Qualitative Research

Nurses' Experiences of Grief Following Patient Death

A Qualitative Approach

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Purpose: To explore the lived experiences of nurses' feelings, emotions, grief reactions, and coping mechanisms following their patients' death. **Background:** On a daily basis, nurses are experiencing patients' death, which exposes them to grief. Nurses' grief has not been sufficiently addressed in practice settings, although it has been a well-known threat to health and work performance. **Design:** A qualitative design guided by a phenomenological approach was adopted. **Method:** Data were collected from a purposive sample of 21 Jordanian nurses by conducting three focus groups and analyzed using Colaizzi's framework. **Findings:** Four themes were generated in which participants reported feelings of grief following their patients' death. Their grief emotions were reported as sadness, crying, anger, shock, denial, faith, fear, guilt, fear of the family's reaction, and powerlessness. **Conclusions:** The study provided evidence that nurses respond emotionally to patients' death and experience grief. Nurses are burdened by recurrent patients' deaths and try to cope and overcome their grief. This study emphasizes the importance of developing strategies to help nurses positively cope with their grief from a holistic perspective. This will reflect positively on the nurses' performance.

Keywords: *grief; death; dying; experiences; support; qualitative; Jordanian nurses*

Grief is an individualized experience and depends on many factors, including social support, self-esteem, and socioeconomic status (Hooyman &

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Kramer, 2013; Thomas & Pierson, 2010). Grief is expressed by physical, emotional, mental, behavioral, and spiritual manifestations (Hall, 2011). The grieving person goes through five stages, denial, anger, bargaining, depression, and acceptance (Kübler-Ross, Kessler, & Shriver, 2014; Kübler-Ross, Wessler, & Avioli, 1972).

Grief is a normal reaction to the loss of a significant thing or person to us, and it is the price we pay for love and commitment to each other (Hooyman & Kramer, 2013). The fundamental goal of nursing care is to ensure recovery, welfare, and survival of the patient. Although the advances in technology and health care are expected to prolong life and decrease the incidence of death, but this is not always true as nurses still encounter patients' death daily. By feeling committed to their patients, nurses also experience grief, especially those who work with terminally ill patients. A study by Kent, Anderson, and Owens (2012) revealed that the earliest memory of patients' death occurs during the undergraduate years and in the first year of nursing practice, affecting their professional and personal lives.

Many studies have investigated patients' or families' grief (Boelen & Prigerson, 2007; Khalaf, 1989; Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001; Piper, Ogrodniczuk, Azim, & Weideman, 2014; Prigerson et al., 2002; Tie & Poulsen, 2013). Other studies have investigated nurses' grief in different countries (Chan, Lee, & Chan, 2013; Jonas-Simpson, Pilkington, MacDonald, & McMahon, 2013; Shorter & Stayt, 2010; Yu & Chan, 2010). To our knowledge and after an extensive review of literature via different databases, including the Jordanian Data Base for Nursing Research, no study has investigated Jordanian nurses' grief experiences following the death of patients. Therefore, the purpose of this study was to explore the lived experiences of Jordanian nurses' feelings, emotions, grief reactions, and coping mechanisms following their patients' death. The study will contribute to filling the knowledge gap related to nurses' grief, to help nurses understand the grief process, and develop needed guidelines to facilitate it.

Literature Review

Grief is a significant human experience (Pilkington, 2006), and health care providers experience grief following a patient's death (Genevro, Marshall, &

Miller, 2004). The death of patients can influence nurses either inside or outside the work place (Wenzel, Shaha, Klimmek, & Krumm, 2011). Shorter and Stayt (2010) found that exposure to death and grief may lead to occupational stress and emotional disengagement that have an impact on the quality of care for both the dying patients and their family, and it is a well-known threat to health and work performance (Saunders & Valente, 1994). The presence of barriers to transition in grieving by nurses can affect them, which contribute to work-related stress, burnout, and increase nurse turnover (Bailey, Murphy, & Porock, 2011; Shorter & Stayt, 2010).

Many studies using different qualitative and quantitative methods explored and examined nurses' experiences, feelings, and attitudes concerning the death of their patients (Peters et al., 2012; Schmidt, 2011; Wilson & White, 2011; Yu & Chan, 2010). A qualitative study conducted by Yu and Chan (2010) described the responses of 12 intensive care unit nurses to patients' death; the study revealed that nurses need to understand their grief experience following patients' death in order to accept the loss and find better ways to support themselves. Furthermore, Conte (2014) concluded that the awareness of the psychological needs of oncology nurses will enable educators and administrators to provide the support needed for nurses.

Understanding the grieving process by nursing faculty, administrators, and leaders can create better learning opportunities and provide a more supportive practice environment for professional nurses (Gerow et al., 2010). However, little attention is given in nursing schools and orientation programs in health care settings to prepare nurses for grief experiences (Jonas-Simpson et al., 2013).

Nurses who grieve need acknowledgment, support, and education. Assisting staff through their grief may eventually have an optimistic impact on the quality of their life (Jonas-Simpson et al., 2013). Houck (2014) implemented an educational program for nurses regarding cumulative grief and compassion, fatigue, holistic self-care, and spiritual self-care in order to help grieving nurses develop strategies to remain physically and emotionally healthy. In the postprogram evaluation, the participants reported that they valued the focus on the nurses' self-care and recognized the need to prioritize the nurses' emotional health. Furthermore, the

nurses reported that they felt less isolated during the grieving process.

The American Association of Colleges of Nursing (2000), supported by the Robert Wood Johnson Foundation, in recognition for human end of life care, and the need for training nurses in such issue, developed the End-of-Life Nursing Education Consortium (http://www.aacn.nche.edu/Publications/ deathfin.htm). The training include several topics, related to nursing care at the end of life, in addition to loss, grief, bereavement, and preparation and care at the time of death (Matzo, Sherman, Penn, & Ferrell, 2003). Furthermore, an international End-of-Life Nursing Education Consortium training program was developed to provide high-quality education to nurses from a variety of countries (Paice, Ferrell, Coyle, Coyne, & Callaway, 2008).

Due to the nature of nursing profession, nurses provide care for persons, families, and communities during periods of wellness, distress, and illness. In Jordan, the mortality rate in public hospitals was the highest in intensive care units, cardiac care units, neonatal intensive care units, and in medical-surgical wards (Ministry of Health, 2014). Thus, it is not surprising to learn that nurses may live through and encounter feelings of grief, sorrow, trauma, and unresolved loss when they care for a patient who suffered from a severe disease or who passed away (Couden, 2002).

Most nurses see themselves as giving and caring persons, which make them hard to nurture themselves, but work–life balance, implementing a holistic self-care plan, and investment in time and energy in caring for themselves will enable nurses to care for others (Boyle, 2011). Moreover, providing helpful working environment, with emotional skill development, will enhance holistic nurses functioning (Aycock & Boyle, 2009).

Some nurses may experience an enormous sense of grief on a personal level when patients die (Gerow et al., 2010; Jonas-Simpson et al., 2013; Shorter & Stayt, 2010), whereas others may not grieve over their patient's death as a result of professionalism (MacDermott & Keenan, 2014). The impact of this experience on nurses at the personal and professional levels should be explored (Kent et al., 2012; Wilson & White, 2011). Physical, emotional, and spiritual exhaustion resulting from caring for dying patients should be addressed as well (Aycock & Boyle, 2009; Shorter & Stayt, 2010).

Research Question

What is the nature of Jordanian nurses' grief experiences following patient death?

Methodology

Design

A qualitative design guided by a phenomenological approach was used to interpret the lived experiences of Jordanian nurses following their patients' death. This design is considered one of the most appropriate designs, as it provides researchers with in-depth exploration of the participants' experience with grief and the grieving process. Data were collected by conducting three focus groups. This method of data collection is efficient in generating large amounts of data from large numbers of participants in a short period of time. Barbour (2005) indicated that focus groups have become an increasingly useful method for nurse researchers in eliciting attitudes and opinions regarding sensitive topics.

Setting and Participants

Data were collected from nurses working in Jordanian hospitals, utilizing a purposive sample approach. The inclusion criteria were registered nurses who were working at Jordanian hospitals in the public and private sectors, providing direct patient care for at least 1 year, and experiencing at least one contact with a dying patient during the previous 12 months of their participation. Nurses working in pediatric units, operating rooms, and emergency rooms, who had a recent experience of personal grief, and who were unwilling to be audiotaped for the focus group sessions were excluded. Ultimately, 21 participants who met the inclusion criteria participated in one of the three focus groups; each focus group consisted of seven participants. Focus groups conducted once, with each focus group, lasted approximately 2 hours.

A moderator's guide developed by the researchers and validated by an expert in the qualitative approach was used. The guide was divided into engagement general questions and an exploration of the research aims with open and probing questions. The participants were asked open-ended questions to describe in detail their experiences related to their feelings, emotions, grief reactions, and coping mech-

anisms following the death of a patient. The participants were asked to reflect on an experience of caring for a patient who subsequently had died. An example of the questions: Can you describe a time when you were looking after a patient that had died? How did it feel? How did you react? How did this event affect you as a person and as a nurse? Why did you experience such feelings? How long had these feelings lasted? What were the procedures you and your colleagues undertook when the patient died? Could you please describe your entire experience (in details) about your patient's death? What support did you have an access to? Could you please suggest sources of support that may help you after losing your patient? During your nursing study, what were the preparations that you had to make to deal with the patients' death? During your professional work, what was the training that was provided to you to deal with the patient's death? What were the challenges you faced when your patient died? What are the thoughts that come to your mind now? What do you advice nurses in their first experience of their patients' death? What do you recommend and suggest to the nurses to help them reduce the impact of their feeling of grief due to their patients' death? The facilitator used probing questions for clarification of the participants' perceptions, when the participants were not forthcoming, or when the situations or meanings of words were not clear.

Each focus group began with a basic introduction, completion of consent forms, issues of confidentiality, clearly defining the topic to be discussed, and the process of group discussion. The first and last 10 minutes of each session were used for introduction and conclusion. The participants were asked to use tags with numbers, which were used by the observer; when writing the transcriptions later on, probing questions were used to guide the discussion; and to avoid missing information, the moderator audiotaped the sessions. The focus groups were conducted in Arabic, and the audiotapes were transcribed and translated into English and translated back to Arabic to ensure trustworthiness of the data. All focus groups sessions were conducted in the School of Nursing as it is safe, comfortable, and accessible to participants.

Ethical Considerations

Approval to conduct this research was sought from the University of Jordan School of Nursing Institutional Review Board committee (November 15, 2015). Privacy, confidentiality, and participants' well-being and human rights were safeguarded throughout the research. Written and verbal informed consent from participants was obtained at the beginning of the study and again prior to the focus group for those agreeing to participate. Participants were informed that they would be free to withdraw from the study at any time, and if they wished not to take any part of the study, they could do so.

All records and participant information were kept confidential in a locked filing cabinet in a locked office and were destroyed at the end of the research project. All electronic data were encrypted and protected by a password. Throughout the interviews and after, participants were encouraged to ask questions, offer queries, and express uncertainties. The participants' rights were preserved and protected throughout the study.

Data Analysis

Interviews were transcribed verbatim, and themes were generated through Colaizzi's framework. Colaizzi's nine-step framework involves describing the phenomena of interest, generating data as described by participants, reading the transcripts in detail to obtain a general judgment about the content, extracting significant statements, formulating the meaning, and then sorting identical meanings into groups or themes, identifying the themes, integrating the study findings into an exhaustive description until exhaustive statement findings are developed and described, and returning the identified themes to participants to verify that the meaning of their statements was correctly understood. Finally, validating the findings was accomplished by comparing the researcher's descriptive results with participants' experiences and returning them to the participants (Speziale & Carpenter, 2007).

Rigor

The interviewer's guide was reviewed by an expert in the field to make sure that the questions met the study aims. To ensure consistency in data collection, the first author conducted the three focus groups. Member checking was performed by the participants to ensure that the identified themes represented their own experiences. A reflective diary

was maintained during the study period to satisfy the basic tenets of Heideggerian phenomenology by the researchers.

Participants' Characteristics

The sample included 12 male participants and 9 female participants. The majority of participants ($n = 17$) were bachelor's degree holders, while two had a master's degree. Most participants ($n = 15$) were working in intensive care units, some in medical-surgical units ($n = 5$), and one nurse was working in the kidney hemodialysis unit. Thirteen participants have clinical experience ranging from 1 to 5 years, six have more than 5 years of clinical experience, and only two have 1 year of clinical experience. Most nurses ($n = 18$) experienced a death incident within the past 6 months, while three experienced an incident within a period more than 6 and less than 12 months (see Table 1).

Table 1.   Demographic Characteristics of the Participants ($N = 21$)

Item	Number of Participants	Percentage
Gender		
Male	12	57.1
Female	09	42.9
Level of education		
Diploma degree	02	09.5
Bachelor's degree	17	81.0
Master's degree	02	09.5
Area of practice		
Medical surgical unit	05	23.8
Intensive care unit	15	71.4
Kidney dialysis unit	01	04.8
Length of experience		
1 year	02	09.5
More than 1 year and less than 5 years	13	61.9
More than 5 year	06	28.6
Date of last experience of patients death		
During the last 6 months	18	85.7
More than 6 months and less than 12 months	03	14.3

Findings

This study explored Jordanian nurses' experiences of grief after a patient's death. Four themes emerged from the data: working through the grief experience, seeking control over grief, diversity of actions around patients' death, and nurses facing challenges. Finally, there were participants' recommendations for improving the grief experience. The themes and subthemes are illustrated in Table 2.

Table 2.   Themes and Subthemes

Theme	Subthemes
1. Working through the grief experience	• Intense grief at first experience • Acceptance of patient death over time • Patients' conditions influencing nurses' grief
2. Seeking control over grief	• Writing about the death events, communicating with peers and families, and confidence about care provided • Faith and spiritual beliefs
3. Diversity of actions around patients' death	• Nurses are afraid to inform the family about patient's death • Preparing the dead patients is a challenging task to nurses • Performing religious and spiritual practices • Supporting the dead patients' families
4. Nurses facing challenges	

Working Through the Grief Experience

During the focus group, participants gave open descriptions of their experiences of grief. They discussed their innermost feelings, demonstrated the nature of Jordanian nurses' grief experiences after patient death, and how significant death and dying were to nurses. The subthemes were intense grief at first experience, acceptance of patient death over time, and patients' conditions influencing nurses' grief.

Intense Grief at First Experience. The participants displayed a mixture of emotional responses toward the first experience of grief at the beginning and especially at the moment of "gasping and exit of spirit," as described by most participants; many emotions may appear sadness, crying, anger, shock, denial, patience, faith, fear, guilt, fear of the family's reaction, powerlessness, and fatigue. One participant described this as, "I think of the deceased and

what happened during the death situation for a week," while another participant said, "I did not enter the room of the deceased and I did not use the room for other patients for a period of time."

Most participants mentioned that, in their first grief experience, they did not know what they had to do. Normally, the death of a patient contradicts the nursing value of preserving life. Several participants considered the death of a patient as a "malfunction" and improper nursing care; accordingly, grief was a reaction.

Acceptance of Patient Death Over Time. The participants reported that their grief response and reaction changed over time. In time, the participants' emotions and grieving varied, the number of death cases, the workload, and the nurses' experience led nurses to better cope with their grief. One participant said, "My feeling differs with experience. I was feeling sad and afraid at the beginning, but later these feelings differed after two to three months of experience." Another participant described the change of grief as the status of being apathetic toward death and grief by saying, "Increasing the death cases make us like a stone; sometimes I deal with five death cases during the same shift."

Periods of grief at the beginning of work differ from those after several months of work. At the beginning of the job, the period of grief ranged from 2 days to 1 week. One participant said, "The first experience of death affected me for a month." All participants revealed that usually after 6 months to 1 year of clinical work, their experience of grief following the death of patients decreased, and some of them said that their grief ended when the deceased left the ward. Now, participants performed the required procedures, such as shrouding the dead patient and sending him/her to the mortuary, and then returned to work. However, some death events influenced them. One participant stated, "I fear death even after 20 years of experience."

Patients' Conditions Influencing Nurses' Grief. Most participants experienced more grief responses if their patients died when young. The level of attachment with patients and their families is another factor influencing nursing grief; they usually tend to build relationships with patients and their families. Consequently, the nature of the relationship and the level of attachment they had developed during the caring

process affect the depth and duration of sadness they felt after their patients' death. The participants stated that the longer they provided care to their patients who died, the greater their experience of grief.

Participants mentioned the health condition of the patient as a contributing factor to their grief. When the death is sudden, nurses' grief is exacerbated, but if the patient was terminally ill and had suffered for a long time, nurses felt that the death was less painful. Most of the participants indicated that they sometimes wished death for the patient, especially if the patient was moribund or a hopeless case. One participant was against this perspective and said, "I disagree with the concept of good death or comfort death," and rationalized his point of view as "nobody can judge if the patient will have comfort by dying. So, nurses and health care providers have to do what they can to help the survival of their patients until the last moment of their lives."

Four participants said they felt guilty, sad, and angry about the death of the patient, especially if death had resulted from medical errors, nurses' shortage, lack of resources, delayed resuscitation, and sudden death. One participant noted, "I don't like to continue my work and I don't like the workplace and to have the feeling that I am the cause of the patient's death."

Seeking Control Over Grief

It was apparent that most participants coped with their grief, while others are still coping. They used multiple coping strategies to address grieving over their patients' death. Four subthemes were revealed: writing about the death events, communicating with peers and families, and confidence about the care provided, and faith and spiritual beliefs.

Writing About the Death Events, Communicating With Peers and Families, and Confidence About the Care Provided. It was apparent that participants' reactions to their patients' death differ over time. Many participants stated that they coped with and adapted to their patients' death, and that they are now better able to control their feelings. One participant said, "Death is a fact of life regardless of the reason for it. So, coping is necessary." At the beginning, they cried and told their families and friends about the death events and stories. One participant

expressed her sadness by writing about her patients' death events in her diary; she said, "Until I could tell the patient's story to my family, I promised myself to write the dead patients' stories as a way of expressing my feelings."

All participants indicated that they received support from their families, colleagues, and friends but not from hospital personnel. One participant said, "I used to tell my mother but my father refused to listen." Another participant said, "The senior staff are supporting us, and until now I was afraid to shroud the dead patient alone."

Another coping strategy used by many participants is the confidence of care provided by them and to be sure that the patient's death is not the result of malpractice.

Faith and Spiritual Beliefs. Several participants agreed that the death of patients make them feel closer to God as well as increases their faith and spiritual beliefs. All participants agreed that spiritual coping strategies are the most frequently used and the most effective coping strategy used, with one participant saying when asked about his coping strategy, "Of course spiritual coping is out of the question," while another participant said, "I couldn't tolerate it anymore, so I took a leave and went to Makah for Omra." Nurses who relied on religious beliefs were able to address stress, including grief, in a positive and purposive way.

Diversity of Actions Around Patients' Death

Participants mentioned that diverse actions were taken when the patient died. Four subthemes were identified: nurses are afraid to inform the family about patient's death, preparing the dead patient is a challenging task for nurses, performing religious and spiritual practices, and supporting the dead patients' families.

Nurses Are Afraid to Inform the Family About Patient's Death. Many participants expressed their fear of possible violent family reaction to the death event, and this may hinder them from informing the family. One participant said, "I tried to delay the time of CPR [cardiopulmonary resuscitation] so that the family members would not beat me." Another participant added that informing the family about the death should be done in the presence of the hospital's security. The participants indicated that hospital policies are involved in the process of informing the patient's family of the death, mainly by the physician.

Several participants tended to leave the room, especially if the family members are aggressive. One participant said, "I tried to support the family, but if they are stressed I leave the room."

Preparing the Dead Patients Is a Challenging Task for Nurses. Many participants mentioned that they applied the hospital's policies, procedures, and protocols related to preparing the dead patient; these include closing the eyes, cleaning the mouth and the face, tidying the hair, removing jewelry, shrouding the dead patient, and removing mechanical aids. One participant said, "I cleaned the dead from blood, shrouded him, then I let the family see him, during which I asked god for forgiveness." In all that is done before allowing the family to see their patient. The ambiguity of the nurses' role in dealing with the dead patient was one of the challenges they discussed; they were confused as to whether or not shrouding the body (*Kafan*) was the work of nurses.

Additional challenges were expressed by some participants regarding how to transport the dead patient to the mortuary. Some participants were dissatisfied with these policies, especially placing the dead patient in the mortuary. One participant said, "One dead patient's commandment was not to send her to the mortuary, as she didn't like feeling cold. We must fulfill her commandment, but on the other hand we must follow the hospital's policies." Another challenging policy is to put the dead patient into a coffin. One participant said, "It's a challenge for me to see the coffin, it's totally uncomfortable."

One participant confirmed that they have a policy where he works to refer to the dead patient as a "mercy case," which is more comfortable, and the participant added, "So we said the mercy case is ready for shrouding, or the mercy case is ready to go to the mortuary." The terms "letting go" or "passing" were used instead of "death" in order to feel more comfortable.

Performing Religious and Spiritual Practices. Participants stated that they practiced religious and spiritual rites when their patients died. These practices may include reading the Quran for Muslim patients

and directing their face to the right and to (*Qeblah*) in Mecca, closing their eyes and mouth, and being bathed by a person from the same sex, while others asked forgiveness from the beginning of CPR until the dead patients were transferred to the mortuary. One participant said, "In Islam, we read (*Fatiha*) from the Quran, pray for the dead patient, uncover the dead person's face and let his/her family see him/her." The same participant said, "I remember a dying Christian patient; her family called a priest for the rituals, brought a dress, and put makeup and perfume on her." Many nurses stated that they acted according to patients' religious and cultural backgrounds, and all participants emphasized the importance of considering these when caring for dead patients, especially in a country with various cultures.

Supporting the Dead Patients' Families. Most nurses stated that they supported the family and asked them to pray for the dead patient. Most participants talked about offering condolences to the family member. One participant said, "What I do personally is complete the administrative procedures, shroud the dead patient, and I may offer condolences to the family, ask god for forgiveness."

Nurses Facing Challenges

Different challenges and shortcomings were addressed by participants regarding preparedness in how to address dead patients at the time of death and/or immediately after death. The most prominent challenge was the lack of knowledge and awareness of how to address patients who are not Muslims at the time of patient death or immediately after death and what should be done and said in such circumstances. One participant said, "I am a Muslim nurse and I am not aware of how to deal with a Christian dead patient and I have not been prepared in how to behave in such situations." Another participant said, "I have a real issue with how to behave if the dead patient is female, because some families forbid male patients to deal or even to check on their female dead patients."

Nurses' lack of preparation at the university level is another concern for the participants; all nurses declared that they did not receive adequate preparation. One participant said, "When I was invited to participate in this study, the subject 'nurses' grief' was strange to me." Two participants stated that they studied the grief concept in some courses, but this was not enough. One participant revealed that nobody cared about nurses' feelings toward patient death, saying, "Nobody ever asked me about my feelings."

Another challenge was the participants' confusion in dealing with the do not resuscitate (DNR) order; they had contradictory feelings: on one hand, they want to do something for the patient, and on the other hand, they have to follow the physician's orders, which in the end affects their feelings toward themselves and their grieving experiences. One participant said,

> I can still remember a female patient who asked to see her family before death in the early morning and she had been categorized as a DNR patient, the family were not able to come; we were stressed because she eagerly wanted to see some of them, but none of them came and after a while the doctor announced death while we looked at her without doing anything, I felt so sad and so angry for that, may God bless her.

Participants' Recommendations to Improve the Grief Experience

The participants stressed the importance of implementing a teaching program, especially for newly graduated nurses, before facing the experience of the dying patient, as nurses are not prepared during their undergraduate studies. One participant said, "Before the nurse starts his/her work in the hospital, he/she should be prepared with necessary training courses to acquire the communication skills that enable him/her to deal properly with his/her colleagues, patients, and patients' families."

Many participants suggest that it is important to provide an explanation for the community about a nurse's feelings; one participant said, "To appreciate our work with our suffering," another indicated that "we need to tell people to understand our position." Many participants revealed the need to advocate and support nurses during their grieving time; one of the best strategies of support is to talk with a senior colleague or the family, while others emphasize the importance of social support through the presence of social workers.

Most of the nurses spoke about the need for religious or spiritual beliefs about the afterlife. While others gave additional suggestions, such as the importance of rotation between hospital units,

more days off for nurses after patient death, allow nurses to choose the department in which they wish to work, correct the reduced nurse–patient ratio, and invest more in formulating a grief support group. Nurses would also like to have the regular opportunity to take a break and leave the ward.

Discussion

Emotional reactions of grief among Jordanian nurses as sadness, crying, anger, shock, denial, patience, faith, fear, guilt, fear of the family's reaction, and powerlessness and fatigue are congruent with previous studies (Conte, 2014; Gerow et al., 2010; Jonas-Simpson et al., 2013; MacDermott & Keenan, 2014; Marcella & Kelley, 2015; Reid, 2013; Yu & Chan, 2010). On the other hand, MacDermott and Keenan (2014) indicated that few nurses felt they had to hide their grief to be professional. Furthermore, Marcella and Kelley (2015) stated that nurses who practiced empathy instead of sympathy considered patients' death a part of their job.

This study findings revealed that repeated exposure to the death experience and being prepared for the death of a patient made nurses more tolerant and less grieving, and this result is consistent with the findings of many previous studies (Marcella & Kelley, 2015; Shorter & Stayt, 2010). In contrast, Yu and Chan (2010) revealed no difference between nurses based on their experiences.

Many participants in the current study dealt with patients' death as a matter of fate and as a normal life process beyond human control, a result supported by Yu and Chan (2010). Our findings showed that grief experience is influenced by the patients' conditions, and this result is consistent with Adwan's (2014) study, which revealed that registered nurses in pediatric units experienced more guilt if their patients died young. Also, patient–nurse attachment, relationship, and the longer time the nurses provided care to their patients who died are other factors that influence the grief among the participants; this result is supported by previous studies (Chan et al., 2013; Gerow et al., 2010; Keene, Hutton, Hall, & Rushton, 2010; Shorter & Stayt, 2010).

In the current study, the participants' grief was intensified when the death is sudden and less intense if the patient was terminally ill and had suffered for a long time, and this result is consistent with Shorter and Stayt's (2010) finding that the

perceived grief was less traumatic when the patients' death was anticipated and expected.

Participants reported several strategies to address their grief toward their patients' death as writing stories about patients' death; this finding is consistent with Rice, Bennett, and Billingsley (2014), who stressed the importance of peer storytelling in illuminating implicit and explicit thoughts and feelings and responses after a patient's death. Similarly, Gerow et al. (2010) revealed that nurses adopted many coping mechanisms. However, the participants described informal conversations with colleagues as means of coping.

Our participants felt that being confident of the care provided to the dying patient helped them have control over their grief and have positive coping toward grief. This finding is similar to Shorter and Stayt's (2010) suggestion that providing quality of care and physical comfort to a dying patient and their families might balance nurses' emotional response to patient's death.

The agreement of all participants on the role of spiritual coping as strategy to control the grief is supported with the findings of previous studies (Gerow et al., 2010; Kent et al., 2012; MacDermott & Keenan. 2014). Likewise, a study conducted in Hong Kong revealed that the participants considered life and death as uncontrolled destiny as a means of coping with patient's death (Yu & Chan, 2010). Nurses who relied on religious beliefs were able to address stress, including grief, in a positive and purposive way (Wu & Volker, 2009). Marcella and Kelley (2015) noted that establishing rituals after a patient's death might help the staff working in long-term care homes decrease the negative effects of their grieving process. An American study investigating nurses' grief experiences indicated that nurses' response to patient's death was based on their spiritual worldview and how they viewed the death experience (Gerow et al., 2010). Furthermore, Meraviglia (1999) indicated that spirituality is an ongoing process, and individuals experience their spirituality in special ways.

Breaking bad news and informing the family about a patient's death is an action that increases our participants' fear, consistent with Marcella and Kelley (2015); the participants were concerned about communicating with the dead patient's family, which requires special training. Participants showed that the hospital policies required the physician to be involved in breaking bad news to the patient's family,

and this was supported by earlier studies (Naik, 2013; Wilson & White, 2011). On the other hand, Jevon (2009) and Wilson and White (2011) showed that the health care professional responsible for informing the family is the one with good communication skills and is not necessarily a physician. However, Bryant (2003) recommended that informing the family might be the responsibility of a team, which may include a physician, a nurse, and a social worker or a clerk. Leaving the room specially if families are aggressive was reported by our participants, and this is consistent with what was suggested by American oncologist nurses (Wenzel et al., 2011).

Challenging tasks during patients' preparation as closing the eyes, cleaning the mouth and the face, tidying the hair, removing jewelry, shrouding the dead patient, and removing mechanical aids are consistent with prior studies (Jevon, 2009; Naik, 2013; Wilson & White, 2011). These procedures were referred to as the "last offices" in the literature, which are concerned with caring for the body after death. It is a continuation of care for the dead patient and a way of showing respect for the patient's dignity, and is based mainly on religious and cultural beliefs (Jevon, 2009; Martin & Bristowe, 2015; Williams, Lewis, Burgio, & Goode, 2012).

Performing spiritual practice by participants to their dead patients was supported by Jevon (2009), who sated that in the Christian religion, nurses call a priest and place small items near the dead patient, such as a crucifix and holy pictures. Many nurses stated that they acted according to patients' religious and cultural backgrounds, and all participants emphasized the importance of considering these when caring for dead patients, especially in a country with various cultures. Nurses' actions based on religious beliefs and faith are identified in the literature (Aycock & Boyle, 2009; Wu & Volker, 2009).

Support for the family was provided by participants in many studies (MacDermott & Keenan, 2014; Marcella & Kelley, 2015; Reid, 2013; Williams et al., 2012). Supporting the family, attending the funeral with them, and offering condolences may all offer an opportunity for nurses to express and ease their grief (Reid, 2013; Williams et al., 2012).

Participants reported that they face many challenges regarding the preparation of the dead patient. Abu-Ras and Laird (2011) indicated that health care providers need to be knowledgeable about providing care for patients from different religious and cultural backgrounds. Bloomer, Morphet, O'Connor, Lee, and Griffiths (2013) found that nurses' training was not enough to help them provide the needed care to patients or the bereaved families.

The contradictory feelings of nurses' challenge in DNR situation is reported by the participants of the current study, and it is consistent with the findings of Brunelli (2005). The participant in the current study emphasized the importance of educating nurses about the grieving process during their undergraduate program; this finding is consistent with Gerow et al. (2010). A tailor-made educational program on grief and bereavement care for nurses that teaches effective coping strategies may also be helpful (Yu & Chan 2010). Rice et al. (2014) found that further education in interprofessional venues is required for nurses to address dying patients.

The current study participants asked for more support to overcome their grief; this result is consistent with Jonas-Simpson et al. (2013) and Shorter and Stayt (2010), studies that indicated the need of therapeutic support from the hospital staff and of providing training and grief counseling. According to Wenzel et al. (2011), supportive resources range from individual support to the design of meditation rooms or quiet spaces in nursing units and the development of an inpatient hospice unit, all of which would be therapeutic for nursing staff, patients, and their families.

Study Limitations

Findings of this research are indeed useful, though we need to exercise more caution in interpreting the data, as the study only explored the nurses' experience as per their memorization ability, which may possibly lead to the loss of some immediate feelings and reactions.

Conclusions

This study heightens the importance of understanding the Jordanian nurses' experiences of grief following patient death. As nurses all over the world face similar situations, it is most likely that nurses from different countries might face similar grief experiences; however, more research is recommended to investigate such issues. Understanding nurses' grief from a holistic perspective provides valuable information for nurses' practice, research, leadership, administration, and education. The results of this study provide evidence that nurses are similar to family members not only in responding emotionally to patient death but also in their experience of grief. Nurses are burdened by recurrent

patients' deaths as they try to cope with and overcome their grief. Indeed, nurses place an emphasis on the need for support to maintain their mental health and keep up with the profession. Additionally, nurses realize the nature of their grief experience and the emotions that follow their patients' death; this makes them able to assent, cope with, and find a way to support themselves, their colleagues, and the families of their dead patients.

Implications to Holistic Nursing and Recommendations

This study highlights the lack of training regarding grief management and the lack of policy regarding supporting grieving nurses. Resources and continuous education are required to raise nurses' awareness of the factors affecting nurses' grief and to identify understandable strategies that can assist in developing organizational policies and practices that provide an additional supportive workplace environment to help nurses manage their grief and loss after the death of their patients. Another important aspect stresses the need to increase the sensitivity of curricula to a nurse's emotions concurrently with patients' emotions by utilizing a holistic caring nursing approach.

Implementing an orientation program that includes the grief process and bereavement for nurses, and especially newly employed nurses, by emphasizing the importance of preparing nurses to address death issues holistically based on different cultural backgrounds (as nurses are responsible for providing care to patients from different cultural backgrounds) is recommended. The International End-of-Life Nursing Education Consortium training program is very needed to be utilized to equip Jordanian nurses with essential knowledge, attitudes, and skills to provide effective end-of-life care. Providing peer support in the workplace and the value of experienced nurses mentoring inexperienced staff, especially where nurses have no previous experience of death and dying, is recommended. Considering the holistic nursing perspectives, it is important to emphasize the importance of providing holistic care to Jordanian nurses during the phases of the grieving process. Understanding the role of spirituality as a strategy to facilitate nurses' grief through a holistic approach, as prayer and other spiritual activities, may provide added value and enrichment to caring for nurses during the grieving process.

Further research could be carried out using a longitudinal approach to better understand the Jordanian nurses' grief and the cumulative loss after the death of their patients; additionally, more investigation is needed to study the impact of nurses' grief on nurses' clinical performance.

Acknowledgments

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