

Bereavement in the Pediatric Emergency Department: Caring for Those Who Care for Others

Brittany Lynn Jackson

“Isn’t it hard working there?” This is a question many pediatric emergency department (ED) healthcare providers are asked. Even for those who have never worked in the emergency environment, the stress and emotional difficulty is widely known and accepted by both healthcare professionals and the general population. The pediatric ED is an exciting, fast-paced, and unpredictable environment, but it is stressful by nature, especially when the death of a child occurs. Emergency medicine is the specialty faced most frequently with death, second only to oncology (Parris, 2012). ED staff are recurrently exposed to the tragedy of others, which has led to expectations of the staff’s ability to “carry on” through their day (Brysiewicz & Uys, 2006, p. E8). The stress experienced by ED staff has become an expected aspect of the job, and its effects are often overlooked. Though ED workers develop a “shell” or self-protectiveness to help make sense of and cope with the tragedy they experience, they are still affected by these experiences, and as a result, can suffer long-term effects (O’Malley, Marata, Snow; & the American Academy of Pediatrics [AAP] Committee on Pediatric Emergency Medicine, American College of Emergency Physicians Pediatric Emergency Medicine Committee, & the

One of the most difficult challenges faced by pediatric emergency department (ED) nurses and physicians is the death of a child, which is often sudden and traumatic. ED healthcare providers experience stress and grief related to the nature of death, resuscitation, death process, providing bereavement services to the child’s family, and ED-specific factors. Other emotional reactions, such as sense of guilt related to perceived failure, are also experienced. The emotional strain endured, however, is frequently unacknowledged and untreated. Addressing and managing these emotional reactions by way of discussion, education/training, and department support can aid in mitigating stress, decreasing risk of long-term effects, and allowing staff to continue to provide high-quality patient care. The aim of this article is to demonstrate the impact of pediatric ED deaths on nurses and physicians involved, and identify practices to best care for these providers.

Key Words: Emergency department, pediatric trauma, caregiver, bereavement, psychological needs of caregivers

Brittany Lynn Jackson, RN, CPNP-AC, was a graduate student in the University of Pennsylvania’s Pediatric Acute Care Nurse Practitioner Program at the time this article was written. She is now a Pediatric Nurse Practitioner in the Pediatric Intensive Care Unit at Children’s Medical Center of Dallas, Dallas, TX.

Acknowledgments: Special thank you to Janet Deatrick, PhD, FAAN, for manuscript review and editorial contributions.

Emergency Nurses Association Pediatric Committee, 2014; Ross-Adjie, Leslie, & Gillman, 2007).

Research on the bereavement of the deceased child’s surviving family and training for ED staff to provide support exists; however, there is little research on the care of pediatric ED healthcare providers when a child dies. The purpose of this article is to evaluate the impact death plays on providers within the pediatric emergency department and determine methods to best address their emotional and psychological needs. PubMed, Scopus, CINAHL, and GoogleScholar were searched using terms, including *emergency department, emergency service, grief, bereavement, staff, death, child, humans, and death of a child*. Results were limited to the years 2000-2015. Reference lists were reviewed for additional applicable articles.

Background and Significance

The death of a child is an infrequent occurrence, but when it occurs, the ED is a common place (Knazik et

al., 2003). Knapp and Mulligan-Smith, for the AAP Committee on Pediatric Emergency Medicine (2005) found that 20% of children 14 years and under die in outpatient settings, notably the ED. Pediatric emergency providers are taught that children are resilient and have the ability to bounce back from illness and injury. Therefore, ED staff strive to provide successful resuscitation measures, and when unable to do so, view the death as a failure, making it difficult to accept (Brysiewicz & Uys, 2006; Knazik et al., 2003).

Emergency department nurses and physicians are at risk for stress and its long-term effects related to the sudden, traumatic death of children. Experiencing certain causes of death, participating in resuscitation efforts, completing the death process, supporting bereaving families, and enduring effects of department/staff specific issues are other important factors contributing to ED provider stress (Knazik et al., 2003; Lawrence, 2010; Parris, 2012). Some stress is inevitable and proper recognition and management

can decrease the emotional reaction and the risk for long-term effects. ED staff who manage stress well will maintain the ability to provide high-quality patient care with lower levels of stress, and better mental and physical health (Healy & Tyrrell, 2013).

Sources of Stress When A Child Dies

According to Healy and Tyrrell (2013), critical incidents are “events that provoke strong emotion reactions” (p. 32). Death, along with violence, abuse, and aggression, are examples of critical incidents and can occur concurrently (Healy & Tyrrell, 2013). The frequent exposure to these critical incidents can take a severe emotional toll on healthcare providers. Death, specifically, is a difficult event for healthcare providers to endure and is often worsened by several contributing factors, including nature of death, resuscitation efforts, death process, bereavement services and support for surviving family, and department-specific factors.

Nature of Death

In their joint position statement, the AAP Committee on Pediatric Emergency Medicine, American College of Emergency Physicians Pediatric Emergency Medicine Committee, and the Emergency Nurses Association Pediatric Committee identified the death of a child as “one of the most difficult challenges in emergency care” (O’Malley et al., 2014, p. 198). The nature of pediatric ED death is particularly oppressive because it occurs in children and is typically unexpected, abrupt, and traumatic (Baren & Mahon, 2003; Knapp et al., 2005; Parris, 2012). Certain causes of death are associated with increased stress and emotional response, including child maltreatment, careless incidents, preventable illnesses, suicides, and homicides (Knazik et al., 2003).

Resuscitation

ED physicians and nurses are presented with difficult resuscitation decisions surrounding pediatric death. Often, few details are known about the child and events preceding arrival to the ED, yet staff are charged with making abrupt critical decisions (Baren & Mahon, 2003).

Currently, no guidelines exist for clinical decision-making of non-initiation and termination of resuscitation

Table 1.
Tasks to Be Completed by Emergency Department Providers Following the Death of a Child

• Notify family of the child’s impending death.
• Contact social services.
• Contact organ procurement and begin discussion with family.
• Announce time of death.
• Identify child maltreatment/neglect and report it.
• Complete proper documentation.
• Provide bereavement services to family.
• Offer and discuss an autopsy (if the case is a non-medical examiner-coroner case).
• Perform post-mortem care.
• Provide supportive environment and time for family visitation with the child.
• Prepare the child for transfer to the morgue.
• Release belongings to family.
• Provide memento for remembrance.
• Complete death certificate.
• Contact medical examiner/coroner.
• Notify funeral home.
• Notify child’s other healthcare providers, including primary care provider, specialists, and medical home.
• Defuse and debrief involved staff.
• Bereavement support for emergency department staff.

Sources: Knapp et al., 2005; Lawrence, 2010; O’Malley et al., 2014.

efforts due to a lack of research. An exception is the preterm delivery of infants, for which guidelines exist based on gestational age (O’Malley et al., 2014). Providers are forced to make decisions based on their own clinical judgment, rather than guidelines founded on evidence-based practice. Deciding to terminate or to not initiate life-prolonging treatments or therapies due to efforts being futile or risks outweighing potential benefits is traumatic for ED physicians (Baren & Mahon, 2003). Stress also arises from the fear of making decisions that may be detrimental to the child. Though most decisions are made by ED physicians, nurses may experience strong emotional responses when discontinuing life-saving measures, such as chest compressions. The idea that children are not supposed to die can lead to prolonged resuscitations and efforts that are not in the best interest of the child (Baren & Mahon, 2003).

Further, health plans and goals for children may be unknown. For most children presenting to the ED, the goal is to return them to a com-

plete state of health. However, children with medically complex conditions, chronic conditions, and those who are technologically dependent often have variable goals. These goals may no longer include total healing, but rather, personalized goals often focusing on comfort. This information may be obtained from family members, advanced directives, and do not resuscitate (DNR) orders. Children in these various states of health often present to the ED with complications of their conditions, which further convolutes resuscitation decision-making, especially when details of medical conditions and personalized goals are not readily available (Baren & Mahon, 2003).

Death Process

When death occurs, a process must be completed by ED staff. This process contains multiple components and can be perceived as stressful to staff, who are often unfamiliar and inexperienced with the process. Table 1 provides a list of tasks to be completed by ED providers, with nursing contributing a large role.

Supporting Bereaving Family

Following the death of a child, ED staff immediately transition from resuscitating the child to providing emotional support and bereavement services to surviving family members (Knapp et al., 2005; Knazik et al., 2003). It can be challenging for staff to support the bereaving family, while personally experiencing stress and grief (Parris, 2012). The family's ability to cope, remembrance of the event, and involvement of grief are affected by the bereavement services provided in the ED immediately following the child's death. The pressure to provide these services greatly contributes to the stress of staff members (Baren & Mahon, 2003; Parris, 2012). When a child dies in the ED, it is typical that staff are meeting families for the first time without the opportunity to develop rapport with them. Therefore, effectively establishing a relationship with and supporting the family is even more challenging, making an empathetic approach vital (Baren & Mahon, 2003; Brysiewicz & Uys, 2006; Knapp et al., 2005; Knazik et al., 2003).

Communicating the death in detail is straining for ED staff, who typically do not have time to gather and analyze their thoughts prior to talking with the family. This can lead to uneasiness and barriers to effective communication (Knazik et al., 2003). The emotional and physical reactions of the family can be overwhelming and emotionally exhausting for staff members (Lawrence, 2010). Other essential conversations to be held with the family include performance of organ donation and autopsy (Knapp et al., 2005; Knazik et al., 2003). Frequently, one nurse is assigned the role of keeping the family informed and remaining with them during the death process, which can be emotionally and psychologically taxing (Knapp et al., 2005; Knazik et al., 2003; Lawrence, 2010). Additionally, nurses often support families in viewing the body following death and assist in obtaining mementos, which are personal and emotional times for families as well as nurses.

ED Specifics

Certain factors unique to the ED become sources of additional stress when the death of a child occurs. Staff must resume caring for other patients and the demands of the department immediately, without time to address

their own needs (Parris, 2012). Infrequency and unfamiliarity with death can create concern of incorrectly completing the post-mortem process. The team caring for a deceased child is often composed of staff with variable experience levels, many of whom may have never been exposed to death (Knapp et al., 2005; Parris, 2012). In a survey conducted by Healy and Tyrrell (2011), staff with less experience identified resuscitations as stressful more frequently than their senior colleagues, leading to the idea that junior staff feel inadequately supported by more experienced staff (Healy & Tyrrell, 2011; Lawrence, 2010). However, contradicting results were found in a study performed by Ross-Adjie et al. (2007), in which nurses with under one year of experience rated death or sexual abuse of children as less stressful than nurses with one through five years of nursing experience did. This finding may be secondary to newer nurses' lack of exposure to pediatric death and sexual abuse (Ross-Adjie et al., 2007). Nurses inexperienced with death may have difficulty caring for the deceased child moments after witnessing and participating in the resuscitative efforts and death. ED providers, whether inexperienced or experienced, feel a lack of departmental support surrounding the death process (Healy & Tyrrell, 2013). In fact, in a study published in 2011 by Healy and Tyrrell, 74% of respondents reported no help from their employer in dealing with stress.

Bereaved ED Staff

Bereavement, defined by Parris (2012) as "the recent loss of a significant person through death" (p. 141), is an experience that nearly all individuals will encounter in their lifetime. Pediatric ED healthcare providers, however, experience this more than most. In addition to typical emotions brought on by the death of another individual, such as stress and grief, emergency providers experience additional feelings related to involvement in caring for the child and family.

Stress and Grief

Stress is prevalent among healthcare providers, especially in those working in the ED. It is an inescapable aspect of the profession. Stress can aid providers in performing at high levels

and keeping focus when appropriately managed (Healy & Tyrrell, 2011). However, uncontrolled stress can be extremely detrimental. Grief is an "emotional reaction to bereavement incorporating diverse psychological and physical reactions" (Schut, Stroebe, & Stroebe, 2007, p. 1960). The varying emotions of grief include anxiety, numbness, yearning, and helplessness. Some physical symptoms include decreased appetite and insomnia. The literature does not discuss chronological timeframes of grief for pediatric ED providers; however, the return to normalcy is expected around six months post-event for average grieving individuals (Parris, 2012).

Other Reactions

ED physicians and nurses experience other reactions following the death of a child. A survey by Serwint (2004) demonstrated that 31% of residents experienced guilt after the death of a patient and 16% even felt responsible. Contributing factors to experiencing guilt include feelings of personal failure or blame, which can be personally assumed or assigned by surviving family or other staff members (Knazik et al., 2003; Plantz, 2008; Serwint, 2004). Guilt may arise from any type of error, but it can also occur when no errors are made at all. ED providers often fault themselves when children's lives cannot be saved regardless of the cause. Serwint's (2004) study identified additional sources of guilt, including personal feelings of inadequacy, lack of aggressiveness during treatment, prolonged continuation of aggressive treatment, professional inexperience, underestimation of the acuity of the child, lack of compassion, personal absence during the death, and parental absence during the death (Serwint, 2004). Though these studies focus on physician perspectives, it is likely that nurses endure similar personal struggles, questioning their performance during the resuscitation efforts and its impact on the child's survival. Helplessness, avoidance, and inability to accept death are other emotions felt by ED staff (Brysiewicz & Uys, 2006; Lawrence, 2010).

Risks and Long-Term Effects

Many studies have validated that recurrent grief and bereavement increase the risk of likelihood for the development of mental and physical illnesses (Parris, 2012), such as chron-

ic stress, anxiety, depression, detachment, post-traumatic stress disorder (PTSD), and physical disability (Lawrence, 2010). Because each individual's response to various stressors and stress management techniques are unique, some individuals have the ability to cope with higher levels of stress over longer periods of time in comparison to those with ineffective coping mechanisms. Without recognition and management of these insufficient mechanisms, staff can become emotionally numb, and their ability to provide high-quality care to the bereaving family and other ED patients is impeded (Healy & Tyrrell, 2013; Lawrence, 2010; Parris, 2012). In fact, ED physicians often feel compromised for the remainder of their shift following a death (Plantz, 2008). Repetitive exposure to tragic deaths, unrecognized emotional needs, and poor stress management also impair the staff's ability to deal with future deaths (Parris, 2012). Over time, ED providers progressively experience compassion fatigue and burnout, eventually leading to increased sick leave and decreased job satisfaction (Healy & Tyrrell, 2013; Knazik et al., 2003). Some staff leave the profession due to the mental and physical tolls caused by exposure to these stress-evoking events (Healy & Tyrrell, 2013; Ross-Adjie et al., 2007).

Management

Several stress and grief models have been developed and are accepted, yet there is no uniform method to handling stress or grief. Each individual's stress management is unique to their personal beliefs and culture (Parris, 2012). Several strategies may be helpful in mitigating stress and grief experienced by pediatric ED staff after the death of child, including discussion, education and training, and department support.

Discuss It

Immediate acknowledgement of the child's death by staff providing direct patient care at the bedside may be helpful, along with voluntary defusion or debriefing (O'Malley et al., 2014). Defusion is an informal discussion immediately following the death of the child. This grants involved staff the opportunity to discuss the death, and address thoughts and emotions right away, rather than waiting until their shift ends (Lawrence, 2010).

Table 2.
Steps of Debriefing in the Emergency Department

1. Introduction
Introduce the debriefing team and explain the purpose of debriefing in the emergency department (ED). This introduction encourages ED provider participation and reduces apprehension of the session. The debriefing team asks and responds to questions, motivates participants, and works to mitigate anxiety.
2. Fact Phase
ED staff members describe the child's death from their view, their recollection of progression of the resuscitation events, their perception of the death process, and their role and responsibility in the process.
3. Thought Phase
Participants discuss their initial thoughts after the death of a child. This is important for ED staff to transition to a deeper, more personal level and to begin to identify how the death has affected them.
4. Reaction Phase
ED providers recall their emotional response to the most personally distressing and traumatic aspect of the child's death. This part of the process is the most intense for staff members.
5. Symptom Phase
ED staff members discuss any other reactions during or post event, including physical or psychological reactions. It is helpful for team members to give examples of these reactions, such as anger, fatigue, or trembling.
6. Teaching Phase
The debriefing team teaches ED staff members to identify stress symptoms and emotional reactions, along with management techniques. This phase aids staff members in normalizing their reaction to the death and in moving forward from the event.
7. Re-Entry Phase
During this phase, staff member questions are answered, and the debriefing is summarized, which allows for closure for involved ED providers. Any need for follow-up for ED staff members is identified and addressed, which may include referral.

Sources: Everly & Mitchell, 1999; Mitchell, Sakraida, & Kameg, 2003.

Further, defusion creates open communication for those involved and uses a multidisciplinary approach, including prehospital services and hospital staff members (Brysiewicz & Uys, 2006). Debriefing, originally developed for soldiers in the military (Serwint, 2004), should be offered 24 to 72 hours after the death (Lawrence, 2010; Parris, 2012), and is defined as the discussion of "one's actions and reactions after the death of a patient" (Serwint 2004, p. 232). Although the efficacy of debriefing has not been proven with evidence-based research, it is thought to be a useful coping mechanism for dealing with death (Ross-Adjie et al., 2007; Serwint, 2004) by identifying emotional effects and needs, allowing time for understanding, mitigating the stress response, and avoiding long-term effects of

physical and emotional burnout (Lawrence, 2010; Parris, 2012; Serwint, 2004).

Although most staff members feel debriefing is important, the majority of facilities do not routinely offer debriefing and do not have formal debriefing guidelines (Healy & Tyrrell, 2013; Ross-Adjie et al., 2007). In a survey conducted by Babl, Magyar, and Theophilos (2009), 69% of clinicians indicated their hospitals did not have debriefing guidelines, and 89% indicated that ED-specific guidelines did not exist. This same study found that 89% of clinicians desired ED debriefing programs and guidelines (Babl et al., 2009). Similar results were found in the cross-sectional study performed by Ross-Adjie et al. (2007) in which 80% reported that debriefing was offered after a stressful event, though 59%

claimed it was not routinely offered. Healy and Tyrrell (2013) found that increased exposure to critical events leads to increased perceived value in debriefing. The critical incident stress debriefing model, known as the Mitchell Model, is the most popular debriefing tool used to address this need (Mitchell, Sakraida, & Kameg, 2003). Table 2 provides an ED-specific modification of this model.

Even in facilities that practice debriefing routinely, barriers stand in the way. The demanding environment of the ED limits time for staff discussion following death. Effective defusion requires timely coordination and the remaining ED staff to take over responsibilities of involved nurses and physicians (Ross-Adjie et al., 2007; Serwint, 2004). Further, because involved team members do not always routinely work in the same environment, it may be difficult to gather the team together for debriefing if not done by the end of the shift (O'Malley et al., 2014; Ross-Adjie et al., 2007; Serwint, 2004).

If formal debriefing is impossible, less formal discussions may prove beneficial. It is important to talk about the death, and discussion can take place with anyone. Two major issues arise, however, if discussions are held with non-coworkers. First, discussion with colleagues may be more beneficial because family members and friends often do not want to hear about these tragedies, or details are left out by ED providers in order to protect their family and friends from eliciting their own emotional response (Knazik et al., 2003; Lawrence, 2010; Serwint, 2004). Second, even if family and friends are able to understand and be supportive, caution must be taken by staff members to avoid violating HIPAA laws. The Health Insurance Portability and Accountability Act serves to protect health information and privacy of individuals, which significantly impedes the extent to which information about the tragedy can be shared with others.

The quality of debriefing sessions is another area of concern, which can be compromised by ill-prepared debriefers. Respondents to the study performed by Ross-Adje et al. (2007) identified poor quality of debriefers as the biggest issue with debriefing sessions. Skilled debriefers with mental health education should lead these sessions, rather than relying on shift

coordinators or senior nurses who are not specifically trained in this area. High-quality debriefing may be accomplished by hiring a full-time chaplain or mental health nurse, or providing debriefing training to the shift coordinators and senior nurses (Ross-Adjie et al., 2007).

Despite these challenges, most ED nurses feel debriefing is useful and should be an option for all, occurring reflexively after major stress-evoking events. In the Ross-Adjie et al. (2007) study, staff felt that debriefing should not be optional, but mandatory. The opportunity for ongoing debriefing may also be useful, particularly for those experiencing late effects of the tragedy or those who initially deny debriefing, but later would like to participate. It is unclear whether one-on-one debriefing (to maintain privacy) or group debriefing (to maintain support among colleagues) is more beneficial, and may depend on individual preference (Ross-Adjie et al., 2007).

Education and Training

Despite the prevalence of death in the pediatric ED, education and training of the pediatric death process in the ED appear to be lacking (Parris, 2012). Though many medical and nursing schools have added and improved this education in their curricula, many are still lacking because classroom education is not paired with real patient experiences (or simulation/role playing at a minimum). Baren and Mahon (2003) found that pediatric residents care for approximately 35 dying children in the first two and a half years of their residency, yet feel unprepared and ill-equipped to do so. According to the literature, education and training should be implemented for all pediatric ED nurses and physicians, and should be reviewed periodically, possibly in nursing and medical grand rounds and staff meetings/in-services (Baren & Mahon, 2003). Content should include topics of emotional involvement, stress and grief recognition and management, pediatric death components, communication, and caring for survivors.

Emotional involvement. Expectations of healthcare providers' response to death has evolved over time. Traditionally, detachment was taught as the means to cope and protect oneself. Now, patients and families expect staff to be compassionate and actively involved (Knazik et al.,

2003). Brysiewicz and Uys (2006) discuss finding this balance as being a "humane professional" (p. E6). Staff should be taught to allow themselves to experience the emotion of the situation (Serwint, 2004) and may be comforted to know that families value healthcare providers who are genuinely compassionate (Lawrence, 2010; O'Malley et al., 2014). Understanding that the death of a child is a tragedy rather than a personal failure and expressing emotion in response to this tragedy is acceptable, appropriate, and even encouraged. It may also be helpful in minimizing repression and long-term effects of stress and grief.

Stress and grief recognition and management. Physicians and nurses should be taught to recognize and understand their own emotions and how to appropriately manage them to avoid long-term effects of stress and grief. Methods to appropriately identify stress and stress management techniques surrounding the death of a child should be incorporated into education and training. Self-care is essential, and staff should find an enjoyable, therapeutic stress outlet, such as yoga or running (Baren & Mahon, 2003; Knapp et al., 2005; Knazik et al., 2003; Ross-Adjie et al., 2007).

Pediatric ED death components. Though it is not specifically discussed in the literature, it may be beneficial to prepare pediatric ED staff for the nature and common causes of pediatric ED deaths. The various education and training methods of the death process within institutions are beyond this report, but are essential for nurses and physicians (Brysiewicz & Uys, 2006). This preparation will provide the knowledge and skills to alleviate stress surrounding the unknowns.

Two components of this process commonly identified as particularly stressful include requesting organ donation and discussing autopsies. Staff must contact the regional organ procurement organization (OPO) for deaths and imminent deaths (O'Malley et al., 2014). OPO representatives experienced in requesting organ donation assist ED staff with the conversation of organ donation. This allows ED providers to feel less apprehensive about having the conversation and to feel more support (Baren & Mahon, 2003; O'Malley et al., 2014). Staff members fear offending and upset-

ting families when discussing organ donation (Plantz, 2008); however, families are typically not offended, and in fact, are usually appreciative when asked at an appropriate time and in a caring manner (Baren & Mahon, 2003; O'Malley et al., 2014). Some families find meaning in and better cope with their child's death through organ donation by knowing the organs are contributing to saving the lives of others (O'Malley et al., 2014). Knowing this conversation regarding organ donation can be helpful to families may then reduce staff member stress (Parris, 2012).

Autopsies are mandated in pediatric death when the death is suspicious or the cause unknown. Cases of mandated autopsies include unidentified cause of death and confirmed or possible child abuse, homicide, and suicide. If these causes of death are not of concern, autopsies are still offered to families. However, ED providers not only fear offending families with this offer, but worry about discussing the results with the family, along with fear of legal action taken against them for the care they provided (Baren & Mahon, 2003). When families are presented with the option of an autopsy, possible benefits should be discussed, including identifying and understanding the cause of death, gaining information about parent and sibling health and epidemiologic data, and aiding in quality improvement and provider education. This information can help families accept the death, and like organ donation, knowing that their child is helping other children is another way families can find meaning in their child's death (Baren & Mahon, 2003; O'Malley et al., 2014).

Communication. Most nurses and physicians lack training on effective communication techniques (Brysiwicz & Uys, 2006; Lawrence, 2010; O'Malley et al., 2014), which is especially important in difficult situations. This training should focus on communication that is clear, simple, and without medical jargon, and be easy to understand (O'Malley et al., 2014; Parris, 2012). Staff should take caution in avoiding bluntness, which could be misunderstood for lack of compassion. Information should be delivered away from the resuscitation room, in a private area, and uninterupted by others (Parris, 2012).

Caring for the bereaving family. Bereavement should focus on sur-

vivors' needs (Parris, 2012). A nurse not involved in the resuscitation efforts should be assigned to and remain with the family, tending to their needs and serving as a primary communicator between the family and healthcare team (Knapp et al., 2005; Knazik et al., 2003; Lawrence, 2010). Common gestures made by ED healthcare professionals after the death of a child include providing family with a memento, such as a handprint, (Lawrence, 2010) or follow-up by way of phone call or condolence card. These gestures have been received positively by families but have not been studied specifically in pediatric ED deaths (Brysiwicz & Uys, 2006; O'Malley et al., 2014). Knowing that these actions make a positive difference in the lives of families help ED staff find comfort, and can be rewarding and beneficial to distressed staff (Lawrence, 2010). Staff in all layers of the health system, including nurses, physicians, and technicians, should be prepared for their roles in these services and to interact empathetically with families. Interactions with ill-equipped staff can detrimentally impact families' memories of an already tragic experience of their child's death (Baren & Mahon, 2003).

Department Support

Preparation for staff bereavement will enable ED providers to manage stress and grief appropriately when death occurs. ED nurses and physicians reported reduced stress levels when they felt supported in their role; however, a survey conducted by Healy and Tyrrell (2011) demonstrated that 74% of ED nurses and doctors surveyed felt no support from their employer. Bereavement care for family members of a deceased child is not solely the responsibility of the ED providers. It is important for nurses and physicians to delegate aspects of family member support to other hospital resources, such as social services, chaplain, and child life (O'Malley et al., 2014). Other strategies to improve department support in the event of death include allowing involved staff time before resuming patient care and/or moving them to a different part of the ED in an attempt to avoid additional resuscitations during that shift (Lawrence, 2010). Open communication and interpersonal support should be encouraged among staff (Brysiwicz & Uys, 2006). This may be

achieved by attempting to place experienced nurses and junior nurses together during the death process in order to help junior nurses navigate the process, provide coworker support, and minimize stress of the unknown for the junior nurses (Lawrence, 2010). Staff should also be granted time to attend debriefing services and be given voluntary access to mental health services (Lawrence, 2010). Improved management support may aid in decreasing ED staff turnover and in raising staff morale (Ross-Adjie et al., 2007).

Limitations

There are several limitations within this article. Limited research exists regarding methods to care for ED staff in the event of a pediatric death, as most of the literature focuses on the specific components of the pediatric ED death process or concentrates on bereavement of surviving family. Debriefing has been identified as an important coping mechanism for ED staff; however, minimal research currently exists, and its effectiveness has not been proven. Many recommendations made in the literature for ED staff bereavement have not been critically evaluated. Further research and studies are needed to determine the effectiveness of debriefing, develop coping mechanisms tailored to these providers, and create structured education and training programs, in addition to ED-specific bereavement guidelines. Additional research is also needed to explore other stress-evoking events experienced by ED nurses and physicians, and how they can be effectively managed to mitigate detrimental and long-term effects.

Practice Implications

The aim of this article was to demonstrate the impact of pediatric ED death on nurses and physicians involved, and evaluate methods of emotional and psychological support for these providers. Literature has demonstrated that experiencing the death of a child is one of the most stressful aspects of pediatric ED providers. This impact should be acknowledged and managed appropriately through ED-specific guidelines that include bereavement programs for staff members, and training and education programs focusing on communication and stress manage-

Instructions For Continuing Nursing Education Contact Hours

Bereavement in the Pediatric Emergency Department: Caring for Those Who Care for Others

Deadline for Submission: June 30, 2019

PED 1703

To Obtain CNE Contact Hours

1. To obtain CNE contact hours, you must read the article and complete the evaluation through the **Pediatric Nursing website** at www.pediatricnursing.net/ce
2. Evaluations must be completed **online** by June 30, 2019. Upon completion of the evaluation, your CNE certificate for **1.4** contact hour(s) will be mailed to you.

Learning Outcome

After completing this learning activity, the learner will be able to identify the impact of pediatric ED deaths on nurses and physicians involved, and evaluate methods of emotional and psychological support for these providers.

Learning Engagement Activity

Download and review:

Knapp, J., & Mulligan-Smith, D.; for the American Academy of Pediatrics Committee on Pediatric Emergency Medicine. (2005). Death of a child in the emergency department. *Pediatrics*, 115(5), 1432-1437. doi:0.1542/peds.2005-0317

The author(s), editor, editorial board, content reviewers, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

This educational activity is provided by Anthony J. Jannetti, Inc.

Anthony J. Jannetti, Inc. is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Anthony J. Jannetti, Inc. is a provider approved by the California Board of Registered Nursing, provider number CEP 5387. Licensees in the state of California must retain this certificate for four years after the CNE activity is completed.

This article was reviewed and formatted for contact hour credit by Rosemarie Marmion, MSN, RN-BC, NE-BC, Anthony J. Jannetti, Inc. Education Director.

Fees — Subscriber: FREE Regular: \$20

ment techniques. Debriefing and debriefing sessions should be offered and accessible to all involved staff with the support of the ED and facilitated by a trained debriefer. Appropriately educating and preparing staff beforehand, and providing bereavement services for ED staff members following the death of a child will allow for improved coping and emotional response, maintain job satisfaction despite repeated exposure to death, and preserve the ability of staff to provide high-quality patient care. In turn, the pediatric ED will succeed in retaining its knowledgeable, skilled and experienced staff, and possibly even lead to increased recruitment of ED nurses and physicians. ■■■

References

- Babl, F.E., Magyar, J., & Theophilos, T. (2009). Debriefing critical incidents in the paediatric emergency department: Current practice and perceived needs in Australia and New Zealand. *Emergency Medicine Australasia*, 21(6), 479-483. doi:10.1111/j.1742-6723.2009.01231
- Baren, J.M., & Mahon, M. (2003). End-of-life issues in the pediatric emergency department. *Clinical Pediatric Emergency Medicine*, 4(4), 265-272. doi:10.1016/S1522-8401(03)00070-3
- Bryiewicz, P., & Uys, L.R. (2006). A model for dealing with sudden death. *Advances in Nursing Science*, 29(3), E1-E11.
- Everly, G.S., & Mitchell, J.T. (1999). *Critical incident stress management (CISM): A new era and standard of care in crisis intervention*. Ellicott City, MD: Chevron Publishing Corporation.
- Healy, S., & Tyrrell, M. (2011). Stress in emergency departments: Experiences of nurses and doctors. *Emergency Nurse*, 19(4), 31-37. doi:10.7748/en.2011.07.19.4.31.c8611
- Healy, S., & Tyrrell, M. (2013). Importance of debriefing following critical incidents. *Emergency Nurse*, 20(10), 32-37.
- Mitchell, A.M., Sakraida, T.J., Kameg, K. (2003). Critical incident stress debriefing: Implications for best practice. *Disaster Management & Response*, 1(2), 46-51. doi:10.1016/S1540-2487(03)00008-7
- Knapp, J., & Mulligan-Smith, D.; for the American Academy of Pediatrics Committee on Pediatric Emergency Medicine. (2005). Death of a child in the emergency department. *Pediatrics*, 115(5), 1432-1437. doi:0.1542/peds.2005-0317
- Knazik, S.R., Gausche-Hill, M., Dietrich, A.M., Gold, C., Johnson, R.W., Mace, S.E., & Sochor, M.R. (2003). The death of a child in the emergency department. *Annals of Emergency Medicine*, 42(4), 519-529. doi:10.1067/S0196-0644(03)00424-4
- Lawrence, N. (2010). Care of bereaved parents after sudden infant death. *Emergency Nurse*, 18(3), 22-25. doi:10.7748/en.2010.06.18.3.22.c7826
- O'Malley, P., Marata, I., & Snow, S.; for the American Academy of Pediatrics Committee on Pediatric Emergency Medicine, American College of Emergency Physicians Pediatric Emergency Medicine Committee, & Emergency Nurses Association Pediatric Committee. (2014). Death of a child in the emergency department. *Pediatrics*, 134(1), 198-201. doi:10.1542/peds.2014-1245
- Parris, R.J. (2012). Initial management of bereaved relatives following trauma. *Trauma*, 14(2), 139-155. doi:10.1177/1460408611420352
- Plantz, D.M. (2008). The death of children in the emergency department: The psychosocial and administrative response. *Pediatric Emergency Care*, 24(9), 632-637. doi:10.1097/PEC.0b013e318185d931
- Ross-Adjie, G.M., Leslie, G., & Gillman, L. (2007). Occupational stress in the ED: What matters to nurses? *Australasian Emergency Nursing Journal*, 10(3), 117-123. doi:10.1016/j.aenj.2007.05.005
- Schut, H., Stroebe, M., & Stroebe, W. (2007). Health outcomes of bereavement. *The Lancet*, 370(9603), 1960-1973. doi:10.1016/S0140-6736(07)61816-9
- Serwint, J.R. (2004). One method of coping: Resident debriefing after the death of a patient. *The Journal of Pediatrics*, 145(2), 229-234. doi:10.1016/j.jpeds.2004.04.055