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Care of the Deceased Patient and the Bereaved Family

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Maureen Ben-Nun and her colleagues have researched, developed and implemented a protocol for the care and respect

of the bodies of deceased patients, to help families during the period of bereavement. This project was awarded the

2003 Professor Bergman prize for Creativity in Nursing by Tel Aviv University.

When a patient dies in intensive care, the patient's body remains connected to machines and technology. The dead body and the newly bereaved family must be cared for and legal and bureaucratic requirements met. The family must be informed and allowed a dignified parting from the deceased. All this must be managed while the routine activities of the unit and care of other patients continue. The staff has a delicate task to perform when besieged by feelings of sadness and failure (Brenner 2002). This article describes how we have developed and implemented a protocol to manage the time from the patient's death until the discharge of the body to the morgue.

Researching, Implementing and Evaluating the Protocol

Before implementing change we researched the issue in house by questioning the 28 nurses in the unit. A majority expressed the need for improved knowledge on how to care for the deceased patient and bereaved family and felt that the existing guidelines did not allow the families a dignified parting from the deceased. They considered themselves inadequately informed as to the bureaucratic process and therefore unable to guide the family. Recognizing the role of the nursing profession in this area, we researched and developed a protocol with guidelines (see table 1 on page 34). We explained these guidelines to all staff at a staff meeting and in individual training sessions. The protocol was designed to improve the care of the bereaved family during the hours after the patient's death and thus as a tool to help staff cope with the needs of the family. It would explain the bureaucratic process necessary after the patient's death, with a checklist available for efficiency, guidelines to consult in case of uncertainty and a preprepared kit with all the requisite documents and forms. After one year we questioned the staff again on the issue of caring for the deceased and all staff felt an increased ability to cope.

We also contacted families of bereaved patients during that year to evaluate their level of satisfaction and thus the effectiveness of the protocol. 16 from a total of 31 families bereaved in the preceding year were contacted by telephone. All agreed to answer the questions. 13 families had been cared for according to the protocol and all expressed extreme satisfaction.

Contributing factors to their satisfaction were:

• the supportive atmosphere in the unit;

• being able to take a decent leave of their relation;

• patience and kindness shown by the staff, even during the most stressful times;

• appreciation of messages of condolence.

The remaining three families had not received any care. Their relations had died at night, they were not formally informed, and their last

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encounter with the patient had taken place in the morgue. These families were extremely dissatisfied, with a zero level of satisfaction. From their testimony the following conclusions were reached:

• avoid telephone notification;

• avoid delays in notification;

• arrange for the family to say their farewells in the unit, never in the morgue.

Rationales for the Guidelines

Notifying the Family

Families need to be informed in a clear, unequivocal manner that the patient has died. This helps families move on from possible denial and initial shock to a phase of recognition that the patient has died (Hudak et al. 1998). Providing privacy and attendance of a doctor and a nurse show the staff's caring attitude. This respect helps to disarm the anger often present in the initial stages of mourning (Kubler-Ross 1969). Formality of approach provides boundaries so that everyone present can feel safe, even in the potentially chaotic circumstances of death. The explanation as to the causes of death can prevent later disturbances in the grieving process, caused by families not understanding why the patient died (Azouli 2002).

Caring for the Body

During their farewells, the family can reclaim the patient as their own, however briefly. To see a loved one's face, dead and at peace may be the first step in the grieving process and may prevent denial from continuing. It is well documented that families of ICU patients have difficulty recognizing their loved ones when they are attached and disfigured by lines, tubes and machines. The immediate removal of redundant lines and presenting the body gracefully is therefore essential (Perry 2002).

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