


Research Paper

Grief and Coping Strategies of Nurses Following Patient Death at the Konongo-Odumasi Government Hospital, Ghana



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ABSTRACT

Background: Nurses working in various patient care departments are exposed to different traumatic situations, patient suffering, and death in their routine care. This study investigated grief and coping experiences amongst registered nurses working in various care departments of a major government health facility in the Ashanti region of Ghana.

Methods: A descriptive cross-sectional survey amongst nurses was conducted. A quota-sampling technique was applied to yield a representative sample of 79 nurses working in different wards of Konongo-Odumasi Government Hospital in Konong, Ghana. A structured self-administered questionnaire was used for data collection. Standard descriptive statistics (e.g. frequency and proportions) were used to summarize the survey data. The data were analyzed using SPSS software, v. 20.

Results: The majority of nurses (63%) reported feelings of grief following the death of patients they had cared for. Most respondents (89%) who did not acknowledge a grief experience did not grieve out of fear or as a show of professionalism. Some reported impacts of grief included insomnia (39%), loss of appetite (51%), tiredness (8%), feeling of depression (24%), and reduced functionality at work and home (27%). Common coping strategies for dealing with grief following patient death included physical exercise (67%), engaging in spiritual practices (51%), listening to music (47%), and discussing with other colleagues (42%). Only 47% of nurses reported access to professional counseling.

Conclusion: Regular training on effective grief coping strategies and emotional support for nurses caring for the dying may positively affect the health and well-being of nurses and improve the quality of care for both the dying patient and their families. Providing professional counseling for nurses is also suggested.

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Highlights

- Nurses are frequently exposed to the death and dying of their patients.
- The majority of nurses reported feelings of grief following the death of their patients.
- Common coping strategies in dealing with grief following patient death included physical exercise, engaging in spiritual practices, listening to music, and discussing with other colleagues.
- Nurses' access to formal professional counseling and support for dealing with grief was limited

Plain Language Summary

There is limited research in low-income countries, such as Ghana acknowledging and describing grieving experiences and coping strategies among different categories of nurses. The current study thus described the grief and coping strategies of registered nurses working in different departments of a major health facility in the Ashanti region of Ghana. The majority of nurses reported feelings of grief following the death of patients they had cared for. They experienced sleep disturbances, loss of appetite, feeling of depression, tiredness, and reduced ability to work effectively as a result of grief. Although the majority of nurses denied access to formal professional counseling, most of them reported using physical exercises, engaging in spiritual practices, listening to music, and discussing with other colleagues as coping strategies.

1. Introduction

Grief is a normal response to the loss of a significant thing or person, and it is the price we pay for love and commitment to each other (Hooyma & Kramer, 2006; Hall, 2011). Grief is experienced not only due to the death of a loved one but encompasses situations, such as divorce, adoption, and living with prolonged illness (Hooyma & Kramer, 2006). It is experienced in several forms, including physical, psychological, cognitive, behavioral, and spiritual manifestations (Hall, 2011). According to Sigmund Freud, grief is a survival process, through which the living break bond between themselves and dead loved ones. He thus proposed the first trajectory of grief involving three stages: (1) releasing the grieved from ties to the dead; (2) reformation to new life situations without the dead; and (3) forming new associations (Freud, 1957). Elizabeth Kubler-Ross later developed a new more accepted theory of grief, which states that grieving individuals navigate through five stages; denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1973).

The goal of nursing is to assist patients to recover from their ailments and, if not, to a peaceful death. Nurses are expected to demonstrate a high level of competency and skill in performing their professional tasks after a patient's death (Meller et al., 2019). When patients are rushed to the hospital, they are expected to recover and survive their illness and improve their quality of life.

This expectation is made possible majorly with the help of nurses who spend most of their time with these patients in their illness trajectory. This ongoing process of caring for patients every day makes nurses develop and feel some bond of commitment to their patients. However, not all patients are able to recover from their ailments and eventually die, notwithstanding the technological advancement and the efforts put up by the treatment team to keep them alive (Shorter & Stayt, 2010).

In Ghana, generally, when a patient dies in a ward, and this is confirmed by a doctor, the nurse is responsible for performing the last offices. The last offices refers to the care given to a body after death, which demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs, as well as health and safety and legal requirements (Higgins, 2010). The nursing responsibilities for the last offices in Ghana include preparation of the body for the mortuary and helping the relatives of the deceased through grief counseling. The family is then responsible for making the necessary plans to bury their loved ones based on their cultural and religious beliefs. The continual experience of a patient's death in the presence of nurses predisposes them to the corporeal and psychological ramifications of grief (Shorter & Stayt, 2010). However, the unfortunate situation is that although most nurses grieve when patients die, their grief may be unrecognized (Jonas-Simpson et al., 2013). In a study on registered nurses in New Zealand, Kent et al. showed that the initial recollection of patients' death occurs as early

as in the first year of qualified practice. These deaths often occur in the acute medical and surgical wards leaving a lasting experience of guilt, meagerness, powerlessness, and distress on nurses that transcends to their professional and personal lives when left unaddressed (Kent, Anderson, & Owens, 2012). Nurses use some mechanisms to deal with the grief caused by the death of their patients to cope with this situation and the resulting pain and suffering. Some of the commonly used coping strategies by nurses in dealing with their grief include sharing and seeking support from colleagues, avoiding dying and death situations, engaging in spirituality, and compartmentalizing experience (Betriana & Kongsuwan, 2019; Gerow et al., 2010). Addressing the issue of nurses' grief due to their patients' deaths and understanding the coping approaches used will help them overcome these challenges in their careers.

Nurses' grief has not been adequately addressed in most care settings, even though it is a well-known hazard to health and work performance (Khalaf et al., 2018). For example, some studies have explored nurses' grief experiences in palliative care, pediatric nursing, and oncology settings (Reid, 2013; Adwan, 2014; Papadatou et al., 2002). However, research on the grief experiences of nurses working in other acute care hospital settings after the death of their patients is limited (Meller et al., 2019). In Ghana, nurses and midwives form the majority of health workers employed in the public sector. For example, in 2018, there were 67, 077 (58% of all healthcare workers) nurses and midwives employed in the public health sector of Ghana (Asamani et al., 2019). Nursing in Ghana is regulated by the Nurses and Midwifery Council (NMC) of Ghana. The NMC ensures that all nurses in Ghana have the license to practice as professional nurses after a one-year mandatory completion of National Service usually referred to as Rotation. Professional nurses have at least a diploma qualification in nursing and this category of nurses includes registered general nurses, registered midwives, registered mental health nurses, registered community health nurses, and post-basic nurses (Alhassan RK et al., 2020). The limited research on the hospital staff's experiences of grief in Ghana has focused mainly on midwives (Dartey, Phuma-Ngaiyaye, & Phletlhu, 2017). No study has focused on the experience of different categories of nurses in Ghana. This study was done to examine grief and coping experiences amongst registered general nurses working in various care departments of a major government health facility in the Ashanti region of Ghana.

2. Material and Methods

It was a descriptive cross-sectional study that was conducted at the Konongo-Odumasi Government Hospital in Konongo. This is a 180-bed health facility and a National Health Insurance Scheme accredited hospital located in a mining community in the Ashanti Region, Ghana. The town serves as the capital of Asante Akyem Central Municipality. The hospital has the following departments to render effective service to its clients: an outpatient department, a pathological and research laboratory, a radiology department, a pharmaceutical department, a physiotherapy department, an emergency department, a dental department, medical ward, surgical ward, pediatric ward, maternity ward, and an operating theatre. The hospital is not affiliated with any university because it is a district hospital; however, physician assistantship and nursing students from the Presbyterian University College of Ghana have their vacation practicum at the hospital due to its proximity to the university campus.

The sample size was calculated using the National Education Association formula:

$$S = \frac{[X^2 NP (1-P)]}{(d^2 (N-1) + X^2 P(1-P))}$$

, where, S= required sample size; X^2 =the table value of chi-square for one degree of freedom at the desired confidence level (i.e., $(1.96)^2 = 3.8416$; N=the total population size= 99 nurses; P= the population prevalence of grief experience (i.e. assumed to be 0.50); and d= the degree of accuracy expressed as a proportion (i.e. 0.05) (Krejcie & Morgan, 1970).

Finally, 79 nurses were identified as the research sample. A quota sampling technique was then used to yield a representative sample of nurses working in different wards. The overall distribution of recruited nurses was as follows: medical ward (n=14), surgical ward (n=13), emergency ward (n=12), theatre (n=14), maternity ward (n=15), and pediatric ward (n=11). Therefore, the questionnaires were distributed in each stratum based on this calculation. The inclusion criteria were all registered nurses (in Ghana, it is mandatory for nurses to do a one-year national service after completion of training and after that, they are given the license to practice as registered/ professional nurses) at the stated wards of the hospital who were present during data collection and consented to participate in the study. All registered nurses on annual leave or excuse-duty were excluded from the study. Rotational nurses and student nurses were also excluded from the study.

The instrument used in data collection was a self-administered questionnaire, which was constructed through the study of authoritative texts and consultation with experts. The final questionnaire was adapted after pretesting among ten registered nurses working in a nearby health facility. The final questionnaire comprised of four sections. The first section had seven items to collect the demographic information of the subjects. The second and third sections were made of nine and seventeen items, respectively to collect information on the grief experiences of nurses after a patient's death and its impacts, respectively. The fourth section with ten items obtained information on how nurses cope with grief after patients' death.

Data were collected in a week to ensure all participants who worked on different shifts during the week had an equal chance of being selected.

Standard descriptive statistics (e.g., frequency and proportions) were used to summarize the survey data. Data management and analysis were performed with the Statistical Package for Social Science (SPSS software version 20).

3. Results

Demographic information

The characteristics of the subjects are shown in Table 1. The majority of the respondents were females (56%) and married (59.5%) and under 40 years of age (83.5%). About a third of the respondents were nursing officers, and most were Christians (76%). Only about a tenth of the respondents had worked for less than a year post-qualification.

Nurses' experiences of grief after patient death

Information on the grief experiences of nurses surveyed is presented in Table 2. The majority of respondents (63.3%) reported the experience of grief after the death of a patient, while about a third of respondents did not. Out of those who reported not experiencing grief, 48.2% (n=14) did not express their grief because of their professionalism, while another 40.7% (n=11) did not express their grief because of fear, and 11.1% (n=3) indicated no reason for not grieving. The majority of respondents (63%) also reported not feeling isolated when grieving after the loss of a patient. However, many respondents (51%) hid their grief when a patient died in their ward, and a similar proportion generally ignored their grief feelings. Furthermore, most respondents (63%) reported developing and building close, personal relationships with their patients, and 49.4% (n=39) of the respondents reported that they have experienced an overwhelming sense of loss when a patient died. Additionally, 83.5% (n=66) of the respondents reported that they were aware of patient suffering but were unable to relieve it due to the death of the patient.

Impacts of grief following patients' death on nurses

Nurses' responses to the impacts of grieving after the death of their patients are presented in Table 3. Some of the impacts reported included insomnia (39.2%), loss of appetite (50.6%), and tiredness (7.6%). Most respondents did not feel depressed (68.4%), did not experience feelings of uneasiness and being easily bothered (55.7%), and responded that the grief did not affect their functionality both at work and at home (65.8%). Only about a third of the respondents reported having feelings of uneasiness and being easily bothered, sleeping late at night, waking up too early, and generally feeling irritable and emotionally overwhelmed follow-

Table 1. Demographic data of the respondents

Nurses' Characteristics		No. (%)
Age (y)	20-29	34(43.0)
	30-39	32(40.5)
	40-49	8(10.1)
	50-59	2(2.5)
	60-69	1(1.3)
	No response	2(2.5)
	Total	79(100)

Nurses' Characteristics		No. (%)
Marital status	Single	26(32.9)
	Married	47(59.5)
	Divorced	1(1.3)
	Widowed	1(1.3)
	Cohabiting	2(2.5)
	No response	2(2.5)
	Total	79(100)
Professional grade	Senior nursing officer	18(22.8)
	Nursing officer	27(34.2)
	Senior staff nurse	11(13.9)
	Staff nurse	20(25.3)
	No response	3(3.8)
	Total	79(100)
Religion	Christianity	60(75.9)
	Islam	19(24.1)
	Total	79(100)
Gender	Male	35(44.3)
	Female	44(55.7)
	Total	79(100)
Work experience	Less than a year	9(11.4)
	1-5 years	31(39.2)
	6-10 years	26(32.9)
	11-15 years	7(8.9)
	16-20 years	3(3.8)
	26 years and above	3(3.8)
	Total	79(100)
Ward	Medical Ward	26(32.9)
	Surgical Ward	15(19.0)
	Emergency Ward	14(17.7)
	Theatre	7(8.9)
	Maternity Ward	8(10.1)
	Pediatric Ward	7(8.9)
	No response	2(2.5)
	Total	79(100)

Table 2. Nurses' responses to the experienced grief after patient death

Responses to Grief		No. (%)
Grief after the death of a patient in the ward	Yes	50(63.3)
	No	27(34.2)
	No response	2(2.5)
	Total	79(100)
If not, why?	Because of professional expectations	13(48.2)
	Because of fear	11(40.7)
	None	3(11.1)
	Total	27(100)
Isolated when you are grieving	Yes	25(31.6)
	No	50(63.3)
	No response	4(5.1)
	Total	79(100)
Care for a patient who passed away	Yes	49(62.0)
	No	28(35.4)
	No response	2(2.5)
	Total	79(100)
What do you do when a patient dies in your ward?	Hide your grief	40(50.6)
	Cry	4(5.1)
	Laugh	1(1.3)
	None	31(39.2)
	No response	3(3.8)
	Total	79(100)
Personal relationships with patients	Yes	50(63.3)
	No	27(34.2)
	No response	2(2.5)
	Total	79(100)
Overwhelming sense of loss when a patient dies	Yes	39(49.4)
	No	38(48.1)
	No response	2(2.5)
	Total	79(100)

Responses to Grief		No. (%)
Wish to relieve the patient's suffering, but the patient dies	Yes	66(83.5)
	No	13(16.5)
	Total	79(100)
Ignore the feelings of grief when a patient dies	Yes	44(55.7)
	No	33(41.8)
	No response	2(2.5)
	Total	79(100)

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ing the death of a patient. Furthermore, less than a fifth of the respondents reported feeling burnout, physically unwell or anxious, abusing alcohol, having low self-esteem, and being absent from work following patients' death. Only a few respondents (less than 10%) reported a decrease in quality of patient care, suicidal thoughts, and a decision to leave the workplace.

Nurses' coping with grief after a patient's death

The answers to the questions related to coping strategies adopted by nurses after the patient's death are presented in Table 4. Most nurses (75.9%) were aware that when they do not recognize grief and cope appropriately, it could explode at any time. Consequently, most of them (75.9%) find activities and practices that replenish, comfort, and revitalize their spirit when a patient dies. The activities reported were engaging in exercise (66.7%), going to church (3.3%), reading the Bible or Quran (8.3%), other spiritual practices, such as meditation or prayers (50.6%), engaging in whatever promotes rest and comfort, such as swimming (16.7%). Furthermore, around half of the respondents listened to music as a coping strategy. About a third of the respondents attended the funeral celebration of the deceased patient. Most respondents did not put away their stethoscope (i.e. they did not quit providing nursing care to other patients) (86.1%) or change clothes (75.9%) to cope with grief. Instead, some (41.8%) talked about their feelings or interacted with other professionals to cope with grief. Almost half of the respondents indicated that they have access to professional counseling to cope with grief.

4. Discussion

The present study revealed that nurses grieve when a patient dies. However, most of them did not show it or did not recognize that they are grieving. This finding is consistent with that of Jonas-Simpson et al. (2013) re-

porting that the unfortunate situation is that although most nurses grieve when patients die, their grief is unrecognized. Therefore, nursing faculty, administrators, and leaders could offer a more conducive and supportive practice environment for professional nurses by developing an in-depth understanding of and acknowledging the grieving process (Gerow et al., 2010; Shorter and Stayt, 2010; Jonas-Simpson et al., 2013).

The current study revealed the reason why nurses hide their grief was professionalism. This means that nurses have to develop some resistance to grief to continue the caring process for their patients. Previous studies also have shown that nurses develop a protection screen to lessen grieving and provide ongoing supportive care to patients (Gerow et al., 2010; Jonas-Simpson et al., 2013; Shorter and Stayt, 2010; MacDermott & Keenan, 2014). However, these experiences tend to have a long-term impact on the nurses' personal and professional lives; hence, they require in-depth understanding to assist them in proper adjustment (Kent et al. 2012).

The finding that nurses experience sorrow and trauma when they care for a patient who passed away corresponds to the study of Couden (2002). This is because nurses develop and build close and personal relationships with patients when caring for them and, as a result, experience a devastating sense of loss. The current study showed the impacts of nurses' grief, such as insomnia, loss of appetite, tiredness, and social isolation. These findings are consistent with a qualitative explorative study in the Ashanti Region of Ghana, which included a purposive sample of 18 ward supervisors and 39 ward midwives (Dartey et al., 2017).

Table 3. The impacts of grief following patients' death on nurses

Grief Impacts	No. (%)	
General effects	Insomnia	26(32.9)
	Loss of appetite	40(50.6)
	Tiredness	6(7.6)
	Social isolation	4(5.1)
	No response	3(3.8)
	Total	79(100)
Depression	Yes	19(24.1)
	No	54(68.4)
	Not sure	4(5.1)
	No response	2(2.5)
	Total	79(100)
Feelings of uneasiness and being easily bothered	Yes	27(34.2)
	No	44(55.7)
	Not sure	6(7.6)
	No response	2(2.5)
	Total	79(100)
Affecting functionality at work and home	Yes	21(26.6)
	No	52(65.8)
	Not sure	6(7.6)
	Total	79(100)
Sleep late at night and wake up early	Yes	27(34.2)
	No	43(54.4)
	Not sure	9(11.4)
	Total	79(100)
Mental episodes of losing a patient	Yes	21(26.6)
	No	50(63.3)
	Not sure	8(10.1)
	Total	79(100)
Alcohol abuse	Yes	10(12.7)
	No	66(83.5)
	Not sure	3(3.8)
	Total	79(100)

Grief Impacts	No. (%)	
Low self-esteem and absenteeism	Yes	10(12.7)
	No	64(81.0)
	Not sure	5(6.3)
	Total	79(100)
Job dissatisfaction	Yes	20(25.3)
	No	50(63.3)
	Not sure	6(7.6)
	No response	3(3.8)
	Total	79(100)
Burnout	Yes	13(16.5)
	No	57(72.2)
	Not sure	7(8.9)
	No response	2(2.5)
	Total	79(100)
Physical illness and anxiety	Yes	18(22.8)
	No	52(65.8)
	Not sure	5(6.3)
	No response	4(5.1)
	Total	79(100)
Suicidal thoughts	Yes	6(7.6)
	No	67(84.8)
	Not sure	3(3.8)
	No response	3(3.8)
	Total	79(100)
Loss of ability to enjoy life	Yes	17(21.5)
	No	52(65.8)
	Not sure	7(8.9)
	No response	3(3.8)
	Total	79(100)
Headaches and/or weight gain	Yes	16(20.3)
	No	52(65.8)
	Not sure	10(12.7)
	Total	79(100)

Grief Impacts	No. (%)	
Decreased quality of patient care	Yes	7(8.9)
	No	67(84.8)
	Not sure	5(6.3)
	Total	79(100)
Decisions to leave the workplace	Yes	11(13.9)
	No	60(75.9)
	Not sure	8(10.1)
	Total	79(100)
Irritability and feeling emotionally overwhelmed	Yes	26(32.9)
	No	42(53.2)
	Not sure	9(11.4)
	No response	2(2.5)
	Total	79(100)

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Inconsistent with the findings of other studies (Mousavi et al., 2007; Fuchs, 2013), most nurses in this study did not report experiencing depression due to grief. However, it is noteworthy that depression may be expressed as insomnia, loss of appetite, exhaustion, and social isolation (Braun et al., 2007; Given et al., 2004; Dartey & Phuma-Ngaiyaye, 2020), which the study participants reported. Similarly, unlike what has been established in other studies (Aycock & Boyle, 2009; Benca & Peterson, 2008), for most nurses in this study, their functionality at work and at home was not affected by grief. This may be related to their coping strategies, such as strategies for revitalizing their spirit. However, this may also indicate a lack of self-awareness amongst nurses in our study.

Poorly managed grief experiences amongst nurses have been shown to result in absenteeism and alcohol abuse (Yoon, 2009; Kim & Park, 2012). However, the finding that most nurses in the present study did not use alcohol due to depression or did not experience low self-esteem and absenteeism due to grief over the patient's death may indicate good grief management strategies. Continual exposure to death and grief may progress to work-related stress and eventually burnout. However, most nurses in the study did not experience burnout due to grief over patients' death. Meert (2011) explains that although caregivers experience a high level of complicated grief, some can integrate it into their daily lives,

allowing them to continue caregiving. It is thus not surprising that most nurses have not experienced a decrease in the quality of patient care due to grief over patients' death. It is, however, established that nurses may experience compassion fatigue in their daily practice, which, if left unresolved, can significantly impact their professional and personal lives and lead to a decrease in the quality of care (Aycock & Boyle, 2009; Coetzee & Klopfer, 2010; Showalter, 2010).

Regarding how nurses cope with grief, the current study revealed that the respondents were aware that when they do not recognize grief and cope appropriately, it explodes at any time, which is in line with the study by Lally (2005), reporting that the first stage of mitigating the impacts of grief is early recognition. When there is a failure to recognize these griefs, they can explode abruptly (Wakefield, 2000).

Most nurses in our study consciously resorted to activities and practices that replenish, comfort, and revitalize their spirit after a patient death. These activities and practices were exercise, family or religious activities (going to church), and spirituality (reading the Bible/ Quran). These are consistent with other studies that reported that nurses find spirituality significant in their daily lives (75%) and it assists them in coping with grief over patients' death (70%) (Shinbara & Olson, 2010). This is further echoed in the study by Bush (2009) re-

Table 4. Nurses' responses on how to cope with grief after a patient's death

Coping Responses		No. (%)
It explodes at any time	Yes	60(75.9)
	No	17(21.5)
	No response	2(2.5)
	Total	79(100)
Revitalize your spirit when a patient dies	Yes	60(75.9)
	No	17(21.5)
	No response	2(2.5)
	Total	79(100)
If yes, what are some of these activities?	Exercise	40(66.7)
	Family or religious activities (going to church)	2(3.3)
	Spirituality (reading the Bible/ Quran)	5(8.3)
	Whatever promotes rest and comfort (swimming)	10(16.7)
	No response	3(5.0)
Total	60(100)	
Putting away a stethoscope	Yes	3(3.8)
	No	68(86.1)
	Not sure	8(10.1)
	Total	79(100)
Changing clothes	Yes	15(19.0)
	No	60(75.9)
	Not sure	2(2.5)
	No response	2(2.5)
Total	79(100)	
Listening to the music	Yes	37(46.8)
	No	40(50.6)
	Not sure	2(2.5)
	Total	79(100)
Spiritual practices, such as meditation and prayer	Yes	40(50.6)
	No	34(43.0)
	Not sure	3(3.8)
	No response	2(2.5)
Total	79(100)	

Coping Responses	No. (%)	
Attending funerals of the patients	Yes	25(31.6)
	No	50(63.3)
	Not sure	4(5.1)
	Total	79(100)
Discussing emotions with other professionals	Yes	33(41.8)
	No	32(40.5)
	Not sure	12(15.2)
	No response	2(2.5)
	Total	79(100)
Access to professional counseling	Yes	37(46.8)
	No	34(43.0)
	Not sure	8(10.1)
	Total	79(100)

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porting that identifying activities and practices in nursing care that refill, relief, and refresh the spirits is ideal for assisting nurses to overcome their grief. These activities might include engaging with the family or religion, spirituality, or whatever the individual might find restful and comfortable (Austin et al., 2009; Pipe & Bortz, 2009; Showalter, 2010).

Furthermore, we found that nurses engage in spiritual practices, such as meditation, prayer, and quiet time to cope with grief and they do not attend funerals of the patients and do not send sympathy cards to cope with grief. These are similar to other studies that have found that nurses' faith and religion protect them from the accumulated consequences of grief (Aycock & Boyle, 2009; Shinbara & Olson, 2010). However, for some nurses, insight and personal experience assist them in coping well with grief (Maytum, Heiman, & Garwick, 2004). Also, recognizing deaths by appearing at the funerals of the bereaved and sending sympathy cards may assist nurses' grief properly (Medland et al., 2004). Furthermore, Fetter (2012) posited that recognizing bereavement and engaging in discussions may assist nurses in mitigating grief.

Additionally, the current study found that nurses discuss emotions or interact with other professionals to cope with grief. Nurses sometimes isolate themselves and are incapacitated to discuss their grief when patients

die (Papadatou, 2000). This unsupportive atmosphere may result in nurses tending to vacate the profession or the ward (Shinbara & Olson, 2010). However, when the working atmosphere is supportive, nurses find meaning in grief experiences (Lally, 2005). Furthermore, avenues to discuss emotional feelings of grief with other professionals during breaks or lunch may offer emotional support to nurses after their last offices (Papadatou, 2000). Examples of these avenues include organized support groups or debriefings. Skilled professionals should spear these discussions and encourage nurses to discuss supportive coping mechanisms with other team members (Keene et al., 2010; Hall, 2011; Medland et al., 2004).

Despite the utility of the findings of this study, one must consider the following limitations of the study. Firstly, as a cross-sectional study, the findings only give a snapshot of the situation at the time of the study. In addition, depending on the culture of nursing in Ghana, different findings may emerge in other countries. Furthermore, as it is with all studies relying on self-reported data, the respondents may have under-reported their true grief experiences after the loss of a patient. To confirm and further improve our understanding of the grief experiences of registered nurses, future research should include methods that allow for direct observation of nurses after the loss of a patient and in-depth interviews with colleagues and housemates.

5. Conclusion

In conclusion, this study provides further evidence that nurses working in different care settings in Ghana respond emotionally to patients' death and experience grief. Most nurses are aware of the effects repeated grief has on their personal and professional lives and thus develop individualized coping habits to manage grief. Only a few nurses reported access to professional counseling support for dealing with grief. Regular training on effective grief coping strategies and professional emotional support should be provided to nurses caring for dying patients. This will undoubtedly improve the health and wellbeing of nurses and also the quality of care for both dying patients and their families.

Ethical Considerations

Compliance with ethical guidelines

The study was approved by the Faculty of Health and Medical Sciences of Presbyterian University College, Ghana, and conducted according to the guidelines of the Declaration of Helsinki. Adequate information was given to the participants regarding the research objectives, benefits, risks, and voluntary participation in the study. Approval was sought from the study hospital, and signed informed consent was obtained from participants before data collection. The collected data were kept confidential and anonymized. Coding systems were developed to ensure that data sources were identifiable only by the researcher.

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Authors' contributions

All authors contributed equally to preparing this article.

Conflict of interest

The authors reported no conflict of interest.

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