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Clinical research article

"What happens behind the curtains?" An exploration of ICU nurses' experiences of post mortem care on patients who have died in intensive care

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ABSTRACT

The Aim of the Study: The aim of this study was to explore the experiences of intensive care nurses performing post mortem care on patients who had died in an intensive care unit at a private hospital in Cape Town. The study further sets out to identify educational needs and to offer recommendations that may address these needs for this sample of nurses.
Methodology and setting: A qualitative research design using a descriptive method was used to explore the experiences of a purposive heterogeneous sample of six nurses who were working in an intensive care unit in a private hospital in Cape Town.
Data collection and analysis: A semi-structured interview which was audio-taped and transcribed verbatim was employed to collect data. Colaizzi's (1978) seven step inductive method was used to formulate naïve themes. Following participant feedback, three main themes emerged: care of the dead body, detachment and thanatophobia.
Findings: Safeguarding the integrity and physical appearance of the dead body was the major finding and of the utmost priority for the participants in this study. Regardless of how the nurses felt about death, providing professional and quality care to the dead body and the family was seen as significantly important.

The nurses, whilst performing post mortem care, experienced detachment from various relationships. This comprised of the nurse detaching him/herself professionally and emotionally from the dead patient, the family and him/herself from the death experience.

This 'unspoken' experience of thanatophobia became apparent when the nurses were confronted by the reality of their own deaths.
Conclusion and recommendations: In a technological society, where answers to many questions can be pursued through science, understanding the experience of death, as opposed to dying, may be logically incomprehensible. Death remains one of the most traumatic events experienced by the patient and their family, and in some instances nurses themselves.

The study has drawn attention to the nurses' experiences and in doing so; the emotional and educational needs have been identified, and in part, pedagogical offerings are recommended.

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Implications for clinical practice

- The experiences of the intensive care nurse in performing post mortem care of a dead patient is ignored and overlooked.
- Safeguarding the integrity and physical appearance of the dead body together with providing professional and quality care to the deceased and the family is a priority.
- Detachment of relationships from the dead patient and the family (emotionally and professionally) may be seen as a coping mechanism for intensive care nurses
- The 'unspoken' experience of thanatophobia is of a concern when intensive care nurses are confronted by the reality of their own deaths.

Introduction

Contemporary society views most aspects of death to be clandestine and regard talking about death as taboo or forbidden (Lawler, 1991). In many hospitals and other healthcare facilities, post mortem care is performed behind closed doors, in which an aura of mystery is created as to what happens to the dead body in the presence of others. Blum (2006) cites Castels and Murray (1979:22) and proposes that death is 'the end of life, or the beginning of eternal life' and may also be perceived as the 'final separation from loved ones' – 'the defeat of man by nature.'

The mere thought of death proves to be challenging for the intensive (ICU) nurse. The nurses' experience of post mortem care differs from that of other occupational groups (paramedics, medical practitioners and law enforcement) as 'the nurse sees the body before and after death and in many cases has an established relationship with the person who has died' (Lawler, 1991:188). The transition from living to death is an event that happens at the bedside with the nurse in attendance (Quested and Rudge, 2002). The practical procedure of post mortem care is widely explored by many authors using various procedural guidelines and/or manuals (Pattison, 2008a, 2008b). The literature review about the topic of post mortem care and nursing is exceedingly limited. Using the keywords to explore the literature; the following studies were identified and are discussed accordingly. It must be highlighted that little is known about ICU nurse's experiences of performing post mortem care on patients who have died in an intensive care unit (Hadders, 2007; Quested and Rudge, 2002).

The term post mortem care

Wolf (1991a, 1991b) explains that post mortem care was historically conducted in private houses. Post mortem care was the common phrase used for autopsy. The nurse's role was to prepare the dead patient for autopsy and also care for the dead patient after the autopsy. This involved dressing the incisions made by the medical practitioner during the autopsy. The word post mortem care evolved from this practice where nurses cared for the dead body on completion of autopsy.

Currently post mortem care refers to 'after–death services' or 'laying out the dead', that nurses perform for their dead patients (Wolf, 1991a, 1991b).

Wolf (1991a, 1991b) acknowledges that nurses continue to have intimate contact with their dead patients. They are witnesses and participants with patients and their families at 'the most private events of human experiences' (Wolf, 1991a, 1991b). Wolf (1991a, 1991b) concludes by commenting that nurses accept this trust and responsibility when performing post mortem care.

Methods

Research question

The following research question was explored: "How do we better understand ICU nurses' experiences of performing post mortem care on patients who have died in an intensive care unit"

Research objectives

In light of the ICU nurses' experiences of patient deaths, this may offer opportunities to attend to the educational and emotional needs that ICU nurses' face whilst performing post mortem care in the intensive care unit.

Setting

A hospital from a consortium of private healthcare institutions in Cape Town was identified as the research setting. The interviews were conducted in a seminar room away from the ICU. The primary investigator in this study has been employed at the study setting for 11 years which facilitated the negotiations for conducting research in this area. A trusting and non-prejudicial rapport had been established with the ICU staff in this setting. Upon hearing about the research study, great interest and enthusiasm was expressed by the ICU nurses who were eager to be part of the study should they be invited to participate.

Ethical approval

Negotiating access consisted of the submission of the proposal to, and receiving approval from the Faculty of Health Sciences Human Research Ethics Committee at the University of Cape Town. Approval for access was obtained from the private hospital's Research Operational Committee HREC:664/2014.

Participants

The primary investigator employed a purposive sampling method and invited suitable participants all of whom had expressed their eagerness to be part of the study. To avoid elitist bias, the investigator ensured that the participants were at different levels of experience in order to ensure all aspects of the phenomenon were fully described.

Eligibility

The invited participants were required to work in the ICU at the research setting, had to have direct involvement in performing post mortem care following patient death and must be fluent in English as the interviews were conducted in English.

Only six of the 11 resident ICU staff were eligible and it was anticipated that these participants would provide honest, credible and detailed information of their experiences.

The participants' years of experience of working in an ICU ranged from two to 44 years. The age range was 31–63 years and included two males and four females. The true identity of the participants was protected by the use of pseudonyms. The pseudonyms chosen by the participants were: Change, Flower, Mystery, Anne, Samantha and Jemisco (Table 1).

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