DISCOMFORT OF NURSES IN PROVIDING END-OF-LIFE CARE

Dagmar MASTILIAKOVÁ[1]*, Eva KUBICZKOVÁ[2]

[1] *Faculty of Healthcare, Alexander Dubček University of Trenčín, Študentská 2, 911 50 Trenčín, Slovak Republic*
[2] *Psychiatric hospital in Opava, Olomoucká 305/88, 746 01 Opava, Czech Republic*
*Corresponding author E-mail address: dagmar.mastiliakova@tnuni.sk

Abstract
Background: The research was aimed at identification of the major stressors and characteristics of the discomfort that nurses experience in providing end-of-life care in the current conditions of hospital environments.
Research sample and methods: The research sample consisted of 105 nurses and medical assistants (7 men and 98 women). 38 (36.2%) respondents worked in acute care wards, and 67 (63.8%) in subsequent care wards in Silesian Hospital in Opava. The research data was obtained by means of a questionnaire.
Results: The survey was carried out mainly by the experienced staff 89 (84.8%) of respondents (depending on the length of their healthcare practice from 6 to 31 years and more in the field of health care). With the death of patients at their workplaces they encounter approx. 4 to 6 times per month: 32 (30.5%) of the respondents encounter with the death of patients. The same number, 32 (30.5%) of respondents encounters with death from 7 to 9 times per month, and finally 10 times or more 5 (4.7%) respondents. 68 (64.8%) respondents are fully aware of need to provide emotional support to a dying person. The feeling of exhaustion in provision of emotional support is evident in the majority of the respondents 38 (36.2%) and "rather yes" claimed 29 (27.6%) respondents. The most common form of emotional support "the presence of a nurse" reported 30 (27.5%) of respondents. The most common feeling in the presence of a dying 50 (36%) of respondents there was reported "a regret". The most stressful situation in the end-of-life care was considered "communication with a family", by 75 (42.1%) of respondents. The most frequent reaction in experiencing stressful situation was reported "excitability" 41 (37.3%) of respondents. Three most frequent factors out of 11 that contribute to the stress at workplace, "lack of time for performing work duties" were claimed by 62 (22.5%) of respondents. For 53 (19.2%) of respondents it was "lack of staff" and for 50 other (18.1%) it was "administration duties". The majority of respondents 48 (45.7%) claimed that nurses are not sufficiently prepared to cope with stressful situations at workplace, and "no" was indicated by 13 (12.4%) of respondents.
Conclusions: Research confirmed that provision of end-of-life care belongs to chief sources of stress in nurses. The other sources of stress are the following: "lack of time to satisfy working duties", "lack of personnel" and "administrative duties". Feeling of discomfort is caused also by feeling "regret", hopelessness and helplessness, anxiety, fear, worry, helplessness, pain, irritability, insomnia and others.

Key words: discomfort, nurse, stress, nursing care, dying patient, death

1 Introduction

Death is inseparable part of life and is individually very difficult to accept. Many persons avoid topics that contain death and dying, because it is difficult for them to talk about it. End-of-life care includes not only the care of individual dying person´s needs, but also a care of his/her closest family. Every person dies in unique and unrepeatable circumstances and therefore end-of-life care should be unique too. A nurse providing end-of-life care has to be able to establish a sensitive and trustworthy relationship with both, the patient and his loved ones. The health care and meeting patient´s needs in an atmosphere of trust and respect, enables his or her transition from life in a calm and dignified manner. During health-care provision a nurse should realise that a patient, during the terminal illness, needs considerate, consistent and realistic care.

Dying persons are usually increasingly sensitive to the feelings of others. They will avoid discussing their death, if they feel that their relatives or friends are not ready to talk about it. Attending nurse should promptly identify a patient dying stages and should not avoid any phase

of the process of dying. Thus nurses should, on ideal conditions, be prepared for this kind of health care provision.

O'Connor and Aranda [1] claims that every health care professional in end-of-life care has to realise his or her strong/weak personality features and should have clear idea of his or her professional identity. A nurse should know herself and her own feelings that relate to dying. She should be aware of her own cultural origin and customs; recollect her encounter with death of people close to her; should realise her own reactions and experiences, so as she was open to her own feelings of anxiety, fear, depression, avoidance, coping mechanisms and coping with difficult situation. He should think of how she looks at her own death, how she shares her feelings concerning the death with the others, and should initiate an open discussion to better understanding of their behaviour. She should how learn to listen, wait with answering patient´s questions, because patients often are able answer their own questions. A nurse should think of her life values and opinions, such as respect for life, dissatisfaction with life etc. She should realise her own power and authority in end-of-life care and his or her reaction to this new hard situation. She should be able to avoid this authority and use it only in case of provision considerate and humane health care. She should also realise that the decision to tell the dying person the truth of the illness, depends on the decision of a medical doctor and a family of particular patient. She should communicate the content of the conversation with the patient and with the rest of the staff, to ensure continuity and to avoid conflicts during emotional support [2].

2 Theoretical Background

Nurses are constantly exposed to emotional pressure during end-of-life health care, because of encounter with death and dying. Schmidbauer [3] claims, that a nurse should pass the study of physiology and other complex subjects, but is not prepared to cope with emotional burden connected with the demands of patients. *"Any encounter with death confronts us with our own mortality. Previous traumas can be opened (uncontrolled grief), or nurses can, instead of the fight the death, experience helplessness, stress or even burnout"* [4: 117]. Frequent encounter with death and grief resulting from it are reflected in the mental state of caregivers, especially crucial is to cope with the feelings of loss and helplessness [5].

As a result of long-time frustration and severe stress or in response to traumatic experience, there are induced changes in the psyche, in terms of perception, thinking and acting, or at least change in the subjective view of life and perception of themselves. The result of adaptation to the stressful situation is the change of values and attitudes towards life, change of relationships to the other people and change of self-perception [6]. Finally, there are identified somatic symptoms. These include heart palpitations, headache and muscle pain, then loss of appetite and bloating, constipation, diarrhoea, increased blood pressure, dry mouth, women may have irregular menstrual cycle [7]. If people feel that they failed in fulfilling work duties or cannot do them properly anymore, and work makes no sense to them, they can experience burn out syndrome. Burnout syndrome is an example of collapse of the adaptation process [8], and that is why in literature there is often used the term *caring for carers* [9: 239].

According to Vachon [2002, in 1], the great part of burden has its origin in the environment and personal characteristics of a nurse. There belong the following: work environment, conflicts with peers, difficulties in the work team, questions of leadership and management, the conflict of roles etc. Much less of a burden causes the care for the dying and their families. In this field there is often neglected the discomfort (feelings and problems) of nurses caring for the dying. Trachtová [in 10: 145] says: *„Our healthcare does not systematically solve the problems of nurse´s burden and overload. Nurses are left alone with their stress"*.

Adamczyk [in 11: 30] claims that *"(…) discomfort is a subjective phenomenon, the personal human experience, it is possible to define its content only dimensionally - naming the*

dimensions, that brings discontentment, knowing that their intensity, mixing ratio and timbre are variable, thus it is not possible to create their complete list". With regard to the permanent topicality of this issue, research inquiries were carried by the nursing staff, who provides care for the dying in the current conditions of hospital.

3 Research Goals

The main research goal was to identify the main stressors and characteristics of the discomfort of nurses caring for the dying.

Partial goals were focused on finding of the following:

- How do nurses provide emotional support to the dying?
- What do they consider the most stressful in the care for dying?
- How does the contact with death and dying affect the mind of nurses?

4 Methodology and Sample

To obtain the research data and fulfil the research goals, we designed a questionnaire. Research sample consisted of 105 nurses and healthcare professionals who worked in Silesian Hospital of Opava, and the total number of respondents was 7 men and 98 women. The research took place at the turn of the year 2013-2014.

Questionnaires were distributed to particular departments and respondents were asked to answer them in the enclosed envelope. Of the total 105 respondents worked on acute care wards 38 (36.2%) and on the follow-up care departments for chronically ill 67 (63.8%) respondents. Of 105 respondents, 68 (64.8%) graduated from nursing school –profession of a nurse; 10 (9.5%) of the respondents graduated from nursing school – a healthcare assistant, 8 (7.6%) of the respondents graduated from vocational school, college – bachelor study 17 (16.2%) of the respondents, and master study graduated 2 (1.9%) respondents. From the total number of respondents 105, 33 (31.4%) claimed that they believe in God and 72 (68.6%) claimed they are atheists.

Table 1 shows the age of respondents.

Table 1 *Respondents according to their age*

Age	Absolute frequency	Relative frequency
Up to 20 year old	0	0.0 %
From 21 to 30 year old	25	23.8 %
From 31 to 40 year old	42	40.0 %
From 41 to 50 year old	28	26.7 %
51 and older	10	9.5 %
Total	105	100.0 %

Out of 105 respondents, the majority belong to the age group from 31 to 40 years, number of respondents 42 (40%); in the category from 41 to 50 years there were 28 (26.7%) respondents and in the category over 50 years, there were 10 (9.5%) respondents.

Length of working practice of the respondents in the field of healthcare is depicted in the table 2.

The length of working practice in the field of healthcare to 5 years, was mentioned by 16 (15.2%) respondents; from 6 to 15 years of practice was mentioned by 29 (27.6%) respondents; from 16 to 30 years of practice was mentioned by 48 (45.7%) respondents; over 31 years 12 (11.5%) respondents.

The largest group of respondents was 89 (84.8%) with the length of practice in the field of healthcare from 6 to 31 years and these nurses were the most experienced.

Table 2 *Respondents arranged according to the length of their working experience in health care*

Length of practice in healthcare	Absolute frequency	Relative frequency
Up to 5 years	16	15.2 %
From 6 to 15 years	29	27.6 %
From 16 to 30 years	48	45.7 %
Over 31 years	12	11.5 %
Total	105	100.0 %

5 Research Results

The research brought very interesting findings. One of them was the frequency of patients´ death on hospital wards, where the respondents work, see table 3.

Table 3 *Frequency of death of inpatients on the wards according to respondents*

The number of deaths on the wards	Absolute frequency	Relative frequency
From 0 to 3 per month	36	34.3 %
From 4 to 6 per month	32	30.5 %
From 7 to 9 per month	32	30.5 %
10 and more per month	5	4.7 %
Total	105	100.0 %

36 (34.3%) of respondents encounters death of patients from 0-3 times per month, 32 (30.5%) of respondents from 4-6 times per month, the same number encounters death from 7-9 times per month and 5 (4.7%) respondents encounters death 10 times per month.

Other findings related to respondents' awareness of the need to provide emotional support to the dying, is shown in the first chart.

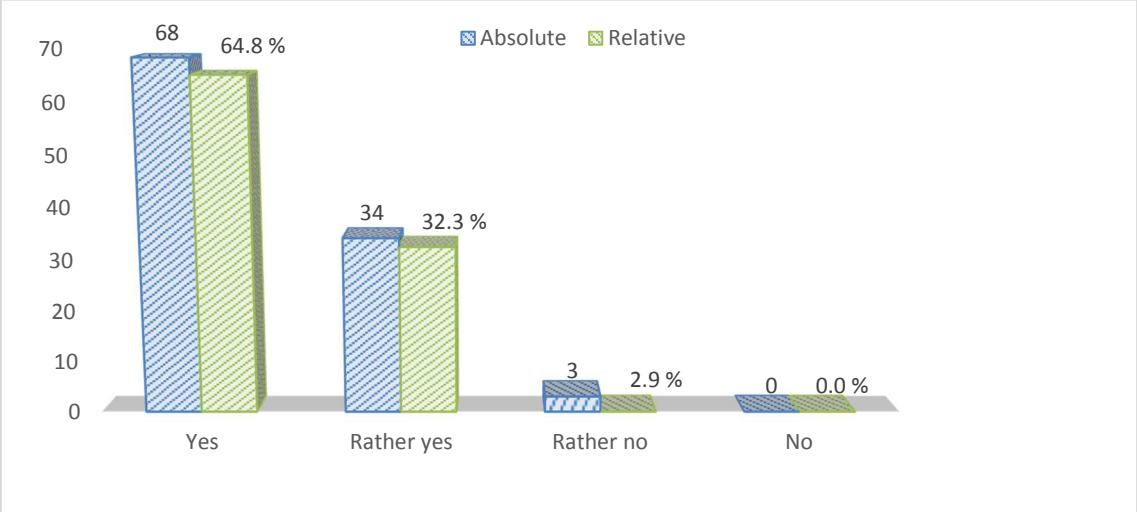

Figure 1 *Awareness of the need to provide emotional support to the dying*

The majority of respondents claimed in their answers to the question whether they realise the need to provide emotional support to a dying patient, that they agree, *yes* 68 (64.8%); *rather no* 34 (32.3%) respondents; *rather no* 3 (2.9%) respondents; and finally the answer *no* wasn´t used by any respondents.

Form of emotional support that respondents prefer depicts the fig. 2.

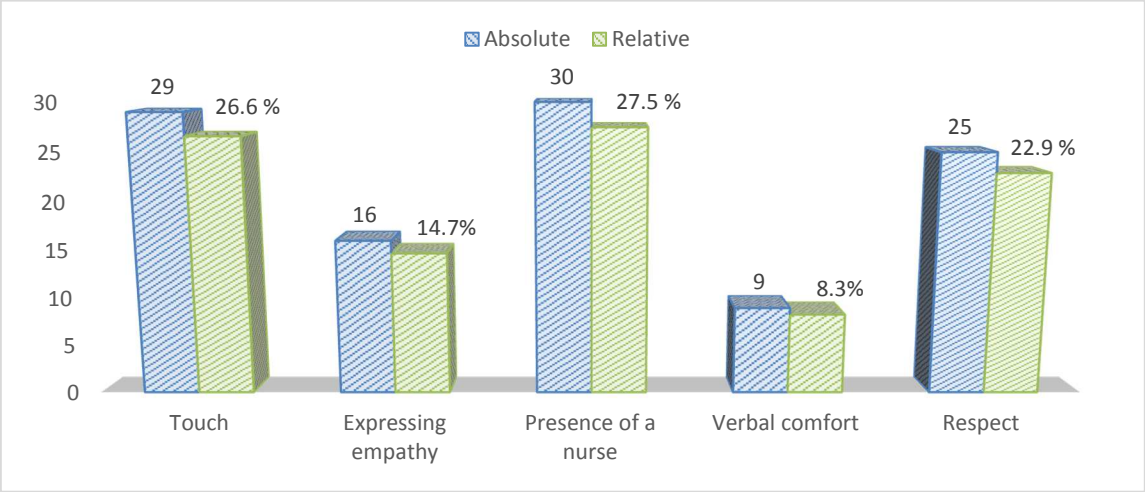

Figure 2 *Preference of emotional support for the dying*

The respondents arranged the offered possibilities according to their own preference from 1 to 5. The most preferred form of emotional support was the *presence of a nurse* 30 (27.5%); *touch* 29 (26.6%); *respect for patient´s wishes* 25 (22.9%); *expressing empathy* 16 (14.7%) a *verbal comfort* 9 (8.3%) of respondents.

Very interesting was the answer whether the provision of emotional support fatigues nurses – more (fig. 3).

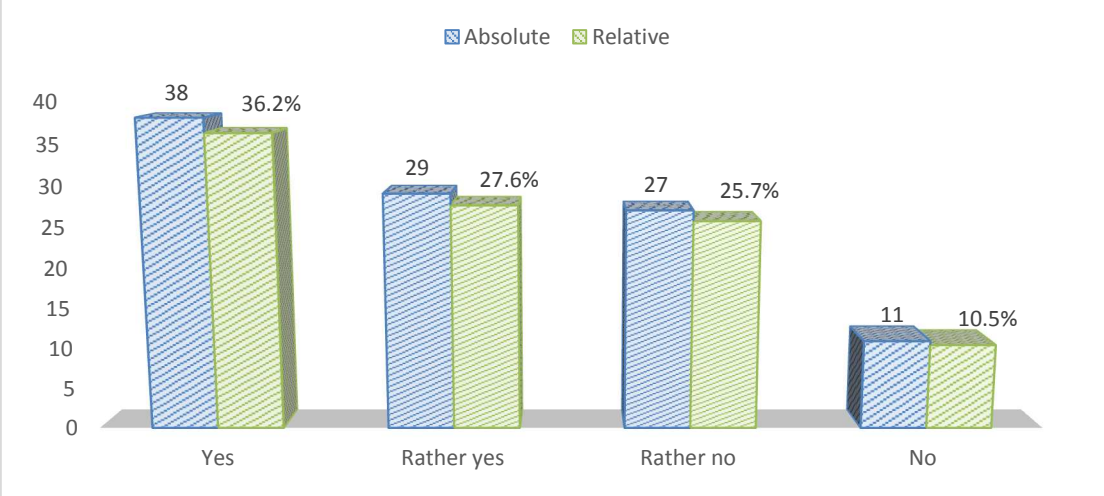

Figure 3 *Feeling of exhaustion/fatigue during provision of emotional support to a dying*

Respondents answered the question whether they are exhausted after they provide emotional support to a dying, was *yes* 38 (36.2%); *rather yes* 29 (27.6%) of respondents; *rather no* 27 (25.7%); and finally *no* 11 (10.5%) of respondents.

The next interesting finding was the one concerning the feelings of respondents in the presence of a dying patient – more (fig. 4).

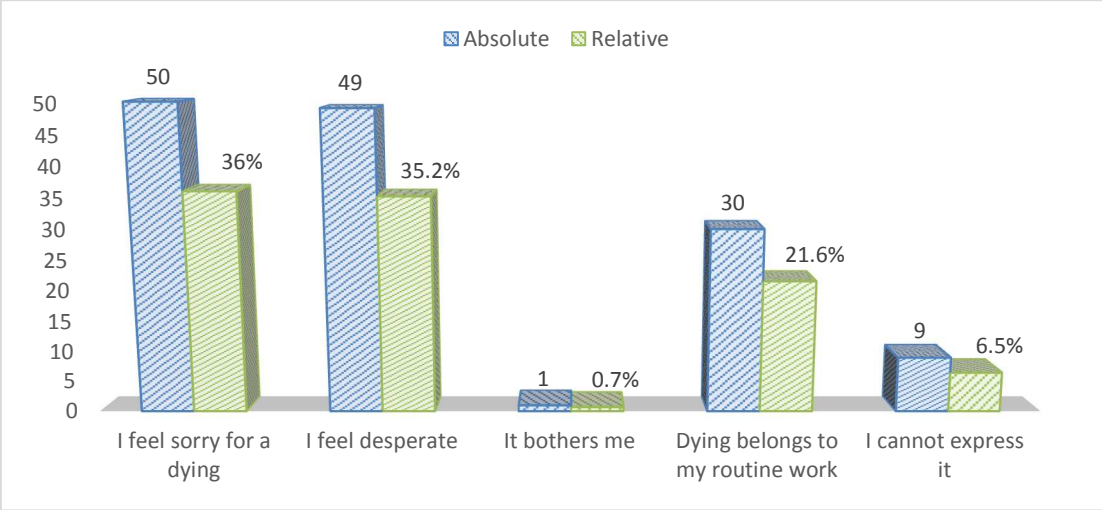

Figure 4 *Feelings of nurses in the presence of a dying patient*

From the given possibilities the feeling *I feel sorry for a dying* the most frequent 50 (36%) of respondents; *I feel desperate* claimed by 49 (35.2%) respondents; *presence of a dying belongs to my routine work* answered 30 (21.6%) of respondents; 9 (6.5%) respondents chose the possibility that *they cannot express their feelings*; and finally 1 (0.7%) respondent claimed that *the presence of a dying patient bothers her*.

Very interesting answer was given to the question considering the feelings of respondents immediately after the death of a patient – more (fig. 5).

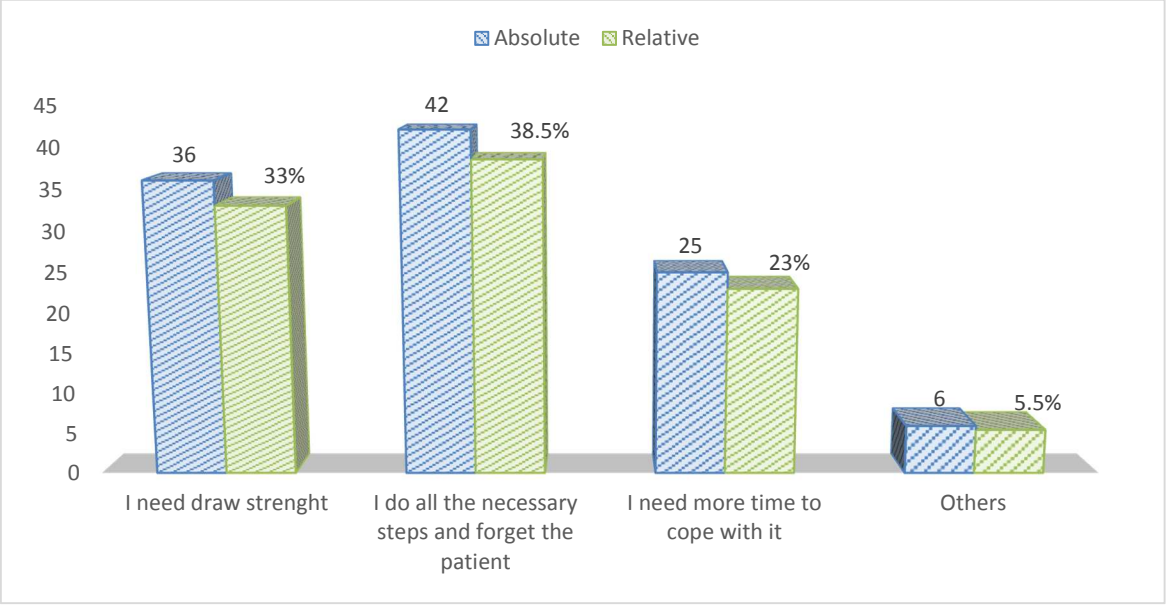

Figure 5 *Feelings of nurses immediately after the death of a patient*

The respondents could choose the option that is related to their own feelings immediately after the patient they cared for, died. The majority of respondents, 42 (38.5%) claimed that they will *do all the necessary steps and forget the patient*; 36 (33%) of respondents claimed that they *need to draw strength* soon after the patient died; 25 (23%) of respondents claimed that they *need longer time to cope with the death of a patient,* 6 (5.5%) of respondents claimed that *other feelings* (*a feeling of helplessness, anxiety, regret, relief for the patient to shock in cases where patients are not expected death).*

Very interesting answers were to the question whether nurses perceive the body of a dying patient as stressful, more fig. 6.

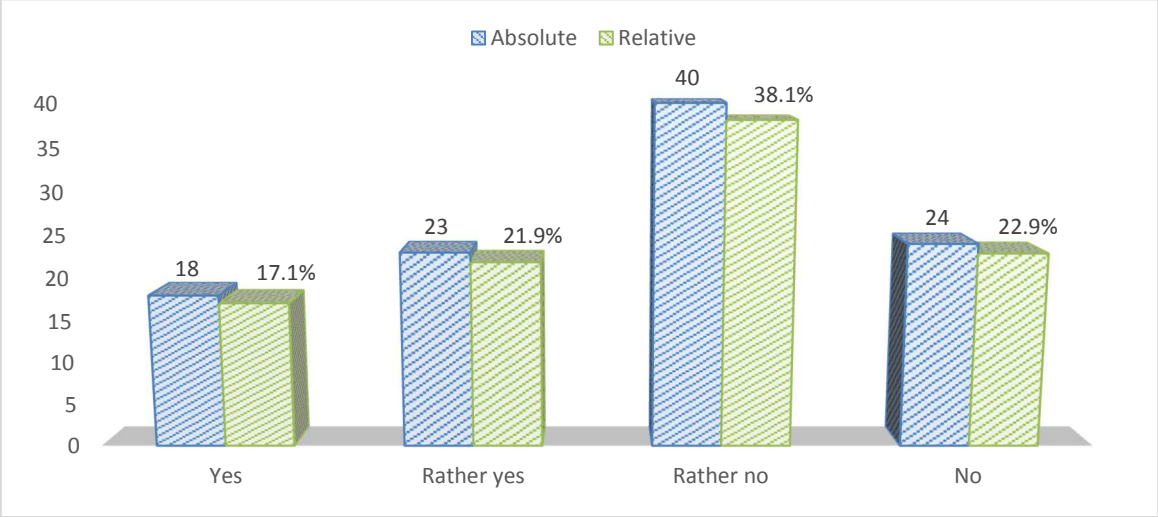

Figure 6 *Perception of a body of the dying person as stressful in end-of-life care*

Majority of respondents 40 (38.1%) answered the question of whether they *perceive as stressful the health care of deceased patient´s body* – as *rather no,* and 24 (22.9%) respondents answered *no*; 23 (21.9%) respondents answered *rather yes*; and 18 (17.1%) respondents answered *yes*.

The nurses´ feelings during the care of the deceased patient´s body are summarised in the fig. 7.

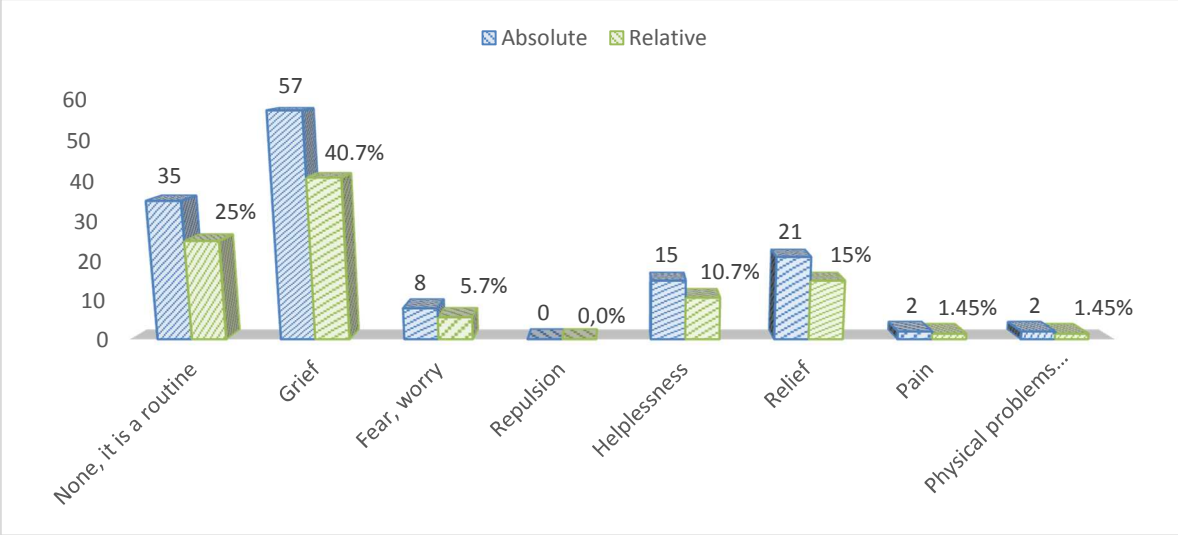

Figure 7 *Perception of a deceased patient´s body during end-of-life care – nurse´s feelings*

The most frequent indication for nurse´s feelings when taking care of the body of a deceased patient´s was by 57 (40.7%) respondents said *regret*; 35 (25%) of respondents said their feelings were *routine* 21 (15%) of respondents indicated their feeling as *relief;* 15 (10.7%) respondents as *helplessness*; 8 (5.7%) indicated *feeling of fear or worry*; *pain* felt 2 (1.45%) respondents; and *physical problems* felt 2 (1.45%) respondents.

The respondents consider the most stressful situations in the end-of-life care the following (more fig. 8).

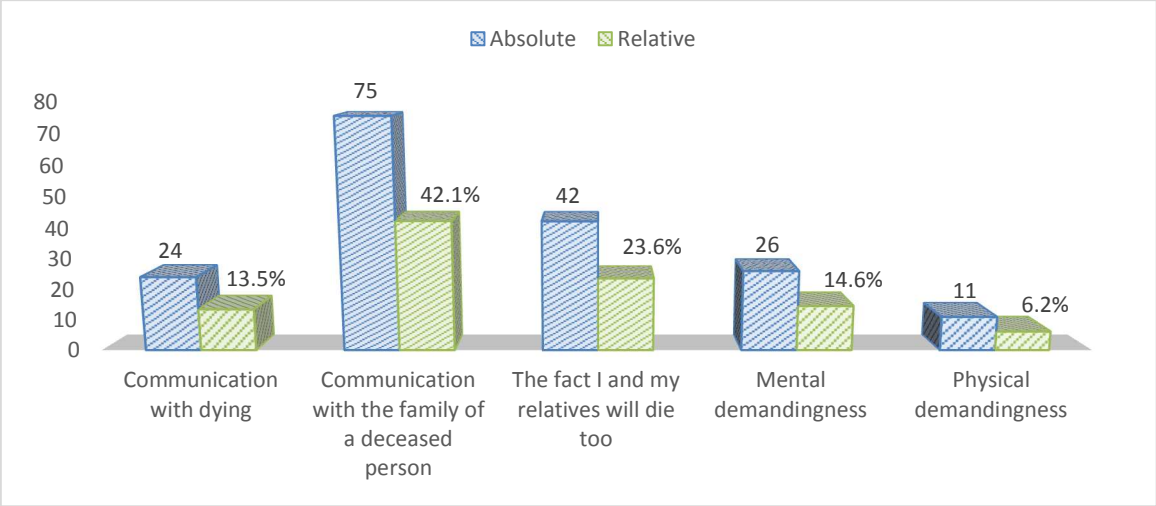

Figure 8 *The most stressful situations in the end-of-life care*

The most stressful situation in the end-of-life care is according to 75 (42.1%) respondents *communication with the family of a deceased person*; for 42 (23.6%) respondents it is *the fact that me and my relatives will die too*; for 26 (14.6%) respondents the most stressful is *mental demandingness*; 24 (13.5%) of respondents considers the most stressful *physical demandingness.*

Respondents responded to the perceived stressful situation as following (fig. 9).

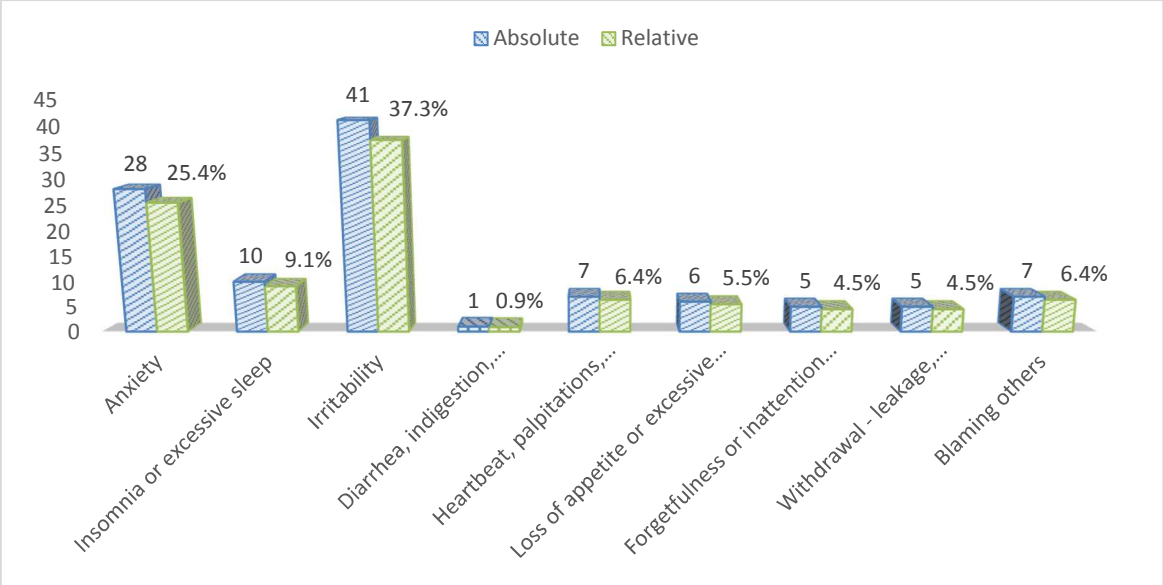

Figure 9 *The most frequent reactions to perceived stressful situations*

The most frequent reaction to perceived stressful situations was marked by 41 (37.3%) respondents *irritability*; for 28 (25.4%) respondents *anxiety*; 10 (9.1%) respondents *insomnia or excessive sleep*; for 7 (6.4%) respondents it is *heartbeat, palpitations, rapid pulse*; 6 (5.5%) respondents indicated *loss of appetite or excessive appetite;* for 5 (4.5%) respondents it was *forgetfulness or inattention to detail;* and finally 1 (0.9%) respondent indicated the following: *diarrhoea, indigestion, stomach pain, nausea and vomiting.*

Very interesting findings about the factors that contribute to excessive stress at workplace are summarised in the fig. 10.

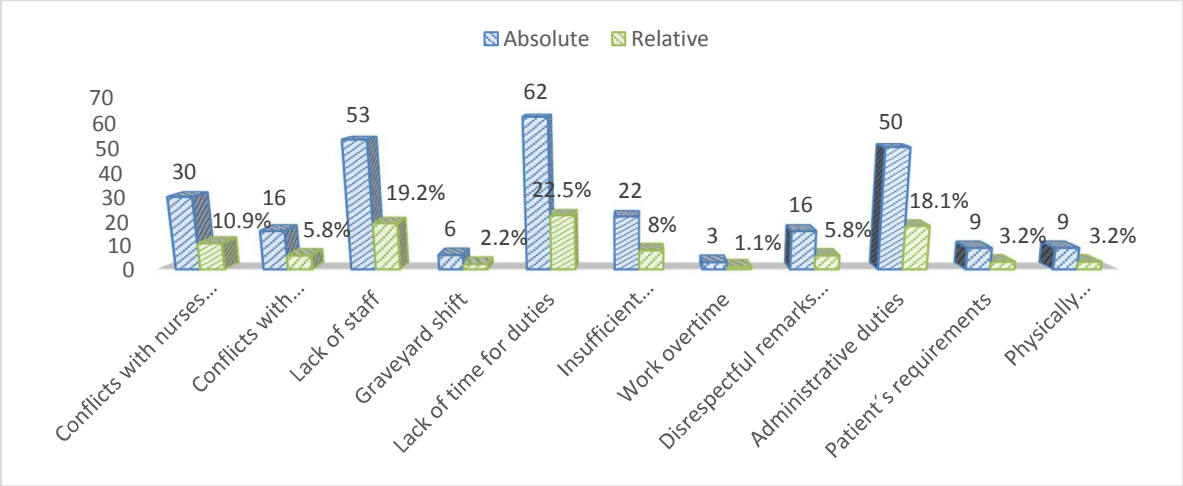

Figure 10 *Factors that contribute to excessive stress at workplace*

Respondents had the option of maximum three preferences from eleven choices. There were selected the answers over the value of 50. The most frequent factors contributing to stress at workplace was indicated by 62 (22.5%) respondents *lack of time to perform duties at workplace;* 53 (19.2%) respondents considers *lack of staff* and 50 (18.1%) respondents indicated *administrative duties* to contribute to excessive stress at workplace.

There is very interesting finding that resulted from the opinion of nurses to cope with and handle demanding situations and tasks at workplace – see more fig. 11.

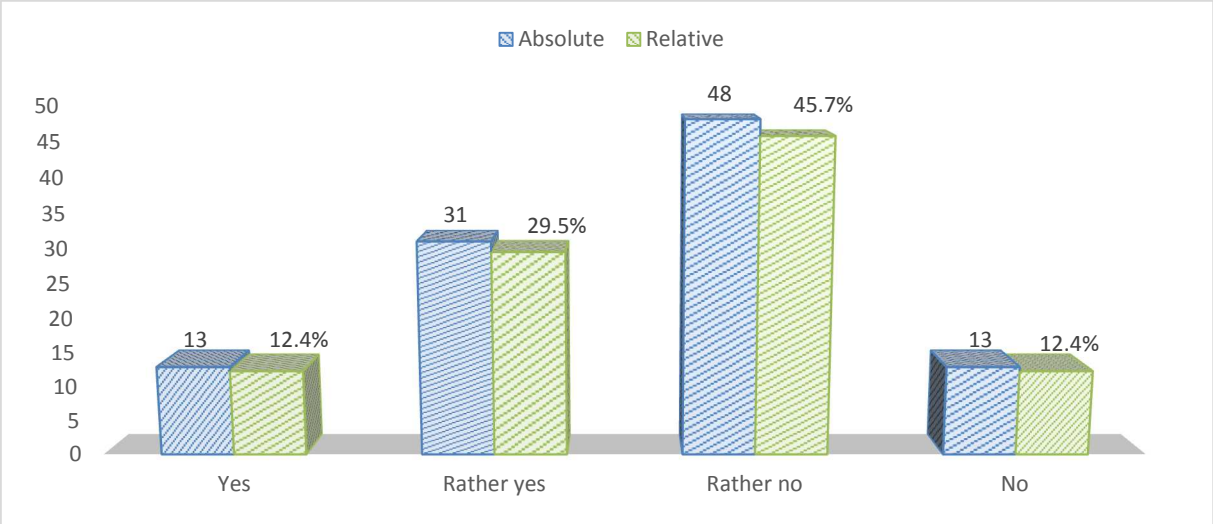

Figure 11 *Nurses readiness to cope with stressful situations at workplace*

The majority of 48 (45.7%) respondents answered the question of a nurse´s readiness to cope with demanding situations at workplace *rather no*, 31 (29.5%) respondents answered *rather yes*; 13 (12.4%) respondents selected *yes* and the same number of respondents 13 (12.4%) indicated *no*. That means only 44 (41.9%) respondents believes that nurses are sufficiently prepared to cope with stressful work situations.

6 Discussion

The research was aimed at the identification of the main stressors and characteristics of nurses´ discomfort during end-of-life care. These findings confirmed the selected research results of Czech and foreign studies. In the electronic databases Evidence based nursing, EBSCO, PubMed, Science Direct a Scholar Google (1981-2014) there were according to key

words *discomfort, stress, nurses, care, dying patient, patient deaths,* found the studies related to the theme of stressors and perceptions of discomfort among nurses who provide end-of-life care. We found 162 thematically related studies and selected 8 of them for comparison with our research results.

In the research study of Pamela Gray-Toft and James G. Anderson [12], conducted in the U.S.A. there were investigated causes and effects of stress in hospital nursing staff, where they identified three main sources of stress: *workload, feeling not sufficiently prepared to meet the emotional needs of patients and their families, death and dying.* The nature of these sources and their ubiquity indicate that these elements are inseparable part of nursing tasks, especially for registered nurses they are important determinants of stress.

Other important stress factors that need to be investigated include the relationship of the level of role conflict, experiences of employees and their personality traits. This research study confirmed that stress has significant impact on job satisfaction. Our research took part in a hospital on wards of acute and follow-up care and research sample consisted of 105 nurses and medical assistants. In our research 62 (22.5%) respondents indicated the most frequent factors that contributed to stress at workplace *lack of time for duties at workplace;* 53 (19.2%) respondents indicated *lack of staff* and 50 (18.1 %) respondents indicated *administrative duties*.

According to the research study of Kent, Anderson, and Owens [13], conducted in New Zealand, there were surveyed initial experiences of nurses with the death of a patient. 80% of respondents first encountered with death in a hospital wards of acute care and the respondents indicated that they felt quite inadequately prepared for the patient´s death. Our research findings showed that, at hospital wards there encounter with the patients' death from 0 to 3 times per month 36 (34.3%) of the respondents; with the death from 4 to 6 times per month 32 (30.5%) respondents; with 7 to 9 times per month the same number 32 (30.5%) of respondents; with death 10 times and more per month encounters 5 (4.7%) respondents.

According to the research study of Bloomer, Endacott, O'Connor, Cross [14], conducted in Australia and aimed at the investigation of nurses´ reactions and end-of-life care at hospital wards, the authors found that not all nurses were familiarised with the procedures connected with this kind of health care. Quite disturbing was the fact that end-of-life care may affect the insufficient cooperation between a medical doctor and a nurse, or a lack of cooperation of inexperienced nurses when compared to experienced nurses. It was confirmed that crucial importance for further health care, especially for coping with situation by the nurse, has the early detection stage in a dying patient.

In our research were the most common feelings in the presence of a dying person the following: *I feel sorry for the patient* 50 (36%) of respondents; *I feel desperate* 49 (35.2%) of respondents; *a dying person is a routine work for me* 30 (21.6%) respondents; *I am not able to express my feelings* 9 (6.5%) respondents; 1 (0.7%) respondent claimed, that *the presence of a dying patient bothers her*. The most frequent indication for respondents´ feelings when taking care of the body of a deceased patient, 57 (40.7%) respondents expressed the feeling of *regret*. 35 (25%) respondents expressed their feelings as *none, it is a routine*; 21 (15%) respondents said they felt *relief;* 15 (10.7%) respondents felt *helplessness*; 8 (5.7%) respondents felt *fear and distress*; *pain* was claimed by 2 (1.45%) respondents; and *physical problems* felt 2 (1.45%) respondents. The care of the body of the deceased patients were not perceived by respondents in general as stressful – most of them – 40 (38.1%) respondents said *"rather no";* 24 (22.9%) respondents said *no*; 23 (21.9%) respondents answered *"rather yes"*; and 18 (17.1%) respondents said *yes*.

Study of Galdikien, Asikainen, Balčiunas, Suominen [15], conducted in Lithuania, was aimed at the perception of stress by nurses in primary health care. Nurses more often perceived stress in connection with the death and dying, it was true mainly for the elderly nurses, then nurses perceived stress during conflicts with medical doctors, patients and their families. Our

research showed that the most stressful situation in end-of-life care was considered by 75 (42.1%) respondents "*communication with the family of a deceased person"*; 42 (23.6%) of respondents *thinks of the similar situation for them and their families,* 26 (14.6%) respondents considers *mental demandingness in end-of-life care* to be the most stressful; 24 (13.5%) respondents says it is *communication with dying* that is most stressful*;* 11 (6.2%) of respondents considers *physical demandingness in end-of-life care* to be the most stressful.

According to research of Kuuppelomäki [16], conducted in Finland it was found that 92% of nurses provides emotional support to the dying patients. From our research is clear that the need to provide emotional support to the dying *are fully aware of* 64.8% respondents and *rather yes* was claimed by 32.3% respondents. Finish study also showed that nurses provide the emotional support in this order: *touch, respecting the patient's wishes, expressing empathy, verbal comfort, encouragement and the presence of a nurse*. The majority of respondents is exhausted from emotional support to a dying – *yes* was confirmed in 38 (36.2%) respondents; *rather no* answered 27 (25.7%); and *no* was chosen by 11 (10.5%) respondents.

The research conducted by Peters, Cant, Payne, O'Connor, McDermott, Hood, Morphet, Shimoinaba [17] in Australia and Great Britain confirmed, that nurses in emergency departments and also in palliative units feel mild *fear from death,* that differs in the following: nurses in emergency wards were afraid of "death factor" and felt much more stress during the contact with death and dying than nurses in palliative units. Older nurses from palliative units, more experienced and with higher education with religious inclinations were more able to manage end-of-life care. Our research findings indicate that the most frequent reaction to stressful situation was marked by 41 (37.3%) respondents *irritability*; 28 (25.4%) *anxiety*; 10 (9.1%) *insomnia or excessive sleep*; 7 (6.4%) respondents indicated stressful *palpitations and blaming others*; 6 (5.5%) respondents said they experienced *loss of appetite;* 5 (4.5%) respondents were *forgetful and retreated to escape;* 1 (0.9%) respondent indicated *diarrhoea, indigestion, stomach pain, nausea, vomiting.*

According to the study of Udo, Danielson, Henoch, Melin-Johansson [18], conducted in Sweden, the authors investigated the perception of stress at workplace where nurses provided care for the seriously ill and dying patients with cancer. In one group of nurses there was conducted educational intervention as an innovation method to improve the health care. Group of nurses that was educated, was subsequently monitored a few days later by questionnaires SOC-13, to confirm the efficiency of innovation programme. There was very clear correlation between educational interventions and increased resistance to stress in end-of-life care. There was also improved the care and positive feedback from patients. Our research indicated that the majority 48 (45.7%) respondents answered the question of preparedness of nurses to cope with demanding work situations *rather no*; 31 (29.5%) respondents answered *rather yes*; 13 (12.4%) respondents *yes*, and the same number of respondents 13 (12.4%) answered *no*.

From research of Havlíčková [19], conducted in the Czech Republic is clear that end-of-life care is physically and mentally demanding care. For nursing staff it is important to clarify their attitudes to death as it is the only way to achieve effective nursing care for dying patients. Long-term stress can cause psychosomatic and other diseases.

7 Conclusions

Our research indicates that the provision of end-of-life care belongs to the main stressors besides the lack of time to perform working duties in a satisfying way, lack of staff and administrative duties. It finally leads to experiencing discomfort of nurses, chiefly of regret, a sense of hopelessness and helplessness, anxiety, fear, worry, helplessness, pain, irritability, insomnia and others.

Nature of the starters of stress and their ubiquity in health facilities show that they are an integral part of fulfilling tasks in the field of nursing, and mainly are significant determinants

of discomfort. The increased resistance of nurses to stress and their feeling of helplessness during end-of-life care is possible to reach by a high quality professional preparation and education.

REFERENCES

[1] M. O´Connor, S. Aranda. 2005. Paliativní péče. Praha: Grada.
[2] A. Berman, S. J. Snyder. KOZIER&ERB´S Fundamentals of Nursing. Concepts, Process, and Practice.9 ed. Pearson: Boston, 1616 p. 2012.
[3] W. Schmidbauer, W. Psychická úskalí pomáhajících profesí. Nakladatelství Portál, 2000. Retrieved from: http://pmj.sagepub.com/cgi/doi/10.1177/0269216313477176
[4] N. Špatenková, Krizová intervence pro praxi. 1. vydání. Praha: Grada, 2004.
[5] J. Kelnarová, J. 2007. Tanatologie v ošetřovatelství. Brno: Littera.
[6] M. Vágnerová. 2010. Psychologie osobnosti. Praha: Karolinum.
[7] J. Křivohlavý. 2010. Sestra a stres. Praha: Grada.
[8] H. Haškovcová. 2007. Nauka o umírání a smrti. Praha: Galén.
[9] E. Kübler-Ross. Odpovědi na otázky o smrti a umírání-rozšířené vydání s příspěvky a komentáři. Jinočany: HaH, 1995
[10] Kolektiv autorů: Stres zdravotníků 1998. 1. vydání. Praha: Galén,
[11] E. Kubiczková. 2014. Diskomfort sester v péči o umírající pacienty. Bakalářská práce. Fakulta veřejných politik v Opavě, Slezská univerzita v Opavě, 2014.
[12] Pamela Gray-Toft, James G. Anderson, Stress among hospital nursing staff. In: Social Science & Medicine. [online]. July 2002, vol. 15, issue 5, [cit.28.3.2015] DOI:10.1016/0271- 7123(81)90087-0. Retrieved from: http://www.sciencedirect.com/ science/article/pii/0271712381900870
[13] B. Kent, N. Anderson, R. Owens. Nurses´ early experiences with patient death: The results of an on-line survey of Registred nurses in New Zeland. In International Journal of Nursing *Studies* [online]. Oct. 2012, vol. 49, issue 10 [cit. 20-11-2013]. DOI: 10.1016/ j.ijnurstu.2012.04.005. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/22572018
[14] M. J. Bloomer, R. Endacott, M. O'Connor, W. Cross. The "disease" of dying: Challenges in nursing care of the dying in the acute hospital setting. A qualitative observational study. In: Palliative Medicine [online]. Sep. 2013, vol. 27, issue 8 [cit. 20-09-2013]. DOI: 10.1177/0269216313477176. Retrieved from: http://pmj.sagepub.comcgi/doi/10.1177/ 0269216313477176
[15] N. Galdikien, P. Asikainen, S. Balčiunas, T. Suominen. Do nurses feel stressed? A perspective from primary health care. In: Nurs Health Sci. [online]. 2014 SEP. vol. 16, issue 3 [cit.18.01.2015] 327-34. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/25389543
[16] M. Kuuppelomäki. Emotional support for dying patients – the nurses' perspective. In: European Journal of Oncology Nursing [online]. Jun. 2003, vol. 7, issue 2 [cit. 20-11-2013]. DOI: 10.1016/S1462-3889(03)00002-4. Retrieved from http://katalog.svkos.cz:2077/ science/article/pii/S1462388903000024.
[17] L. Peters, R. Cant, S. Payne, M. O'Connor, F McDermott, K. Hood, J. Morphet, K. Shimoinaba, Emergency and palliative care nurses' levels of anxiety about death and coping with death: A questionnaire of survey. In Australasian Emergency Nursing Journal [online]11/2013, vol. 16, issue 4 [cit. 20-09-2013]. DOI: 10.1016/j.aenj.2013.08.001. Retrieved from: http://www.sciencedirect.com/science/article/pii/S1574626713000815
[18] C. Udo, E. Danielson, I. Henoch,C. Melin-Johansson. Surgical nurses' work-related stress when caring for severely ill and dying patients in cancer after participating in an educational intervention on existential issues. In European Journal of Oncology Nursing [online]. Oct. 2013, vol. 17, issuse 5 [cit. 20-09-2013]. Available: http://www.ncbi.nlm.nih.gov/ pubmed/23522827

[19] M. Havlíčková. Vliv péče o terminálně nemocné na psychiku sester [online]. Zlín: Univerzita Tomáše Bati ve Zlíně, 2007 [cit. 03-10-2013]. Retrieved from: http://dspace.k.utb.cz/bitstream/handle/10563/4172/havl%C3%AD%C4%8Dkov%C3%A1_2007_bp.pdf?sequence=1