**NHS Education for Scotland**

**Transcript of ‘Dealing with death and bereavement at work: perspectives from an Emergency Department team’ film**

**Speakers:**

* Dr Katy Ritchie, Registrar in Emergency Medicine, NHS Grampian
* Julie McWilliam, Senior Staff Nurse, NHS Grampian
* Sarah Black, Physician Associate, NHS Grampian
* Suzanne Edwicker, Porter, NHS Grampian
* Donna Knowles, Receptionist, NHS Grampian

Donna Knowles (DK): I never really slept or anything for that night, I just kept thinking "this poor family". And just kept thinking over and over and over about... it was just the scream.

Sarah Black (SB): We deal with death all the time and it is part of our job, but I don't think it becomes any easier when you see, sort of, years of life and happiness and memories spontaneously and instantaneously end over a, a simple decision that went wrong.

Julie McWilliam (JMcW): At the end of the day, we are human beings, we have feelings like everybody else, and it does affect you. You go home from your shift at night, and all that you can think about is that grieving family, what they're going through.

Suzanne Edwicker (SE): Sometimes it's just heartbreaking, and there's nothing that anybody can do.

Katy Ritchie (KR): We're a really close-knit team in the emergency department. We see a lot of things that many people would find really distressing, and we experience death frequently. Most of the times we've developed coping mechanisms so that we can move on quite quickly. That might sound quite heartless to some people, however, the reality is when the department is busy we need to move on to the next patient, the next clinical scenario, quite rapidly. However, there are some situations where the death of a patient really does stay with you.

JMcW: So, I was coming in for my duty to start at 7 o'clock. I'd just arrived in at the coffee room and I was told I needed to go down to the resus room straight away. It was a, a gentleman who had been stabbed multiple times. We removed the two internal organs that we needed to, but unfortunately the gentleman passed away. Because I was in charge of the department that day, my role is to go along with the consultant or the senior registrars, and break the, the news to the family. But I think the wife knew when we walked in, and then that's when our feelings start building up inside because you're seeing the distraught, the grief, they're crying, they're hugging each other, they don't know what's going on, they're confused. And while I was in the room the son and the daughter started showing me pictures of their dad, videos of their dad. By the end of the day I actually felt as though I, I knew the gentleman, I knew so much about him, I'd seen so many photographs, so many videos about him. And deep down inside I was feeling their grief, I had recently not long lost my father as well, so I, I knew a bit about how they were actually feeling.

KR: Sometimes you'll feel more affected if it's been a particularly distressing case. Or perhaps if there's something going on in your personal life, that's quite upsetting as well. Or perhaps you've been chatting with a patient, getting to know them a little bit, and then they unexpectedly arrest, and that can be really difficult to deal with. Sometimes it's the drip, drip effect, the cumulative effect of seeing death frequently over time. Or sometimes we really don't know why a death affects us so much, and that's okay.

SB: One of the deaths that, I guess, has stuck with me primarily in my time in the emergency department, was, I was part of the trauma team that was assembled to deal with an elderly lady that was coming in to the department. She had been out with her husband and going to the shops and whilst cars were stationary at traffic lights, they decided to nip between the two cars to cut across and take a shortcut to the shop. Unfortunately the traffic lights had changed, and they'd started to pull off but not see the pedestrians that had cut out between them, and unfortunately hit both her and her husband over. The lady came in to us, and she had pretty significant head injuries. Pretty graphic injuries to her face and to her head. She was put into a medically induced coma and intubated, and we put her through the CT scanner, and unfortunately she had injuries that weren't particularly sustainable with life, so the decision was made to palliate this lady, and to let her pass away comfortably. The husband had sustained really minor injuries, and had got off relatively luckily, but obviously had this horrific thing happen to his wife and she passed away in the department. This death stuck with me particularly longer than other ones have. I was fairly newly qualified and this was very early on in my clinical career, and I think my coping mechanisms with death then were pretty new, and this was certainly a new concept to deal with as part of your working life.

KR: It's important that we consider the more junior members of the team when dealing with a death. The coping mechanisms that we have take time and experience to develop, so we need to check in with somebody for whom it might be the first death they're experiencing. And as well, it's not just nursing and medical staff that can be affected. Portering, reception and domestic staff may be inadvertently exposed to quite traumatic scenes.

SE: I don't think people actually know how much a porter actually does, or witnesses, or has to deal with. I've walked into resus, and a trauma that came in, a bike accident, and there's been a foot amputated on the floor, still in the boot. I've seen stabbings, heart attacks, strokes, anything respiratory, CPR. And you also see the relatives that are, come in to see that patient. You see them going into the relatives' rooms, which reception take them there. And you just, you feel, you feel everything in there. Whatever, whatever the atmosphere is, you feel it.

DK: Just a normal Saturday morning, which is normally quiet. And then the phone rings and there's a cardiac arrest coming in. And normally when you get a cardiac arrest you think it's somebody of an older age, but this one was a young person that was coming in. So, went to pick the family up, took them through the long walk up the doors in the ED department, dropped them off at the relatives' room. So, I just gets back, gets back into the desk, and then more family members came. Every family -- it makes no difference who it is, or what it is, the first thing they say to you is, "how are they?". And it's difficult because you know, probably, what's going on, but we can't say anything. So I remember taking the family up to this double doors, the next thing, the doors open and there was this scream, an absolute pitching scream, it went right through you. And the girl turned to me and she said, "well, you don't have to tell me, I know now he's dead." But that scream... No, it'll never go away from me. Never.

SE: A major protocol bleep went off, so I went and attended resus. It was a major haemorrhage. On that particular day I came back from the blood transfusion, and I walked into resus, and I walked into his chest being wide open, and his heart getting massaged. It was a bit of a shock. I didn't expect it. That's the type of thing you would actually expect to happen in theatre, or witness in theatre. But because of the injury it had to be done there and then.

KR: People deal with the death of a patient in different ways, and the same person will deal with different deaths in different ways. Sometimes it might feel like everyone else is completely fine, whereas you're really affected by it, but that's okay. There's no one-size-fits-all approach, it's nothing to be embarrassed or ashamed about.

DK: I never spoke to anybody when I came back-- I come back, sat down. Think I took-- had a coffee, and just carried on with working, but I just kept thinking about the scream. I think I should've spoke about it at the time, but I didn't. I never slept that night, it affected me for a long time. It still affects me when I go up to that double doors. I just don't like going to the double doors.

SE: I didn't really think about it too much at the time, you just have to do what you have to do, and it's after... that's when it hits you. That's when you start thinking about it. And when you also see your colleagues are struggling, when they're hugging each other, crying. Everything just comes through your head. Everything. You start questioning what you'd done. You get concerned about your colleagues and how they're feeling.

SB: The thing that was particularly difficult was the fact everything had happened so quickly with this couple, so it was an instantaneous and spontaneous decision to cross the road, which we all make every day, and unfortunately on this occasion it ended with a devastating outcome. I couldn't stop thinking about how the husband must feel, after spending so long together being married, then for it all to finish in such a traumatic and devastating way.

KR: People need to feel able to seek the support that they need, and not to suffer in silence. There are so many resources out there, it can take a little bit of time to figure out what works for you. After a particularly distressing event, there's often a hot debrief. That's where we take a few minutes after the event to make sure everyone's okay, deal with any uncertainties, talk about what worked, and what could have gone better. A cold debrief tends to happen days to weeks down the line, and that's really more of a chance for professional reflection, rather than looking at the emotional side of things.

JMcW: I felt it was really, really important to have a debrief of what had just happened. It's something we don't see-- I've never seen organs being taken out in an A&E department before. But what we've got to remember is, we've got students; it's maybe the first time they've ever seen CPR being done on a patient. It's maybe the first time they've ever seen somebody dead. So we've got to be really aware of that, and aware that they are gonna be okay when they go home at night, and that we are there for them, that they can speak to us, we can refer them on if they need further help. Having the debrief, having colleagues that you're able to speak to just makes you think, yeah, at the end of the day we are normal, we do have feelings, we are gonna be sad. But having a supportive team about you can help you get over that. So by the end of the debrief, I felt a lot better in myself, and, and how we managed it.

SE: For some reason I couldn't go to the debrief, I think it was my shifts. And then the next time I did see nurses that were on shift with me that day, two nurses actually did come up to me and ask me if I was okay. They were concerned, it was nice. It, it changed the way I felt about debriefs as well. I felt, they are there for anybody-- anybody, whether you're a porter, receptionist, nurse, doctor, anybody.

SB: When the lady had passed away, I felt personally quite overwhelmed with different emotions. The debrief process helped my understanding as to why decisions were taken as they were, and afterwards I had a, a better understanding of the clinical course that this lady had through her journey in the resus room and in the emergency department. And that in turn probably helped me deal with the emotional side of things. Debriefs aren't for everybody, and some people don't like talking about what's happened, but I think if you're new to experiencing death at work, you should try and attend a debrief if you can. I think, don't be scared to ask questions, I think some of the feeling when you're new to a team is that you don't want to say something that's stupid that other people might judge you for. But actually being open, and if you have questions in your mind that's a good opportunity to answer them, because I think if you can clear up how things are in your own mind, that will help you deal with things further down the line.

KR: While clinical debriefing is essential so that we learn lessons and improve practice over time, some people don't find that they get the emotional support that they need from the debrief session. There are some forms of debrief that are no longer done, such as psychological debrief. The intention of this was to prevent post traumatic stress disorder, and involved taking a staff member step-by-step through a stressful or traumatic event in one session. This was proven to be harmful for some people, and is therefore no longer recommended, and not done in clinical practice any more. In some health boards and departments TRiM practitioners -- Trauma Risk Management Practitioners, are available, and they can provide peer support for people after a traumatic or distressing event. Psychological First Aid calls on the principles of comfort, emotional support, making sure people have the resources, and know that they're not alone, and that can be very helpful for some people. More information on the different forms of debrief can be found on the NHS Education for Scotland Psychology and Bereavement websites. However, for some people all that's needed is just an informal chat with a trusted colleague, whether they were involved in the case or not, and that can often be enough.

DK: What I would say to anybody that's in my role is, if you're in the same situation as I've been or of any of us has been, is to speak to somebody; definitely speak to them. Maybe you don't want to speak to them right at that precise moment, but do it that day, because I know I didn't, but people should do.

JMcW: Definitely speak, speak about your feelings, it is really important. Keeping things inside you is, is not good.

SE: First thing is not to, not to build, build it up, just open up if you're struggling with any thoughts or feelings. If you don't feel like you could go to a debrief, and you want to speak to somebody just one-to-one personally, do it. Do what's best for you.

KR: I know from my own experience how easy it can be just to try and get your head down, get on with it, bottle things up, but actually that can really add to your stress, both in your work life and your personal life. So it's really important just to talk. Tell someone how you're feeling. Ask for help and support when you need it. And listen to others when they are opening up to you. And be kind, it goes such a long way. More often that not, you'll find your colleagues, they've been there, they understand, and they feel the same way. We're all human and you're not alone.

The film was produced in March 2024 and can be found at [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk/) or <https://vimeo.com/925094613>

For more information visit [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk/) or contact SupportAroundDeath@nes.scot.nhs.uk

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