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Hospice Reflection Journal

Before I arrived, I was expecting more anguish. Generalized and vague, but still, I didn't expect peace. If that's yet another aspect I've learned about myself, it's that I subconsciously believed in death being associated with a negative connotation. We learned in class about anticipatory grief, but the anticipation came more from the families than it did the patients. The patients were better at evolving to the acceptance stage in their grieving process; it was the families left behind that culminated their grief with varying intensity. The patients helped me learn more about grief in that death does not have to be viewed as scary, but as the end of a chapter and the beginning of a new one. This was a major communication barrier between the patient and family which added to their anticipatory grief, the gap between "understanding something non-physical from a physical point of view" (Holmes, 33).

The definition of the occurring language barrier is called "grief work". When doing research into the functions of hospice, and from speaking to the nurses, it became prevalent to me. When families are in a sense of mourning, especially in the presence of death, the direction of patient care is focused on comfort measures. Through the functionality of "grief work", this helps families handle the phases of grief more efficiently (Semenescu et al., 2022). "This allows not only for greater therapeutic success, but also avoids a high number of risks and complications that appear during the critical care period" (Semenescu et al., 2022). This is what fascinated me about the shift in patient care; on a med-surg floor, the goal of patient care is ultimately healing close to a normal or optimal point of functioning. However, with Hospice, you're helping the patient and families heal through your abilities to provide palliative measures. Through these measures, you're helping the family mourn and grief; ultimately returning them to an optimal point of functioning.

I also expected there to be more pity for the patients displayed through interprofessional communication and care. Instead, I found that the nurses were committed to bringing peace to the family and patient through a wide variety of therapeutic approaches. They communicated this through providing up-to-date, depth education and resources. When interacting with one of the patients, they were silent. This silent noise filled the room. This came to no surprise to me because we also learned in class the importance of implied silence when helping a patient cope with their health or diagnosis. "Engaging in a silent activity together can also be a great way to connect with grievers. There is a beauty in the stillness shared with another. Connecting with others through an activity such as drawing, cooking, reading, and other activities without verbal communication can be equally as supportive" (Connecting in the Silence of Grief, n.d.).

Knowing that implied silence is a therapeutic communication technique, I utilized this when providing the patient personal care. I also learned that this is a technique used by the hospice nurses when providing space for mourning. Some of my beliefs pertaining to this technique is the undeniable usefulness. I have used silence in multiple areas in my seven years of healthcare experience, and I can firmly say that it has never failed. I've come to realize that when the highest acuity patients feel that they do not have control over their lives or their health, giving that power back to them can make revelations. Silence allows them room to formulate thoughts, sit with their feelings, encourages and reassures the patient that their care is moving at their pace. These all allow for a trusting relationship to form.

Having witnessed this style of technique used to help families mourn has taught me silence can be used for many different routes of healing. This is a common theme that keeps

popping up in healthcare; that healing takes on the form of what the patient identifies it to be. As nurses, we can state facts about different therapy routes to allot physical normalcy, but this is not universal. This is where the shift in thinking should be for healthcare. Like how the patient defines family, the patient defines normalcy. This goal of individualized normalcy was shown time and time again through end-of-life care and has helped me realize this epiphany.

Due to this epiphany, I know I can use this tool to help patients across all different types of nursing. I'm thankful that I got to witness nursing care in a different light, yet be so like patients at complete opposite ends of bedside nursing care. The tools I've gained from a single day can help in my education to others entering the nursing profession when it comes to forming a trusting relationship with your patient at any point in their health journey.

References

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