Research Article

Promoting Neonatal Staff Nurses’ Comfort and Involvement in End of Life and Bereavement Care

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Background. Nurses who provide end of life and bereavement care to neonates and their families are potentially at risk for developing stress-related health problems. These health problems can negatively affect nurses’ ability to care for their patients. Purpose. Nurses need to be knowledgeable about end of life and bereavement issues to provide quality care. This study sought to evaluate the effect of a bereavement seminar on the attitudes of nurses regarding end of life and palliative care of neonates. Design. A convenience sample of fourteen neonatal nurses completed a Bereavement/End of Life Attitudes about Care of Neonatal Nurses Scale after a bereavement seminar designed to provide information on end of life care. A pre- and posttest design with an intervention and control group was used to assess changes in nurse bereavement attitudes in relationship to comfort, role, and involvement. Results. After bereavement seminar, the seminar attendees had higher levels of comfort in providing end of life care than nurses in the control group (t = −0.214; P = 0.04). Discussion. Nurses’ comfort levels can be improved by attending continuing education on end of life care and having their thoughts on ethical issues in end of life care acknowledged by their peers.

1. Introduction

Nurses who provide end of life and bereavement care to infants and their families are potentially at great risk for developing stress-related health problems. The emotional strain associated with end of life and bereavement care not only affects a nurse’s health but can also affect relationships at home and with coworkers. The stress experienced by a nurse can even affect the quality of care provided to patients and parents [1, 2]. Moral distress is recognized as one of the major sources of stress for nurses who provide end of life care to infants. Factors that induce moral distress in nurses can result from providing care to infants who have withdrawal of treatment followed by death or extending futile treatment that induces unnecessary suffering [3]. There has been an increase in the proportion of deaths associated with decisions to forgo intensive care treatment from 23% in 1987 to 1988 to 64% in 1998 to 1999 [4]. More than half of neonatal deaths are associated with withdrawal of treatment [5], and treatment-related stressors to health care professionals have no doubt increased over the years as a result of advanced treatment options [6, 7].

Nurses need to be knowledgeable about bereavement and end of life issues and need to be comfortable in their interactions in order to provide quality bereavement and end of life care [8, 9]. It is a nurse’s obligation to act on behalf of the patients and their families to ensure that the care provided is congruent with their preferences. A key to fulfilling this obligation is to cultivate relations with patients and their families [10]. The American Academy of Pediatrics committee on bioethics and its committee on hospital care stated in their integrated model of palliative care that palliative care should be offered at diagnosis and continued throughout the course of illness, whether care results in cure or death [11]. It is recommended that an uncertain prognosis should be a signal to initiate, rather than to delay, palliative care discussion [12]. Palliative care is not limited to end of life care; however, it ensures quality of end of life care. However, studies have indicated that neonatal nurses often are not comfortable with providing end of life care to infants. Some
of the reasons associated with this discomfort are inadequate
nursing education related to bereavement care in nursing
school or in their place of employment [13, 14]. Other factors
that may elevate the stress levels of nurses who provide
end of life care to infants are provider’s age, life experience,
and clinical experiences that involve management of ethical
dilemmas. It has been suggested that nurses’ prior knowledge
of end of life care is correlated with nurses’ comfort in
providing related care [15]. Nurses’ moral distress can affect
communication with parents, thus leading to changes in
parents’ perceptions of the quality of nursing care [16].
Nurses are viewed by families as being more supportive than
physicians during grief. However, communication problems
and a lack of awareness of cultural issues can serve as barrier
that can cause parents to feel abandoned and that nurses
lack sensitivity [17]. In addition, noneffective communication
between health care professionals and infant’s parents has
been identified as one of the barriers that could cause
unnecessary conflict in providing infant’s care [18]. Issues
related to the parents’ cultural background can profoundly
influence medical ethical decision making for infant’s care
[19, 20] and can result in moral distress in nurses.

The literature indicates that nurses experience stress and
moral discomfort in the provision of end of life and bereave-
ment care. Ethical issues related to withdrawal of treatment
and futile treatments are major contributors to nursing stress.
Nurses’ personal characteristics and experiences can impact
their response to bereavement stress. Communication and
awareness of cultural needs are also recognized as important
in the care of patients and families. This study contributes
to the literature because it is an intervention study which
evaluates nurses’ perceptions about their role, comfort, and
involvement in end of life and bereavement care following an
educational seminar.

2. Purpose

In recognition of the stress experienced by nurses in provid-
ing end of life care to infants, the women’s center of a level
II hospital in the southeast offered a bereavement seminar
to nurses who work in areas that experience infant deaths.
The purpose of this study was to evaluate the effectiveness
of the bereavement seminar on the attitudes of nurses regarding
end of life care of neonates. The research questions were as
follows: (1) what are the characteristics and attitudes of nurses
who provide end of life/bereavement care to infants? (2) Is
there a difference in nursing role, comfort, and involvement
in providing end of life care between pre- and posttest scores
of nurses who attended a bereavement seminar? (3) Will
nurses who attend the educational seminar have higher scores
in the domains of comfort, role, and involvement than the
control group?

3. Design and Methods

A pre- and posttest design with a nonequivalent control
group and intervention group was used to compare the
effect of the bereavement seminar on role, comfort, and
involvement. A convenience sample of nurses was drawn
from a community hospital in the southeastern United States.
Nurses were eligible to participate in the study if they worked
in Labor and Delivery, NICU, Mother Baby, Pediatrics, or the
Emergency Department and worked directly with patients
and were not in an administrative position. Nurses who
attended the one-day education program were enrolled in
this study as the intervention group. The control group
comprised those who did not attend the education program,
but worked in areas that provide end of life or bereavement
care to infants. Nurses voluntarily signed up to attend the
bereavement seminar and participate in the study.

3.1. Instruments. Bereavement/End of life Attitudes About
Care of Neonatal Nurses Scale (BEACONNS) was the instru-
ment used for this study [21]. Permission to use the BEA-
CONNS Scale was obtained from Engler & Associates, the
researchers who had developed the instrument. Reliability
for the instrument when used in a descriptive study ranged
between 0.81 and 0.95 [21]; it has not yet been used in a
quasiexperimental design. There are three domains in the
BEACONNS scale: (1) the comfort level of handling end of life
and bereavement care, (2) role of propensity in providing end
of life and bereavement care, (3) tendency of allowing family
involvement in providing end of life care.

3.1.1. Comfort Scale. The comfort scale measures nurses’
perceptions about the degree of comfort they felt with various
aspects of bereavement/end of life care. There are 19 Likert-
scale items in this subscale, with scores ranging from 1 (very
uncomfortable) to 5 (very comfortable). The 19 items are
summed for a total score. Higher total scores indicate greater
comfort levels with providing end of life care. The reliability
for the comfort scale Cronbach α is 0.95 [21].

3.1.2. Role Scale. The 18-item Likert-type role scale measures
nurses’ perceptions of their roles with families of critically ill
and/or dying infants; scores range from 1 (strongly disagree)
to 5 (strongly agree). Some items required reverse scoring.
The 18 items are summed for a total score. Higher total
scores indicate more supportive roles in facilitating families’
involvement in end of life/bereavement care. The reliability
of the role scale Cronbach α is 0.85 [21].

3.1.3. Involvement Scale. The 14-item involvement scale mea-
ures nurses’ ratings of the importance of various factors
relative to their involvement with patients and families. The
Likert-type scale ranges from 1 (very unimportant) to 5 (very
important), and the items are summed for a total score.
The higher the total score, the more the involvement nurses
thought they should have with their patients and families. The
reliability for the involvement scale Cronbach α is 0.85 [21].

3.1.4. Other Demographic Variables. In the BEACONNS in-
strument, there are additional items that acquire information
about a nurse’s educational background, ethnicity, prior
experience with infant death, and significant personal loss.
4.2. Data Analysis. To answer the research question “was there a difference between pre- and posttest scores of nurses who attended the bereavement seminar?” a paired t-test was used. Data from nurses prior to the seminar and two months after the seminar were compared. Nineteen participants completed the pretest questionnaire; only 14 participants returned the posttest questionnaire of nurses’ comfort level with end of life/bereavement care being significantly increased (t = -3.37, P = 0.01). However, postrole scores were not significantly different from the prerole scores (t = 1.09, P = 0.30). Likewise, postinvolvement scores were not significantly different from the preinvolvement scores (t = -0.19, P = 0.84). Boxplots and paired “ladder” plots were used to provide illustrative support for these findings.

An independent t-test was performed in order to answer the third research question, “is there a difference in the three domains between the nurse groups who attended the workshop and the group that had not attended the workshop?” The first survey prior to the seminar was used to analyze the difference. No differences were found between these two groups in comfort level (t = 0.77, P = 0.44), role (t = 0.09, P = 0.92), and involvement (t = 0.24, P = 0.82). Further, no difference was detected in those who signed up for the class and those who did not sign up for the class in whether they had previous training in end of life care/bereavement care. However, the difference in satisfaction with previous end of life/bereavement care training was significant in those who came to the workshop and those who did not come to the workshop. Those who came to the workshop were less satisfied with their previous end of life/bereavement care training than those who did not come (t = -2.21, P = 0.03).
were less satisfied with their previous end of life nursing education training, which may have been a motivator for their attendance at the bereavement workshop. These nurses in the study have been working in areas that experience neonatal deaths; surprisingly only a third had attended continuing education on end of life/bereavement care.

Another important finding was that the intervention group's comfort level had increased at the posttest which was 2 months after the seminar. This supports the findings of Fredrickson et al. who found that a nurse's prior education about end of life care increases comfort and decreases moral distress. The comfort level increments could be the result of the seminar content as well as the interactions among nurses during the daylong seminar. A noticeable observation from this seminar is that nurses are gaining new knowledge while they were sharing their own experience and acknowledging their peers. There was not a significant difference in role perceptions between or among groups. The participants felt that their role in providing support to families of critically ill infants on a daily basis was more important than that provided by physicians. Involvement was not significantly different between the two groups. A lack of statistical difference between the control and intervention group may have been due to the small sample size. Also, nurses who did not attend the seminar may have already felt at ease in the areas of comfort, role, and involvement. In addition, the reliability of the involvement scale may have been affected by the phrasing of the directional stem on the Likert scale; many nurses found the involvement scale confusing.

The results of this study supported the use of a bereave-ment seminar to increase nurse comfort levels in the provision of end of life/bereavement care to infants and families in the intervention group. Nurses overall were not satisfied with the end of life/bereavement education they had received in their undergraduate nursing programs. This suggests a need for nursing schools to ensure their curricula should include content on caring for critically ill and dying neonates and their families. Nurses who work on units with neonates need supportive continuing education, since three-fourths of the nurses had experienced neonatal deaths, yet only one-fourth had attended continuing education on end of life/bereavement care. Future intervention studies are needed with larger nurse populations in order to evaluate the effectiveness of end of life/bereavement education on comfort and involvement in end of life care. Studies should also assess whether greater nurse comfort scores impact family satisfaction with end of life/bereavement of their neonate.

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References
