2003 and Robinson, Clements & Land, 2003). Death itself is an inevitable and a stressful event for anyone, but for healthcare providers it is often perceived as a failure to prolong or save the patient's life which can be more distressing for them. Adding on to that, frequent encounters with sudden, traumatic deaths and deaths of young people further characterizes death as an unavoidable work stress for many healthcare providers (Payne, Dean & Calus, 1998).

Factors influencing attitudes towards death and dying:

Many factors impact healthcare providers' attitudes towards the death of a patient. Nurses' attitudes towards caring for dying patients can vary because of their professional, past and personal characteristics (Benner, 1984). Professional experiences include the amount of contact time with patients and clinical experience in dealing with dying patients. One study revealed that

emotional stress is much higher in healthcare providers who provide end-of-life care to patients and who have spent more time with dying patients (Rickerson et al., 2005). Past experiences such as level of education, training related to end-of-life care and personal experiences like age, race, and religion were highlighted as factors influencing nurses' attitudes towards death and dying process (Dunn, Otten & Stephens, 2005) (See figure 1 in appendix). This concept of determinants of attitudes towards death and dying can also be applied to a wider population of healthcare providers similar to nurses (Benner, 1984 as cited by Dunn et al., 2005).

Impact of patients' deaths on healthcare providers:

The death of a patient and caring for a patient throughout the dying process can be challenging and stressful for healthcare providers. The literature highlights that dealing with death and dying process can create death anxiety, compassion fatigue and feeling of grief among healthcare providers. The term "moral distress" is also used to describe "emotional distress and moral suffering faced by healthcare providers when institutional barriers and workplace responsibilities prevent them from acting according to their own moral judgement" (Rushton, 2017, p.11). Moral distress is a complex term and it is not limited to the emotional distress faced by healthcare providers who care for dying patients. Therefore, due to the limited focus of this paper and, the complex nature and presence of controversies around the concept of moral distress, this term is not discussed further in this paper.

Witnessing a person going through the pain, trauma and suffering that can be associated with dying may provoke anxiety among healthcare providers. Frequent experience of the death and dying processes of others reminds a person of their own mortality and can evoke fear, anxiety and uneasiness (Peters et al., 2013). As noted by Deffner & Bell (2005), **death anxiety** is a well-known phenomenon that revolves around end-of-life healthcare providers dealing with patients

who have life-limiting illness or injuries. "Death anxiety" is defined as "a feeling of dread, anxiety or fear at the thought of death or anything to do with dying" (Lehto & Stein, 2009, p. 14). This phenomenon is complex and it includes thinking about one's own mortality, fear of death of significant others and fear about the dying process. As patients' deaths are a frequent part of healthcare providers' experience, many healthcare providers have to deal with their own fears about death, and simultaneously have to cope with frequent patients' deaths (Payne et al., 1998). Death anxiety can pose both negative and positive impacts on a person, depending on the personal and professional factors discussed earlier in this paper (Peters et al., 2013). Many studies suggest that patients' deaths can cause a feeling of self-awareness and help healthcare providers reflect on their own life's purpose. On the other hand, it can have a disruptive impact on mental well-being of healthcare providers (Nia, Lehto, Ebadi & Peyrovi, 2016). According to Dunn et al., (2005) and Peters et al., (2013), the quality of care and caring attitudes towards dying patients can be impaired by death anxiety. Death anxiety can become worse after the patient's death and it can impair the grief responses and the ability of healthcare providers to manage and cope effectively with death events in the future (Peterson et al., 2010).

Besides death anxiety, **compassion fatigue and burnout** can be seen in healthcare providers who frequently deal with death and dying processes. The term compassion fatigue, which was introduced around 1980, is used to refer to caregivers who experience an unexpected sense of helplessness and uncertainty. It is defined as "a stress reaction that arises from caring for or yearning to care for people who are most likely to die" (Figley, 1995 as cited by Branch & Klinkenberg, 2015). Compassion fatigue often includes burnout and secondary traumatic stress (STS). Burnout is the feelings of frustration, despair and helplessness, and STS is stress faced by caregivers who are dealing with terminally ill patients (Branch & Klinkenberg, 2015). Healthcare

providers working in pediatric, trauma and oncology units are at highest risk of developing

compassion fatigue (Branch & Klinkenberg, 2015). Nurses and frontline healthcare providers are

at higher risk for developing compassion fatigue than other healthcare providers due to their

direct contact with patients (Bush, 2009). Compassion fatigue can lead to many negative

outcomes, including irritability, anger, poor decision-making, poor caring attitudes, absenteeism

and drug use (Cocker & Joss, 2016). Therefore, high levels of death anxiety and compassion

fatigue can worsen or complicate the grieving process among healthcare providers after their

patients' deaths (Wilson, 2014 and Papadatou, 2000).

The death of a person is a stressful event for the family, but the death of a patient can also create

a feeling of **grief and loss** among healthcare providers (Papadatou, 2000). However, the grief

experienced by healthcare providers is different than the grief the patient's family experiences.

The death of a patient is a subjective experience for healthcare providers that is directly linked to

their professional efforts and investment. According to Papadatou (2000), this professional

investment can be related to their close relationship with patients and families, their goals and

efforts, their dreams and ambitions and their professional role. Therefore, the death of a patient

can be viewed as the loss of their investments. Due to the different levels of investment in a

particular patient, grief among healthcare providers can vary widely (Papadatou, 2000).

Healthcare providers working in palliative, hospice, long-term and oncology care settings who

have long-term relationships with patients and families, can experience the loss of their

relationships with the patient and his family following the patient's death. In contrast, staff

working in emergency or acute care settings might experience a different type of loss or grief.

Grief reactions include feelings of helplessness, the need to cry, to reflect about the patient and

distance oneself from the daily activities. Healthcare providers can also feel guilt, anger or

depression after patients' deaths (Papadatou, 2000). Papadatou further noted that these reactions can last for a few minutes, hours or even for months. However, due to the busy work environment and professional commitments, healthcare providers often limit or fail to acknowledge and share their grief reactions or experiences. As noted by Gerow et al. (2010), healthcare providers often try to hide their emotions and create a "curtain of protection" to hide their grief, so that they can continue to work. Furthermore, grieving and feeling sad over patients' deaths is sometimes considered a sign of weakness and professional incompetency as reported by many healthcare providers, especially physicians (Shorter & Stayt, 2010). Many studies reveal that healthcare providers exposed to frequent patients' deaths have reported having experiences of unresolved grief or disenfranchised grief, leading to a variety of emotional and physical consequences that can affect the personal and professional life of those individuals (Shorter & Stayt, 2010). Many healthcare providers who witness frequent and sudden deaths and do not get a chance to vent their feelings can be victims of cumulative grief. Therefore, it becomes important to explore personal and organizational factors that influence the grieving process among healthcare providers and to deal with workplace barriers to ensure effective coping with grief among healthcare providers.

Determinants of grieving process among healthcare providers:

Healthcare providers' ability to effectively cope with grief after a patient's death is an interactive process that depends on the individual (lifestyle) and work-environment (workstyle) factors (Papdatou, 2000) (See figure 2). Lifestyle factors include personality traits and a healthcare provider's value or belief systems. The personal history of loss and how it was dealt with also affects a person's coping mechanism. Institutional or workstyle factors, which contribute to how healthcare providers process their grief, include the goals and value systems of the organizations,

availability of organizational resources to staff, organizational attitudes towards its staff and the

culture of the work environment (Papdatou, 2000). For instance, if the organization recognizes

that caring for a patient throughout the dying process is a challenging task and acknowledges the

emotional and psychological needs of healthcare providers by developing appropriate provisions,

it becomes easier for healthcare providers to express and share their grief and become involved
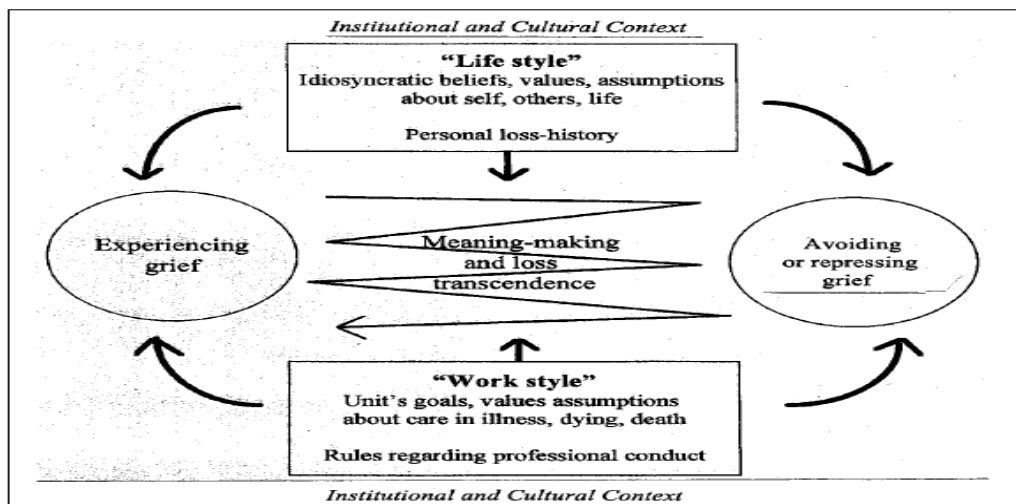
in effective coping.

Figure 2: Healthcare providers grieving process (Papdatou, 2000)

Institutional barriers can hinder effective coping among grieving healthcare providers. On many

occasions, healthcare providers have identified that the lack of training to deal with grief, lack of

support from their organization, lack of time to grieve over patients' deaths and excessive

workload as some workplace barriers to effectively cope with their grief after a patient's death

(Wenzel, Shaha, Klimmek & Krumm, 2011). Marcella & Kelly (2015), studied organizational

factors in long-term care setting that can influence grief and coping among frontline healthcare

providers. Many healthcare providers reported that the unpredictable nature of death, lack of

proper training and education regarding grief and loss, the concept of death being a part of work

and the silent culture in the organization regarding death are some of the barriers to effective processing of grief experiences (See figure 3 in appendix).

Organizations play a critical role throughout the grieving process of healthcare providers. If healthcare providers are not supported and helped during their grieving after patient death, it can affect their mental and emotional well-being, and lead to a cascade of stress that can ultimately cause exhaustion and high staff turnover rates, posing a negative impact on both quality of patient care and organizational budgets (Brosche, 2007) (See figure 4 in appendix). Therefore, it becomes vital to identify organizational strategies for healthcare organizations to support healthcare providers caring for dying patients.

Methods:

I used a literature review as the principal method for my capstone project. The search methodology focused on peer-reviewed articles. My search was not limited to any particular time range. However, due to scarcity and small number of peer-reviewed articles informing the role of supportive workplace strategies for healthcare providers dealing with patients' deaths, I incorporated the "gray literature" – non-peer reviewed articles, governmental, non-governmental and international organizational reports – to supplement the literature review. The aim of this literature review is to identify existing supports or strategies to provide grief support, reduce burnout and promote resilience among healthcare providers. Promoting resilience among healthcare providers means "enabling healthcare providers to successfully overcome or withstand sudden, unpleasant workplace events like patient death" (McEwen, 2011, p.2).

I employed a comprehensive search strategy in consultation with the SFU Health Sciences Librarian. The databases used for carrying out a literature search includes **Current Index of Nursing and Allied Health Literature (CINAHL)**, **Medline** and **Psych info** to identify

qualitative and quantitative research studies of workplace strategies to support healthcare providers' grief and loss after their patients' deaths. These three databases were included in the literature search to provide access to a wide range of peer–reviewed articles and texts relevant to this topic. To augment the literature search, some articles were manually searched from the bibliography of articles found from these three databases. The initial search used general key word search such as ("support for healthcare staffs or healthcare providers after patient death"), followed by a more advanced search using MeSH (subject headings) terms, such as "Attitude of Health Personnel" OR "Nursing Staff" OR "Medical Staff " OR "Nursing Staff, Hospital" OR "Medical Staff, Hospital" AND "Palliative Care" OR "End of Life Care" OR "Terminal Care" OR "Dying or Death " AND "Grief Support" OR "Bereavement Debriefing".

These search strategies yielded a total of 101 peer-reviewed articles. All titles and abstracts were skimmed and 20 articles were selected for the full-review. Further scrutiny of those 20 articles resulted in 13 articles that met the inclusion criteria for analysis. Articles were included if they reported stress among healthcare providers dealing with dying patients or end-of-life care, and provided information on workplace strategies to support staff caring for dying patients. I scanned the bibliography of all the eligible articles to identify additional sources relevant to the subject of this capstone. I also searched for relevant gray literature using key word search "Grief support for healthcare providers dealing with dying patients" and "emotional support for healthcare providers dealing with dying patients" in Google Scholar. Only English language and full text journals were reviewed for this literature review.

Results: Supportive workplace strategies

I identified a considerable amount of information on strategies to reduce burnout, compassion fatigue and grief among healthcare providers dealing with dying patients, especially in oncology

and palliative care setting. There was, however, a lack of empirical studies about the effectiveness of those strategies.

Following are some examples of workplace programs and strategies that have been proven to help healthcare providers cope with patients' deaths, and enhance effective grieving to reduce burnout and compassion fatigue among healthcare providers. The results of this literature review are divided into three parts: supportive policy development, resource development and appropriate practice changes.

1. Supportive policy development

Emotional safety policy: Providing physical safety in the healthcare setting is well established, but little attention is given to provide an emotionally safe working environment for healthcare providers. Administrators of Mercy Hospice Auckland (MHA) in New Zealand identified emotional needs of healthcare providers and introduced the emotional safety policy. The aim of the policy was to provide an emotionally and psychologically supportive work environment for palliative healthcare providers (Huggard & Nicholas, 2011). Before the formulation of this policy, the emotional safety committee was formed to identify the supportive needs of healthcare providers (Huggard & Nicholas, 2011). The policy includes a number of steps taken to avoid and reduce emotional stress, fatigue and burnout among staff of MHA. According to Huggard & Nicholas (2011), following are the range of organizational strategies that were introduced to promote and restore emotional safety:

- Proper recruitment of staff

- Precise job description

- Provision of thorough orientation program

- Ongoing, organized opportunities for professional supervision and support

- Ongoing feedback systems and regular discussion forums

- Encouraging reflective practices

- Debriefing of critical incidents when required by staff

- Effective scheduling of staff

- Acknowledgement of personal and workplace stressors among staff

- Celebrating individual and team success together

- Provision of two weeks of annual leave

Apart from the above workplace strategies, healthcare providers were encouraged to take responsibility for their own emotional safety by using available resources (See figure 5 in appendix). Huggard & Nicholas (2011), reported that MHA participated in the national online workplace survey in 2010 along with 245 organizations in New Zealand. The aim of the survey was to identify best practices and gain knowledge about how employees' attitudes and performances can be improved. The MHA was ranked fourth among the best practice organizations. More than 92% of the MHA staff had full trust in their organization; they felt that MHA cared about them and that they were respected by the organization (Huggard & Nicholas, 2011). Staff satisfaction wasn't solely due to the emotional safety policy; many other organizational factors contributed to staff satisfaction. Some healthcare organizations are already practicing some of the activities described in the emotional safety policy, but intentionally documenting those activities in its organizational policy can increase its recognition and utilization by staff. Furthermore, healthcare providers will get an idea that their emotional needs are being acknowledged and accepted by their organization.

2. Resource development

Quality Palliative Care in Long Term Care Alliance, Grief tool kit for staff: In the province

of Ontario, Canada, efforts have been made to support healthcare providers who work in

palliative and long-term care settings. A grief tool kit was formulated based on research

conducted by the Quality Palliative Care in Long Term Care (QPC-LTC) Alliance, including

four long-term care settings, group of researchers and 50 organizational partners. This tool kit

highlights the appropriate workplace interventions to support staff during their grief experienced

throughout end-of-life care or after a patient's death.

The QPC-LTC grief tool kit noted that healthcare providers often learn how to deal with

patients' deaths in their work environment. Therefore, it becomes crucial for the organization to

provide adequate training and resources to healthcare providers. Through this tool kit, staff in

different LTC settings in Ontario identified a number of coping strategies in managing their

grief. These coping strategies are:

-The acceptance and preparation for a patient's death

- Reflecting and acknowledging a patient's achievement during his or her lifetime

- Seeking support from peers and co-workers

(Grief support tool kit, 2006)

Additional strategies suggested by the LTC staff as supportive during their grieving process

through the research survey conducted by QPC-LTC alliance are as follows:

- Proper education and training during orientation process

- Informal support from peers and co-workers

- Additional formal supports such as debriefing sessions on regular basis

- Adopting some rituals after the death of patient as a standard part of practice

- Memorial service bi-annually or annually.

The formation of this tool kit recognizes the emotional needs of healthcare providers and accepts their need to grieve. It also highlights the critical role organizations can play in influencing loss and grief experienced by staff working in long-term care settings and other areas of care. The generalizability of these strategies, which were identified as helpful by those LTC staff who participated in the research, requires further validation.

3. Practice changes or interventions

a. Art therapy to reduce death anxiety and burnout in End of Life care providers:

Art therapy may help healthcare providers dealing with dying patients in expressing their emotions and grief, reducing and managing stress, promoting support seeking behaviors. Art therapy has been beneficial to assist in expressing emotions and feelings which are difficult to verbalize (Potash et al., 2014).

In 2014, Potash and his colleagues conducted a quasi-experimental study to understand the effects of supervised art therapy in end-of-life care providers, including nurses, doctors, clergy, social workers and volunteers, occupational therapists and physical therapists from different hospice care settings in Hong Kong. The study participants were assigned randomly to two groups, either supervised art therapy or a skill-based supervision group, which was a part of a regular training program for all hospice workers organized by the Society for the Promotion of Hospice Care. Each group shared similar demographics. Each course was offered three times in one year period, having 25 participants in each session. There were six weekly-3 hour sessions for art therapy based supervision offered by a certified art therapist (Potash, Ho, Chan, Wang & Cheng, 2014). The activities in this session included deep breathing exercise, guided imaginary, making art, reflective writing and group discussions (Potash et al., 2014). The details about the

focus area of these sessions are in table 7 in the appendix. The skills-based supervision included three 6-hour sessions on a daily basis led by a counselling psychologist and nurse consultant. The focus areas of this session were providing opportunities to acquire new clinical skills and engage in case analysis (see table 8 in appendix). The self-standardized surveys or scales used prior and post to evaluate course effectiveness include Maslach Burnout Inventory-General Survey (MBI-GS), the Five Facet Mindfulness Questionnaire (FFMQ), and the Death Attitude Profile- Revised (DAP-R) (Potash et al., 2014).

The MBI-GS results suggested the exhaustion among art based supervision group was reduced significantly from the baseline mean (Baseline mean=15.46 and post intervention mean=13.73) (P-value=0.011) as compared to control group in which mean reduction was not very significant (baseline mean=15.19, post intervention mean=14.74). The FFMQ results revealed a significant increase in observing the external world for the art-therapy-based supervision group from baseline (M=26.55) to post-intervention (M=28.26) (P-value=0.002). The art therapy based supervision group experienced significant decreases in acting with awareness from baseline (M=21.17) to post-intervention (M=19.69) (P-value =0.013) and for non-judging of inner experiences from baseline (M=22.42,) to post-intervention (M=21.47) (P-value=0.038) compared to control group. Along with this, DAP-R scale also showed significant reduction in fear of death and death avoidance score among art-based supervision group as compared to control group (Refer to the table 4 for detailed results).

Tool	Subscale	Art-therapy-based supervision group (n=56)						Skills-based supervision group (n=57)					
		Baseline mean	SD	Follow-up mean	SD	t	P	Baseline mean	SD	Follow-up mean	SD	t	P
	Exhaustion	15.46	5.93	13.73	5.40	2.64	0.011*	15.19	6.22	14.74	6.15	0.82	0.42
	Cynicism	10.84	5.17	11.58	4.83	-1.08	0.29	11.63	4.71	12.94	3.65	-2.60	0.012*
MBI-GS	Professional efficacy	26.29	6.46	25.78	5.61	0.87	0.39	24.80	6.02	24.27	5.66	0.78	0.44
	Observing	26.55	4.27	28.26	4.41	-3.29	0.002*	26.22	4.26	26.33	3.91	-0.31	0.76
	Describe	24.18	2.03	24.49	1.89	-1.32	0.19	24.31	2.34	24.17	2.35	0.37	0.71
	Acting with awareness	21.17	4.79	19.69	4.50	2.58	0.013*	20.53	4.30	20.86	4.19	-0.72	0.48
	Non-judging of inner experiences	22.42	4.91	21.47	4.51	2.13	0.038*	22.84	3.94	23.27	4.22	-0.94	0.35
FFMQ	Non-reactivity to inner experiences	22.04	2.85	22.46	3.30	-1.08	0.29	21.45	2.29	21.47	2.28	-0.06	0.95
	Fear of death	2.64	0.87	2.33	0.92	3.63	0.001*	2.98	0.97	3.22	0.99	-2.88	0.006*
	Death avoidance	2.45	1.17	2.21	1.15	2.14	0.037*	2.75	0.92	3.07	1.10	-2.25	0.029*
	Neutral acceptance	5.91	0.63	5.96	0.80	-0.48	0.64	5.73	0.68	5.52	0.83	1.90	0.063*
	Approach acceptance	5.23	1.24	5.45	1.23	-2.67	0.010*	4.84	1.12	4.77	1.03	0.92	0.36
DAP-R	Escape acceptance	3.90	1.28	4.11	1.57	-1.28	0.21	4.00	1.26	4.15	1.38	-1.00	0.33

Table 4. Results of the burnout and death anxiety measure self-analyses

DAP-R, Death Attitude Profile—Revised; FFMQ, Five Facet Mindfulness Questionnaire; MBI-GS, Maslach Burnout Inventory—General Survey; SD, standard deviation. *Significant at $P<0.05$.

Source: Potash et al., 2014

This research suggests that art-therapy based supervision can reduce burnout, exhaustion and death anxiety among healthcare providers working with dying patients. Further studies are needed to validate its effectiveness in different healthcare settings around the globe and to demonstrate the benefits in longitudinal studies.

b. Bereavement Debriefing Sessions:

Bereavement debriefing sessions appear to be an effective strategy to support anyone who is exposed to critical, traumatic or devastating incidents (Mitchell & Everly, 2001). To improve quality of care provided to pediatric patients with terminal illnesses, multidisciplinary bereavement debriefing sessions were developed as a part of palliative care program at John Hopkins Children's Center in 2002, and offered to members of the team caring for these patients (Rushton et al., 2006). Under the pediatric palliative care program, 113 bereavement sessions were organized to provide adequate emotional support to multidisciplinary staff in distress after the death of a patient. These sessions offered healthcare providers a platform to express and

reflect on their relationship with the patient and their feelings about his or her death. Further, the sessions were an opportunity for healthcare providers to reflect on the circumstances of a patient's death and express their feeling about how the patient's death affected their caring role. The format of the debriefing sessions is shown in figure 6 below.

Format and Structure of Bereavement Debriefing Sessions

Format	Structure
Welcome and Introductions	• Review purpose of bereavement debriefing sessions • Invite participants to give names and answer • "How were you involved in care for this patient and family?"
Factual Information	• Review time of death circumstances
Case Review	• "What was it like taking care of this patient?" • "What was the most distressing aspect of the case?" • "What was the most satisfying aspect of the case?"
Grief Responses	• "What have you experienced since the death?" (Elicit physical, emotional, behavioral, cognitive, or spiritual responses)
Emotional	• "What will you remember most about this patient/family?"
Strategies for Coping with Grief	• "How are you taking care of yourself so you can continue to provide care for other patients and families?" • Review grief coping strategies • Review available resources
Lessons Learned	• "What lessons did we learn from caring for this patient/family?"
Conclusion	• Acknowledge care provided • Review bereavement support available for families and staff

Figure 6: Format of debriefing sessions (Keene et al., 2010)

The impact of these debriefing sessions was evaluated using self–report. The evaluation process showed that staff who participated in these sessions reported an increased sense of well-being by helping them to manage their grief effectively and also help them to involve in reflective practice for professional growth (Keene et al., 2010). Hence, debriefing sessions can be used as a platform to help healthcare providers to reflect on the death of a patient and express their feelings of grief.

c. Formation of Grief team:

Establishing grief teams to support healthcare providers after a patient's loss is critical to reduce compassion fatigue and burnout, and promote emotional and mental well-being of the nurses and

other healthcare providers (Brosche, 2007). The grief team is a resource that can help healthcare providers feel that it is appropriate to grieve after patient death and provide them opportunity to grieve in their own manner and at their own pace. Brosche (2007) noted that grief teams can help minimize the "disenfranchised grief or cumulative grief" among healthcare providers. The formation of a grief team can help eliminate the taboo or stigma attached with mourning after a patient's death, including critical care areas such as intensive care units. The grief team consists of experienced healthcare providers, including nurses and doctors, who are trained by crisis management teams and bereavement counselors (Brosche, 2017). After every incident of patient death, the grief team offered support to healthcare providers. This intervention was developed for intensive care unit nurses, but it can be used to support other healthcare providers during their grieving process. Establishing grief support teams need further study before it is widely implemented (Brosche, 2007).

All of the examples shared in the results section have limited evidence regarding long-term efficacy in reducing burnout, promoting resilience and supporting staff during their grieving process. Further research studies are needed to validate their long-term efficacy in different settings and among different healthcare providers around the world. In my opinion qualitative research approaches such as Focus Group Discussions (FDGs) and individual interviews can serve as an effective tool to identify the needs and expectations of healthcare providers in different settings, in regard to their emotional safety. It can also help to identify supportive strategies or interventions required by healthcare providers to maintain their emotional well-being at their workplace. After conducting FGDs and interviews, healthcare providers would be randomly assigned to receive an intervention or serve as a control group. Self- reported evaluation and other standardized survey tools can be used to understand the outcomes of that

experimental study. This type of research study will help administrators of the organization to understand the effectiveness of those proposed strategies over a certain period of time and will guide them in implementing effective strategies on a wider level.

Discussion:

The workplace environment has a big impact on the health of healthcare providers. The World Health Organization (2008) considers employment and working conditions as among the key social determinants of health. The social determinants of health affect a person's overall health status. Therefore, WHO (2008) clearly states that every healthcare organization has a responsibility to develop appropriate occupational health policies and programs, and adds that a primary focus should be on upholding healthcare providers' health and well-being.

The Canadian Healthcare Association (CHA) (2013), identifies psychological and emotional health as a primary component for creating and sustaining a productive, effective and mentally healthy workforce. CHA sets out a standard for psychological health and safety in the workplace and strongly recommends all health organizations follow those standards. The implementation of appropriate strategies to promote emotional and psychological health of workers can be critical in the reduction of staff turnover and job productivity. Also, a psychologically safe workplace environment is important in reducing the number of patient-safety errors and leads to well-functioning healthcare systems by providing highly engaged healthcare providers (Hugh & Shamian, 2013). Indeed, employers or organizations have a legal responsibility to maintain healthy and safe workplace environments for workers, which also includes providing emotionally and psychologically safe work environments (Shain, 2009).

Healthcare profession is regarded as some of the most stressful professions. According to Statistics Canada, work-related stress among healthcare providers is potentially higher than any

other occupation. The Occupational Health and Safety Agency of Healthcare (OHSAH) in BC, under the Healthy Workplace initiative, conducted a survey that revealed that dealing with trauma and patient death is one of the key workplace stressors affecting the psychological and emotional health of healthcare providers (2007).

Many organizations around the globe have recognized the importance of providing psychologically healthy and safe working environment. However, only a few organizations in some countries, including Canada, are now working to provide a psychologically safe working environment (Lowe, 2006 & Kitts, 2013). Healthcare organizations are trying to engage in developing innovative strategies to address emotional and mental stress among healthcare providers. Examples include providing training on emotional intelligence and reflection. Peer-support programs have also been used as a supportive strategy for tackling mental health issues among workers in Canada (Mental Health Commission of Canada, n.d.). But these peer-support programs have not been established in the workplace settings that raises accessibility issues (OHSAH, 2007). Another program in Canada is an Employee Assistance Program (EAP) that provides counselling, crisis management, and advice to the employees of certain organizations (Health Canada, 2016). Again, it requires time to make an appointment and some people might not feel comfortable discussing their situation with a person who is outside of their profession or stranger. Therefore, supportive strategies should meet the needs of the healthcare providers and be easily available to them.

Supportive workplace strategies have been identified for healthcare providers who work in a palliative care setting and oncology units to help them grieve and cope after a patient's death. Informal caring rituals, such as a healthcare providers gathering in the room of a deceased patient to talk about their feelings and emotions can be beneficial. Attending the funeral of a deceased

patient can also help healthcare providers cope with a patient's death. (Gerow et al., 2010 and Hildebrandt, 2012). If healthcare providers wish to attend the funeral of a deceased patient, organizations should provide opportunities for staff to attend those rituals. Moreover, organizing staff retreats, get-togethers, sending out bereavement cards to patient families, creating a memory tree having the names of the deceased patients on the leaves of the tree have also been described as effective strategies (Medland, Howard-Ruben & Whitaker, 2004 and Houk, 2013). Formal and informal peer support is viewed as beneficial among many staff and it provides a platform for effective closure after the death of a patient (Hildebrandt, 2012). Some healthcare providers reported that their religion, their faith, or engaging in alternate therapies, like meditation, was one way to overcome grief after the death of a patient (Granek, et al., 2016). Houk (2013) views effective coping and reduction of compassion fatigue as a shared responsibility of the organization and staff. The summary of roles and responsibility of healthcare providers and organizations in dealing with patients' deaths and dying processes as cited by Aycock & Boyle, 2009 is shown in figure 9 in appendix.

My literature review clearly highlights the need for supportive workplace strategies to maintain the emotional and psychological well-being of healthcare providers who care for dying patients. It also provides some valuable examples of supportive strategies that can be potentially helpful for reducing death anxiety, burnout and compassion fatigue among healthcare providers. However, according to Van Staa et al. (2000), the successful implementation of a strategy cannot be achieved if it does not meet the needs of the target population. Thus, it is important to consider the perceived needs and coping mechanisms of healthcare providers, their level of experience and training, the nature of their work specialty, the culture of the organization or

specific unit, the working relation between healthcare team members, the availability of existing resources and funding, and the organizational willingness to implement new initiatives.

Recommendations:

My literature review suggests that healthcare organizations should provide appropriate and accessible strategies to support their employees' emotional and psychological well-being. The supportive strategies could include proper training and education, supportive policy development and resource development after proper assessment of emotional needs of the healthcare providers.

The key to building resilience among healthcare providers is the provision of appropriate training in emotional intelligence and reflective practices. Providing training in reflective practices and emotional intelligence will enable healthcare providers to identify their own emotional responses and will provide them ability to manage them successfully. Educational sessions should be organized for healthcare providers regarding the warning signs of cumulative grief and information about supportive resources available in the workplace. Besides appropriate training and education for healthcare providers, establishing a culture of acceptance within an organization is pivotal. The healthcare organizations should establish the importance of acknowledging grief as a normal human response to the patient death and offer opportunities for healthcare providers to reflect on their work experiences. This can be achieved by introducing policies and initiatives focused towards upholding the emotional well-being of healthcare providers. Placing emotional safety as an integral part of organizational policy reflects that the organization is acknowledging healthcare providers' emotional needs and is willing to provide them support. This can create awareness among all organizational staff regarding emotional stress and grief of healthcare providers, and in turn, this will encourage healthcare providers to

seek help and utilize organizational resources effectively when needed. Furthermore, healthcare organizations should conduct a needs assessment to identify the strategies that healthcare providers feel is supportive for them to deal with patient death and also help them to provide quality care to dying patients.

Lastly, making the grieving resources accessible to every staff person within their own work setting regardless of their specialty area, is critical as dealing with death is a subjective feeling, and attitudes towards death and dying can vary widely among healthcare providers irrespective of their area of specialty and other demographic factors. Thus, organizations can support healthcare providers in dealing with death and dying of patients by acknowledging their emotional needs, creating a culture of acceptance in the workplace, providing appropriate training, and providing adequate, suitable and accessible resources within their own work environment.

Conclusion:

The evidence presented in this paper indicates that there is a growing awareness about stress in dealing with dying patients and the need for supportive organizational initiatives. Most of the previous research, with a focus on grieving and cumulative stress, was targeted to nurses in palliative/ hospice and oncology; increasingly, the focus is expanding to include all healthcare providers who can expect to care for dying patients.

In this literature review, it became evident to me that some strategies exist to support healthcare providers after the death of a patient to enhance compassion, and to prevent burnout and cumulative stress. Unfortunately, the long-term effectiveness of these strategies is lacking.

<u>Reflection:</u>

The MPH program at Simon Fraser University was a unique and inspiring experience for me. I entered this program having clinical experience as a nurse, but I had no public health training. I appreciate the knowledge and skills that I have acquired as being part this program, and it has contributed a lot towards my professional development as an emerging public health practitioner. This capstone project is the last step towards completion of the MPH program, built not only on the knowledge and skills gained from this degree program, but on my commitment and passion to enhance the health and well-being of healthcare providers. Through this capstone project, I was able to apply concepts of environmental and occupational health, including risk assessments, policy and program evaluation, and system thinking approach. The subject area of this capstone was of particular interest to me because I am a nurse, and my capstone helped me in articulating the steps and strategies needed to support healthcare providers caring for dying patients. Now, I feel more confident in articulating the critical steps needed to improve emotional well-being of healthcare providers and look forward to serving as an agent of change to ensure that healthcare providers have access to safe, healthy and supportive workplace environments.

References:

Aycock, N., & Boyle, D. (2009). Interventions to manage compassion fatigue in oncology nursing. *Clinical journal of oncology nursing*, *13*(2), 183.

Bagdasarov, Z., & Connelly, S. (2013). Emotional labor among healthcare professionals: the effects are undeniable. *Narrative inquiry in bioethics*, *3*(2), 125-129.

Branch, C., & Klinkenberg, D. (2015). Compassion fatigue among pediatric healthcare providers. *MCN: The American Journal of Maternal/Child Nursing*, *40*(3), 160-166.

Brosche, T. A. (2007). A grief team within a healthcare system. *Dimensions of critical care nursing*, *26*(1), 21-28.

Cocker, F., & Joss, N. (2016). Compassion fatigue among healthcare, emergency and community service workers: A systematic review. *International journal of environmental research and public health*, *13*(6), 618.

Commission on Social Determinants of Health (2008). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf

Deffner, J. M., & Bell, S. K. (2005). Nurses' death anxiety, comfort level during communication with patients and families regarding death, and exposure to communication education: a quantitative study. *Journal for Nurses in Professional Development*, *21*(1), 19-23.

Dunn, K. S., Otten, C., & Stephens, E. (2005). Nursing experience and the care of dying patients. *Oncology Nursing Forum-Oncology Nursing Society*, *32*(1), 97-104.

Fowler, R., & Hammer, M. (2013). End-of-life care in Canada. *Clinical & Investigative Medicine*, *36*(3), 127-132. Retrieved from http://cimonline.ca/index.php/cim/article/view/19723

Gerow, L., Conejo, P., Alonzo, A., Davis, N., Rodgers, S., & Domian, E. W. (2010). Creating a curtain

of protection: Nurses' experiences of grief following patient death. *Journal of nursing*

scholarship, *42*(2), 122-129.

Grandey, A. A. (2000). Emotional regulation in the workplace: A new way to conceptualize emotional

labor. *Journal of Occupational Health Psychology, 5,* 95–110. doi:10.1037/1076–8998.5.1.95

Granek, L., Ariad, S., Shapira, S., Bar-Sela, G., & Ben-David, M. (2016). Barriers and facilitators in

coping with patient death in clinical oncology. *Supportive Care in Cancer*, *24*(10), 4219-4227.

Health and health care for an aging population. (2013). A policy summary of the Canadian Medical

Association. Retrieved from https://www.cma.ca/Assets/assetslibrary/document/en/advocacy/policy-

research/CMA_Policy_Health_and_Health_Care_for_an_Aging-Population_PD14-03-e.pdf

Health Canada. (2016). Environmental and workplace health. Employee Assistance Program. Retrieved

from http://www.hc-sc.gc.ca/ewh-semt/occup-travail/empl/eap-pae-eng.php

Hildebrandt, L. (2012). Providing grief resolution as an oncology nurse retention strategy: a literature

review. *Clinical journal of oncology nursing*, *16*(6), 601.

Huggard, J. & Nicholes, J. (2011). Emotional safety in the workplace: one hospice's response for

effective support. *International Journal of Palliative Nursing 17*(12), 611-617.

Houck, D. (2014). Helping nurses cope with grief and compassion fatigue: An educational

intervention. *Clinical journal of oncology nursing*, *18*(4), 454.

How healthy are Canadians? The government of Canada. (2017, April 11). Retrieved from

https://www.canada.ca/en/public-health/services/publications/healthy-living/how-healthy-

canadians.html

Keene, E. A., Hutton, N., Hall, B., & Rushton, C. (2010). Bereavement debriefing sessions: an

    intervention to support health care professionals in managing their grief after the death of a

    patient. *Pediatric nursing*, *36*(4), 185.

Kitts, J. (2013). Psychological health and safety in Canadian healthcare settings. *Healthcare quarterly*

    (Toronto, Ont.), *16*(4), 6.

Lehto, R. H., & Stein, K. F. (2009). Death anxiety: an analysis of an evolving concept. *Research and*

    theory for nursing practice, *23*(1), 23-41

Lowe, G. S. (2006). Creating healthy health care workplaces in British Columbia: Evidence for

    action. *Provincial Health Services Authority of British Columbia.* Retrieved from

    http://www.phsa.ca/population-public-health-

    site/Documents/Creating%20Healthy%20Health%20Care%20Workplaces%20in%20BC-

    Evidence%20for%20Action%20(2006).pdf

Marcella, J., & Kelley, M. L. (2015). "Death is part of the job" in long-term care homes: Supporting

    direct care staff with their grief and bereavement. *SAGE Open*, *5*(1), doi: 2158244015573912.

McEwen, K. (2011). *Building resilience at work.* Australian Academic Press. Retrieved from

    https://books.google.ca/books?hl=en&lr=&id=Vw8NAaaaCR4C&oi=fnd&pg=PA1&dq=buildin

    g+resilience+at+work&ots=MNwAqRdR-

    q&sig=6CwbKJePjf8nV7BhrxLTmi7E0k8#v=onepage&q=building%20resilience%20at%20wor

    k&f=false

Medland, J., Howard-Ruben, J., & Whitaker, E. (2004). Fostering psychosocial wellness in oncology

    nurses: Addressing burnout and social support in the workplace. *Oncology Nursing Forum, 31,*

    47–54.

Mental Health Commission of Canada. (n.d.). *Issue: Peer support*. Retrieved from

http://www.mentalhealthcommission.ca/English/issues/peersupport?routetoken+1191ef639935d

862fe2f19be006a4bad&terminitial=25

McVicar, A. (2003). Workplace stress in nursing: a literature review. *Journal of advanced

nursing*, *44*(6), 633-642.

Mitchell, J.T. & Everly, G.S. (2001). 3rd Ed. Critical Incident Stress Debriefing: An Operations Manual

for CISD, Defusing and Other Group Crisis Intervention Services. Ellicott City, MD: Chevron

Publishing Corporation.

Nia, H. S., Lehto, R. H., Ebadi, A., & Peyrovi, H. (2016). Death anxiety among nurses and health care

professionals: A review article. *International journal of community based nursing and

midwifery*, *4*(1), 2.

Occupational Health and Safety Agency for Healthcare in BC. (2007). *Changing the workplace.

Improving mental health among hospital workers*. Retrieved from

http://www.phsa.ca/Documents/Occupational-Health

Safety/FactSheetChangingtheWorkplaceImprovingMentalHealth.pdf

O'Connor, D. B., O'Connor, R. C., White, B.L., &. Bundred, P.E. (2000). The effect of job strain on

British general practitioners' mental health. *Journal of Mental Health*, *9*(6), 637-654.

Papadatou, D. (2000). A proposed model of health professionals' grieving process. *OMEGA-Journal of

Death and Dying*, *41*(1), 59-77.

Payne, S.A., Dean, S.J., & Kalus, C. (1998). A comparative study of death anxiety in hospice and

emergency nurses. *Journal of advanced nursing*, *28*(4), 700-706.

Peters, L., Cant, R., Payne, S., O'Connor, M., McDermott, F., Hood, K., ... Shimoinaba, K. (2013). How

    death anxiety impacts nurses' caring for patients at the end of life: a review of literature. *The*

    open nursing journal, *7*(1).

Peterson, J., Johnson, M., Halvorsen, B., Apmann, L., Chang, P. C., Kershek, S., … Pincon, D. (2010).

    What is it so stressful about caring for a dying patient? A qualitative study of nurses'

    experiences. *International Journal of Palliative Nursing*, *16*(4).

Potash, J. S., Ho, A. H., Chan, F., Wang, X. L., & Cheng, C. (2014). Can art therapy reduce death

    anxiety and burnout in end-of-life care workers? A quasi-experimental study. *International*

    journal of palliative nursing, *20*(5), 233-240.

Quality Palliative Care in Long Term Care Alliance. (2006). Grief Support for staff. Retrieved from

    http://www.palliativealliance.ca/assets/files/Alliance_Reources/Org_Change/Grief_toolkit-

    Oct._11.pdf

Rickerson, E. M., Somers, C., Allen, C. M., Lewis, B., Strumpf, N. & Casarett, D. J. (2005). How well

    are we caring for caregivers? Prevalence of grief related symptoms and need for bereavement

    support among long term care staff. *Journal of pain and symptom management,* 30(3), 227-233.

Robinson, J. R., Clements, K., & Land, C. (2003). Workplace stress among psychiatric nurses. *Journal*

    of Psychosocial Nursing and Mental Health Services, *41*(4), 32-41

Rushton, C. H. (2017). Cultivating Moral Resilience. *AJN The American Journal of Nursing*, *117*(2),

    S11-S15.

Shain, M. (2009). Stress at work. *Mental injury and the law in Canada: A discussion paper for the*

    Mental Health Commission of Canada.

Shorter, M., & Stayt, L. C. (2010). Critical care nurses' experiences of grief in an adult intensive care

    unit. *Journal of advanced nursing*, *66*(1), 159-167

Statistics Canada. (2017). Deaths in hospital and elsewhere, in Canada, provinces, territories. Retrieved

   from http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1020509

Van Staa, A.L., Visser, A., van der Zouwe, N. (2000). "Caring for caregivers: experiences and

   evaluation of interventions for a palliative care team". *Patient Education and Counseling* 41, 93-
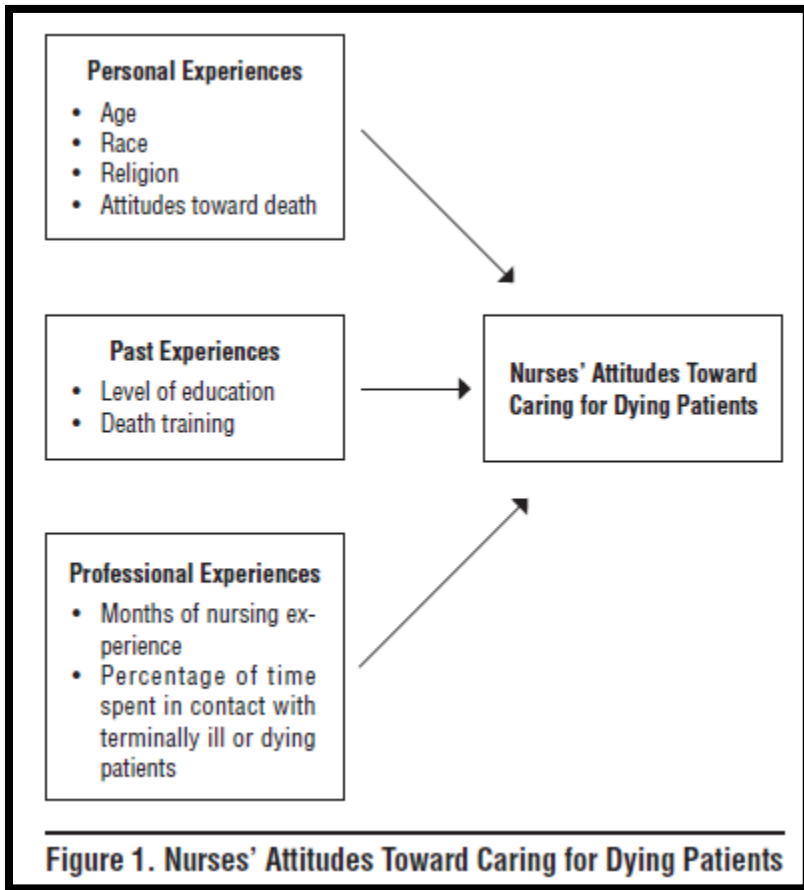
   105.

Wenzel, J., Shaha, M., Klimmek, R., & Krumm, S. (2011). Working through grief and loss: Oncology

   nurses' perspectives on professional bereavement. *Oncology nursing forum, 38*(4), 272.

Whitebird, R. R., Asche, S. E., Thompson, G. L., Rossom, R., & Heinrich, R. (2013). Stress, burnout,

   compassion fatigue, and mental health in hospice workers in Minnesota. *Journal of palliative*

   medicine, *16*(12), 1534-1539.

Wilson, J. (2014). Ward staff experiences of patient death in an acute medical setting.

   Nursing Standard, 28 (37), 37-45.

Wilson, J., & Kirshbaum, M. (2011). Effects of patient death on nursing staff: a literature review. *British*

   journal of nursing, *20*(9), 559-563.

Appendix:

Figure 1. Nurses' Attitudes Toward Caring for Dying Patients

Source: Dunn, Otten & Stephens, 2005

Figure 3: Organizational context influencing grieving process among healthcare providers long-term care settings. (Marcella & Kelly, 2015)
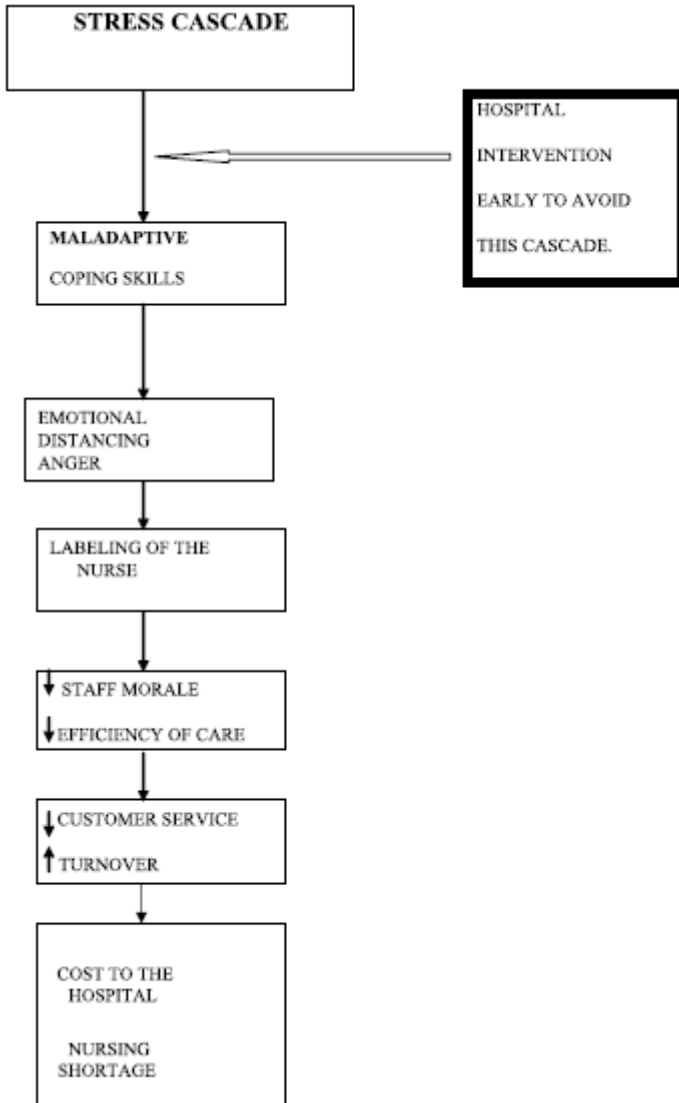
```
STRESS CASCADE
        │
        │          ◄──────────────  ┌─────────────────┐
        │                           │ HOSPITAL        │
        ▼                           │ INTERVENTION    │
┌──────────────────┐                │ EARLY TO AVOID  │
│ MALADAPTIVE      │                │ THIS CASCADE.   │
│ COPING SKILLS    │                └─────────────────┘
└──────────────────┘
        │
        ▼
┌──────────────────┐
│ EMOTIONAL        │
│ DISTANCING       │
│ ANGER            │
└──────────────────┘
        │
        ▼
┌──────────────────┐
│ LABELING OF THE  │
│     NURSE        │
└──────────────────┘
        │
        ▼
┌──────────────────┐
│ ↓ STAFF MORALE   │
│ ↓ EFFICIENCY OF CARE │
└──────────────────┘
        │
        ▼
┌──────────────────┐
│ ↓ CUSTOMER SERVICE │
│ ↑ TURNOVER       │
└──────────────────┘
        │
        ▼
┌──────────────────┐
│ COST TO THE      │
│   HOSPITAL       │
│                  │
│   NURSING        │
│   SHORTAGE       │
└──────────────────┘
```

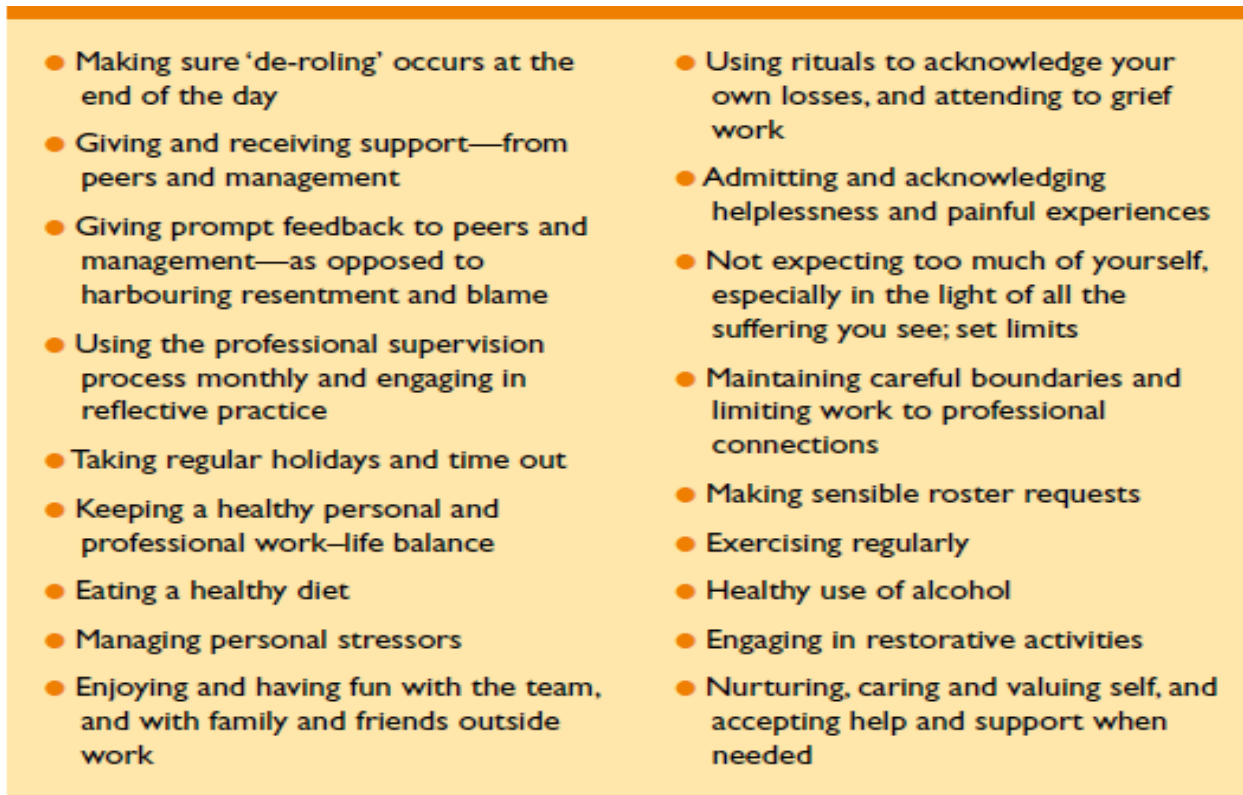Figure 4: Stress cascade among healthcare providers. (Brosche, 2007)

- Making sure 'de-roling' occurs at the end of the day
- Giving and receiving support—from peers and management
- Giving prompt feedback to peers and management—as opposed to harbouring resentment and blame
- Using the professional supervision process monthly and engaging in reflective practice
- Taking regular holidays and time out
- Keeping a healthy personal and professional work–life balance
- Eating a healthy diet
- Managing personal stressors
- Enjoying and having fun with the team, and with family and friends outside work
- Using rituals to acknowledge your own losses, and attending to grief work
- Admitting and acknowledging helplessness and painful experiences
- Not expecting too much of yourself, especially in the light of all the suffering you see; set limits
- Maintaining careful boundaries and limiting work to professional connections
- Making sensible roster requests
- Exercising regularly
- Healthy use of alcohol
- Engaging in restorative activities
- Nurturing, caring and valuing self, and accepting help and support when needed

Figure 5: Personal responsibilities to ensure emotional safety for self (Emotional safety policy as cited in Huggard & Nicholas, 2011)

Broad theme	Sub-theme	Activity
Self-care and stress management	Self-awareness	Create a mandala (circle) to symbolise present feelings
	Symbols of stress	Create art to represent stress and then transform it to make yourself feel better
Case sharing and clinical skills	Meaningful patient interactions	Create art about a patient interaction that demonstrated professional strength
	Challenging patient interactions	Create art about a patient interaction that was challenging
Grief and bereavement	Symbols of grief	Create art to represent an encounter relating to a patient's death
	Finding meaning	Create a mandala to demonstrate meaning

Table 7: Focus areas of art-therapy-based supervision sessions (Potash, et al., 2014)

Broad theme	Sub-theme	Activity
Overview of basic and intermediate counselling skills	Basic concept and skills	Mini-lecture with examples from trainer's past clients
	Concept elaboration and advanced skills	Mini-lecture with examples from trainer's past clients
Case presentation	Patient interaction	Sharing of selected tape-recorded client interactions and transcriptions
	Reflection on patient interaction	Present how the situation was handled, the thoughts and feelings evoked, and how the worker experienced themselves in the situation
	Reflection on death	Case enactment with 'family sculpture' or role play
Case analysis	Reflective learning	Group discussion on reflections and interpretations of the situation, possible solutions and alternative approaches

Table 8: Focus areas of Skill-based supervision sessions (Potash, et al., 2014)

Organizational Responsibilities
- Allow time and opportunities for grieving—meditation areas, memory boards or books, and remembrance ceremonies.
- Ensure outlets for sharing emotional expressions, such as closure conferences, debriefings, retreats, professional counseling, and pastoral care.
- Offer education on grief theories, compassion fatigue, end-of-life care, and communication.

Personal Responsibilities
- Recognize feelings of grief and loss, allowing time to grieve.
- Identify ways to renew personal strength and well-being (e.g., spirituality, music, yoga, relaxation).
- Find activities that bring comfort and refreshment.
- Maintain physical health.
- Develop an appropriate work-life balance.
- Build positive relationships in personal and professional lives.
- Seek professional help when needed.
- Recognize the positive impact nurses have on patients and families.

Figure 9: Interventions for reducing compassion fatigue and Cumulative grief by Aycock & Boyle, 2009