Nurses’ experiences of end-of-life care

A descriptive literature review

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Abstract

Background: Although end-of-life care has developed to a certain extent in recent years, there are still deficiencies in all aspects. In China, end-of-life care is also getting more and more attention. The nurses play an important role in end-of-life care, and their end-of-life experience can promote a comprehensive understanding of end-of-life care.

Aim: To describe nurses’ experience of caring for end-of-life patient.

Method: A descriptive review was undertaken. Database Medline was used to search scientific qualitative articles. The selected 9 articles were processed to determine the similarities and differences in the results.

Result: The following four synthesized findings were emerged regarding nurses’ experience of caring for end-of-life patients: challenge, dilemma, cognition, nursing care and rewarding.

Conclusions: In the process of end-of-life care, the nurses experienced challenges, including communication difficulties, lack of experience, lack of professional support and so on, as well as dilemmas. However, through the implementation of nursing care, the nurses gained rewards, such as experience, and gratitude from patients and their families.

Keyword: end-of-life care; experience; nurse
Abstract in Chinese:

背景: 尽管近年来临终关怀发展到一定程度，但各方面仍存在不足。在中国，临终关怀也越来越受到重视。护士在临终关怀中起着重要的作用，护士对临终关怀体验的描述可以促进对临终关怀的全面理解。

目的: 描述护士护理临终病人的体验。

方法: 在 Medline 数据库中搜索采用定性方法的科学文章。对选定的 9 篇文章进行处理，以确定结果的相似性和差异性。

结果: 护理人员临终关怀的经验表明，护理过程中存在着挑战、困境、认知、护理和收获等方面的问题。所选文章的数据收集方法都被清晰地描述了出来。

结论: 在临终护理过程中，护士会遇到沟通困难、缺乏经验、缺乏专业支持等方面的挑战，也会遇到困境。然而，通过实施护理，护士受益很多，如经验，来自病人和他们家人的感激。

关键词: 临终关怀; 体验; 护士
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1 Introduction

There has been an inseparable relationship between death and spirituality since recorded time (D’Antonio, 2017). In the biblical book of Genesis, it describes Jacob’s spiritual preparations for his death, and accompanied by his family, Jacob prayed and remembered his ancestors and blessed his family (D’Antonio, 2017). In the past, it seemed to be the norm to die at home in the company of a family member, but until the middle of the 20th century, the advent of modern medicine shifted other places of death to hospitals and nursing homes (Puchalski and Ferrell, 2010). Therefore, the nurses become essential and increasingly important in end-of-life care.

In 1960s, it brought an imperative revolution in end-of-life care (D’Antonio, 2017). Especially, the main impetus for change is to reestablish the vital link between spirituality and end-of-life care (Puchalski and Ferrell, 2010). In 1967, lady Cecily Saunders of the United Kingdom founded st. Christopher's Hospice, marking the beginning of the modern hospice movement (National Hospice and Palliative Care Organization, 2014). The world hospice program was launched in 2002, and more than 885,000 patients in the United States use hospice services. In addition, 90% of patients with advanced cancer need these services (Walshe and Luker., 2010; Csikos et al., 2010).

In China, more and more people suffered from cancer, and aging population is an increasing stress on the healthcare system (Wu et al., 2016). According to the Xinhua News Agency (2014), There are about 249 million people aged 60 and over in China. The end-of-life care is an emerging specialty which developed since the year 1988, while the establishment of End-of-Life Fare Association was an important step in the development in end-of-life care in 1993, which was a milestone in the history of end-of-life care in China (Wu et al., 2016). Still and all, the need for end-of-life care is becoming more and more urgent with the increasing aging population, which brings great challenges to the government and society (Wu et al., 2016).

Death is still a universal and inevitable phenomenon of all people (Cevik &Kav, 2013). Nowadays, people emphasis on improving the quality of end-of-life care to promote and achieve a good death (Ellershaw, 2010). From the website of World Health Organization (WHO. 2018), it is estimated that around 40 million people are in need of
palliative care every year, but only about 14% of those have received it (WHO, 2018). Nurses have more contact with these patients and their families and are responsible for providing primary end-of-life care (Fink et al., 2010). However, with the increasing aging population globally and the development of the economic status, people's demands on the quality of life have increased, which also includes the improvement of the quality of their death (Ellershaw, 2010). When the patients face death, factors, such as occupation, education, personal experience and religious belief, affect people's views on death, causing different people having different attitudes and behaviors towards death. (Rooda et al., 1999). Nurses, as hospice care providers, are responsible for observing the emotions of end-of-life patients, evaluating the psychological needs, communicating with patients, caring for patients, establishing a good relationship with patients (Ingebretsen and Sagbakken, 2016). However, nurses’ own feelings during end-of-life care are often missed or have not been taken care of (Ingebretsen and Sagbakken, 2016). Caring end-of-life patients and coping with death is one of the most difficult things when nurses encounter it in their careers. It is inevitable for nurses to face the reality of death when caring for these patients. Therefore, nurses’ attitudes towards caring for end-of-life patients need to be explored (Brosche, 2007).

1.1 Definition

1.1.1 End-of-life care
End-of-life care is the provision of palliative care when death is imminent and it could be delivered in different context such as hospice, specific units in hospital wards, or in private homes (Payne et al., 2008). End-of-life care is an approach to provide patients and their families with legal, financial, emotional, or spiritual counseling as they needs, to improve the quality of life for patients who is in their last year of life, including bereavement care for the family. It can be at home, in the hospital, or in the hospices. It can effectively alleviate the early identification of the pain from dying patients and their families, which involve the physical, mental or spiritual portions (WHO, 2018). In end-of-life care, the Peaceful End-of-life Theory provide support (Alligood, 2014). This theory contains five aspects of content and they are not being in pain, experience of
comfort, experience of dignity and respect, being at peace and closeness to significant others which are of relevance for this study. This theory came from the standards of care written by a team of professional nurses, who solved a practical problem, so the concept of metaparadigm explicitly related to nursing and people (Alligood, 2014). The theory was mentioned in other article (Kongsuwan and Touhy, 2009). Meanwhile, Swanson’s Theory of Caring also gave the support (Alligood, 2014). This theory includes six major concepts and they are caring, knowing, being with, dong for, enabling and maintaining belief which can be applied to the research and clinical work of different populations (Alligood, 2014). This theory was also mentioned in other articles (Andershed and Ternestedt, 1999; Kavanaugh et al., 2006; Ahern ea al., 2011; Adolfsson, 2011).

1.1.2 End-of-life patient
End-of-life patient is the person who has a quantity of physical, psychological, social, and spiritual problems and they are in great need of good care. When in the terminal of life, they require more assistance to support their death (Wasserman, 2008).

1.2 The nurse’s role
Nurses are indispensable in the field of nursing, and they need to be familiar with all areas of nursing. Caring for end-of-life patient is one of the most challenge things in nursing profession. The nurse not only should take care of the end-of-life people but also need to face to their families, so before coping this, there should be a correct cognition of end-of-life (Costello, 2006). The nurse is a person who helps patients recover and maintain a stable mental status and a good health condition. However, nurses who have close contacts with end-of-life patients, are emotionally affected by them (Boyle, 2015). In order to provide high quality care to end-of-life patient and family, nurses need to have a good acquaint of their own fears, emotions, and attitudes about death (Cevik and Kav, 2013).
1.3 Earlier review

Due to the high cost and low quality of end-of-life care, people are paying more and more attention to end-of-life care (Pizzo et al., 2004). Lorenz et al (2008) said that, previous systematic reviews on end-of-life care have provided a wide range of clinical interventions in health-related quality of life for patients and caregivers. A systematic review done by Evan et al. (2019) highlighted the necessity of integrated palliative and geriatric services and its clinical evidence supports the nurses to focus on patients’ quality of life primarily. Three main findings were identified in another systematic review (Adams et al. 2011), (a) give information to physicians, (b) give information to family, and (c) mediate. Recommended by Adams et al. (2011). The role played by nurses in end-of-life improved the overall communication quality in end-of-life care and help more patients and families to make decisions consistent with their values and goals. Noome et al. (2016) showed the role of ICU nurses in the end-of-life care process, and the interaction between patients, family members, and colleagues. The literature clearly indicates that the role of ICU nurses concerns care for the patient, family and environment. It described which care should be given, but it remains unclear how care should be given (attitude). Meanwhile, there's also a previous article that talked about valuing and respecting patients in end-of-life care and mentioned the importance of community end-of-life care services. Studies highlight the value district nurses place on palliative care provision, the importance of developing a relationship with patients, and the emotional difficulties of providing such care. District nurses have key skills in providing physical care and in coordinating the work of others, but struggle more with psychological aspects of care (Walshe and Luker, 2010).

1.4 Problem statement

Previous reviews mostly focus on the quality of life and the patients’ own experience in their end-of-life time. But there is a lack of review focusing on nurses’ experience of caring for end-of-life patients. Therefore, this study is needed. The nurse may encounter end-of-life care and face patients who needs end-of-life care. In order to address these needs, it is important that the nurse has good skills in nursing practice, perception and the ability of controlling emotions and can take care for the dying patients better and
improve their quality of life. Therefore, it is of importance to describe nurses’ experience on end-of-life care.

1.5 Aim and research question

The aim of the review was to describe nurses’ experience of caring for end-of-life patients.

What’s the nurses’ experiences of caring for end-of-life patients?

2 Methods

2.1 Design

A descriptive review was conducted (Polit and Beck, 2012).

2.2 Search strategy

In table 1, it presents search limits, which included Högskolan i Gävle, 10 years, English and Humans. the database (PubMed) and search terms used to search the articles, which were 'Emotion', 'Experience', 'Reflection', 'perspective', 'Nurs*', 'Terminal care', 'Hospices', 'Critical illness', 'Cancer' and 'End-of-life'. According to the search terms, the similar meanings of word have used the Boolean term OR to connect the search but the different meanings of word have merged with each other using the Boolean term AND. Indexed search terms fetched from MeSH and title/abstract (TIAB) were used in the search. Table 1,

After reading the titles and abstracts from 697 articles, there were 46 articles selected as appropriate. Two articles were found through manual searching which are relative to inclusion criteria, aim and specific questions.
Table 1. Results of database searches.

<table>
<thead>
<tr>
<th>Database + Date of search</th>
<th>Limits</th>
<th>Search terms</th>
<th>Number of hits</th>
<th>Potential articles (excluding doubles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medline through PubMed 2018-05-30</td>
<td>Hogskolan i Gavle, 10years, English, Humans</td>
<td>Emotion (Mesh) OR Experience (TIAB) OR Reflection (TIAB) OR Perspective (TIAB) OR Feeling (TIAB)</td>
<td>260417</td>
<td></td>
</tr>
<tr>
<td>Medline through PubMed 2018-05-30</td>
<td>Hogskolan i Gavle, 10years, English, Humans</td>
<td>Nurs*</td>
<td>163357</td>
<td></td>
</tr>
<tr>
<td>Medline through Pubmed 2018-05-30</td>
<td>Hogskolan i Gavle, 10years, English, Humans</td>
<td>Terminal care (Mesh) OR End of life (TIAB)</td>
<td>18997</td>
<td></td>
</tr>
<tr>
<td>Medline through Pubmed 2018-05-30</td>
<td>Hogskolan i Gavle, 10years, English, Humans</td>
<td>Emotion (Mesh) OR Experience (TIAB) OR Reflection (TIAB) OR Perspective (TIAB) OR Feeling (TIAB) AND nurs* (TIAB) AND end-of-life care (TIAB)</td>
<td>432</td>
<td>20</td>
</tr>
<tr>
<td>Medline through Pubmed 2018-05-30</td>
<td>Hogskolan i Gavle, 10years, English, Humans</td>
<td>Nurses (Mesh) AND Terminal care (Mesh)</td>
<td>265</td>
<td>26</td>
</tr>
</tbody>
</table>

697 Total: 46
2.3 Selection criteria

When selecting the articles, the following exclusion and inclusion criterion were used. The exclusion criterion were articles that only contained patients’ experience, parents’ experience, the care of end-of-life patients. What’s more, articles not written in ten years, not written in English, not in full-text from Högskolan i Gävle or review study were also excluded. In other words, the inclusion criteria for articles should be associated with nurse experience, end-of-life care which is relative to the subject. Meanwhile, only qualitative approach was used in articles.
2.4 Selection process and outcome of potential articles

According to the above search strategy, 260417 articles were preliminarily yielded. Due to the huge number of data, it was difficult to find relevant articles. Therefore, the authors reduced the amount of data by changing the search terms, and finally 432 articles were obtained. After browsing the titles and abstracts, the authors selected the articles that could answer the research questions, 20 articles were left. By changing the search terms, the authors obtained another 265 articles, and 26 articles were left using the same method. A total of 46 articles were then available. The authors scrutinized these articles more closely to determine whether they were relevant to the literature review. Later, 39 articles were removed for the reason that 13 articles were not in line with the aim, 14 articles were not about end-of-life care, 5 articles were literature review and 7 articles were quantitative research. What’s more, 2 suitable articles were found through searching from reference list by authors. At last 9 studies were included in this qualitative synthesis.

2.5 Data analysis

The research results of the selected articles focus on the questions and methods section. All the articles were first read and re-read independently by the two authors and then read together several times carefully. Useful information in the articles were merited for discussion and analysis. Therefore, a summary according to the similarities and differences of the studies results. Data were extracted from the studies and for the convenience of the study, the authors used different tables. Each article was given an alphabetic code (a-i) in appendix 1 and Table 2, which presents the author, title, design/method, sample characteristics, data collection method, and analysis method of the selected article. The appendix and Table 3 summarize the research objectives and results of the selected articles. According to Polit and Beck (2012) it’s a good choice to organize in Table 3 the useful information from the articles. The analysis was inspired by the recommendations from Joanna Briggs Institute (Joanna Briggs Institute, 2014; Lommi et al. 2015).
2.6 Ethical considerations

The literature review used published material which has been subjected to ethical review and approval. Articles have been objectively read and evaluated without the affecting by subjective factors, such as the author’s own view, attitude, perception and prejudice. What’s more, the results have presented in the form of a complete and it hasn’t been changed as the authors’ wishes. The degree project averted plagiarism.

3 Result

The results all base on 9 articles which used qualitative approaches. The included studies were published from 2008 to 2018. There are totally 108 clinical nurses as the sample presented in the study, including 5 males and 65 females (three articles did not mention the gender of the participants). Meanwhile, seven articles mentioned that the working experience of nurses ranged from 2 months to 15 years. Two studies were conducted in China, one in Malta, one in Sweden, one in US, one in South Africa, one in Ireland, one in Singapore and one in Australia.

After reading 9 articles repeatedly, 5 categories were obtained after aggregating 33 study findings (see Table 4), which are challenge, dilemma, cognition, nursing care and rewarding. Through the analysis of these factors, we found that the nurses in the process of end-of-life care have to confront with the difficulties and challenges and get the corresponding measures and achieved harvest. It makes the clinical nurses to deliver and share in the end-of-life care experience.

3.1 Challenge

In the selected articles, the results showed that challenge refers to all aspects of the end-of-life care process that nurses subjected to setbacks. Providing end-of-life care was an emotional and psychological burden for nurses, which could cause physical and mental harm in the long run. In the process of caring for patients at the end-of-life, nurses
witnessed the pain of patients, their families and the nursing team, which leads to the strong feeling of responsibility of nurses to help them to alleviate the pain, which has an impact on the emotional needs of nurses. When the patient were offered care that was ineffective, the suffering was exacerbated, and even they felt a strong sense of guilt (Johnson and Gray, 2013; Ong et al., 2017). As for nurses in the intensive care unit, they were chronically exposed to grief and fear in intensive care, and their constant handling of death and dying had left them in desperate need of emotional support (Ranse et al., 2012). It could take care of different patients every day. If patients die, they needed a certain amount of time to adjust their emotions (Kisorio and Langley, 2016). Reading, traveling, sports and any others which is a safe way to get an outlet (McConnell and Porte, 2017). Most nurses said they did not feel they were getting enough support in the care of dying patients, including support for professional education, support for interpersonal communication and support between teams. Positive coping include recognizing the potential of seeking training and guidance (Johnson and Gray, 2013; Ong et al., 2017). They wanted more training to make up inadequate experience in end-of-life care (Kisorio and Langley, 2016). Always, nurses were afraid of saying something wrong to the patients and families, because the end of life was an unforgettable time for the whole family. To communicate effectively the nurses need to keep on learning, and it was also important to learn from experienced nurses about specialist skills and experience. Nurses in end-of-life care felt they needed the support from colleagues, doctors and the whole nursing team -- the support from the organization. Sometimes, the guidance of the group leader could not help junior nurses solve the complex problems of hospice care. Nurses often felt support was reduced when the end-of-life patients were withdrew the participatory treatment (McConnell and Porte, 2017; Ranse et al., 2012). In the culture of care, nurses needed to provide patients with a painless and comfortable death process, respect end-of-life patients, pay attention to emotional and psychological reactions, because of the patient's condition and other reasons, the support from the family members was oppressive. Despite dedicating to caring for patients and their families, there was no denying that there was uncertainty and ambiguity on end-of-life care. They weren't sure if the end-of-life care was really appropriate for patients and their families (Ong et al., 2017; Ranse et al., 2012).
3.2 Dilemma

Dilemma means nurses’ conflict in the end-of-life care. The ideal working model for end-of-life would be one-to-one, but this was hard to do because there were not enough staff (Tse et al., 2016). The reality of end-of-life care today was that nurses often struggled with ineffective care. Patients were often forced to accept invasive and undignified treatments, such as intubation, when they were dying. In addition, many unnecessary examinations, such as drawing blood which increased the patient’s pain. Although nurses tried to communicate with doctors, their suggestions were not paid attention to and affirmed by doctors. Due to the imbalance of power between doctors and nurses, doctors had a stronger voice in the nursing plan and patients' end-of-life care was hindered (Ong et al., 2017). Although end-of-life care had been practiced for years, the results were not ideal. There were often the following situations: 1. Patients and their families signed the Do Not Resuscitate agreements, but when the patient was dying, the family members took back their word and asked the doctor to do all they could to save the patient. At this point, the patient may be intubated, and the life was meaningless to him/her. 2. The family members supported end-of-life care and palliative care, but neither the patient nor the family members were prepared for death, resulting in the patient being forced to wait for death. These situations were real and made nurses sighed with emotion (Liu and Chiang, 2017). In many countries, death is a taboo topic. Therefore people avoid talking about it. Nurses found it difficult to answer the questions of death raised by patients or their families. On the one hand, nurses did not want patients or their families to lose confidence for they knew the true condition; on the other hand, they did not want patients and their families to be concealed (Liu and Chiang, 2017; Grech et al., 2018). Caring for dying patients was depressing and traumatic. Nurses often struggled with feelings of helplessness. In today's medical environment, nurses work at a fast pace, which leads to their lack of time to sort out their inner emotions. Some people even believed that the particularity of the nursing profession required that nurses should not reveal their inner emotions. Over time, these negative emotions would build up and eventually affected external behavior (Liu and Chiang, 2017; Grech et al., 2018; Kisorio and Langley, 2016). Long-term end-of-life care created an intimate relationship between the nurse and the patient, much like a
families. The age of the patients often affected the immediate feelings of the nurses. When the time of separation come, the anxiety of separation will arise, which will also arouse the nurse's missing for the deceased relatives, causing the nurse desperately to hope that the patient can be saved (Grech et al., 2018; Liu and Chiang, 2017).

3.3 Cognition

According to selected articles, nurses’ cognition was constantly revised and summarized on end-of-life care. Critical care disrupts the concept of comfort in the final stages of life, yet nurses value quality over quantity in end-of-life care (Ong et al., 2017). It presents that the philosophical meaning of life and death is cognized (Ong et al., 2017). Meanwhile, nurses’ emotions were often influenced by patients and their families which leads to the recognition of the emotional significance of life and death (Ong et al., 2017). However, the beliefs of end-of-life care showed that the value and complexity of end-of-life care was not always appreciated by nursing colleagues (Ranse et al., 2012).

3.4 Nursing care

Results from the selected articles showed that the final stages of the older persons are described as a natural progression towards death (Holmberg et al., 2018). As a human being, elderly people hope their life and personal needs to be respected and satisfied (Holmberg et al., 2018). Therefore, nurses, in the selected articles, said that focusing on their happiness and helping elderly people cherish daily enjoyments are the main tasks of nursing care in end-of-life (Holmberg et al., 2018). In end-of-life care, nurses should create a peaceful and intimate environment and remove the clinical equipment which can affect patients' mood (Kisorio and Langley, 2016; Ranse et al., 2012; Tse et al., 2016). It’s also necessary for nurses to provide comfort and care to satisfy the needs of end-of-life patients, such as bathing, hair care, mouth care, pressure area care, spiritual care, and the administration of analgesics, sedatives and antimucolytics (Ranse et al., 2012; Tse et al., 2016). Furthermore, nursing care included connecting the nurses with patients by finding a genuine interest in details in their lives, respecting and listening to the patient's choices about emotional well-being and physical well-being (Johnson and
Although the nurse said they cannot make decisions like a doctor, they may offer opinions and advocate for the patient when necessary (Kisorio and Langley, 2016). The focus of nursing shifted to maximizing the quality of patients’ life for the rest of their lives which is considered suitable care rather than controversial and invasive interventions (Tse et al., 2016). For family members, nurses reported that it was important to encourage them to be at the patient's bedside, to talk to the patient, and to touch the patient (Kisorio and Langley, 2016; Ranse et al., 2012; Tse et al., 2016). Moreover, the nurse should support the family members to express the care and love to the patient, and involve the patient's family in the intervention program as far as possible (Tse et al., 2016). Nurses, in the selected articles, described that it was also important to respect the cultural customs and rituals of patients and families (Kisorio and Langley, 2016). When patients have to face to death, people around should avoid irrelevant talk, give patients a silent care, respect for the dead person (Holmberg et al., 2018). At last, as a nurse, it’s important to make nursing work more effective integration and achieve meaningful outcomes (Johnson and Gray, 2018).

### 3.5 Rewarding

Nurses, in the selected articles, expressed that it’s inevitable to get the sentiment from patients and family members and gain some life experience in end-of-life care (Johnson and Gray, 2018; Liu and Chiang, 2017; McConnell and Porte, 2017; Tse et al., 2016). Personal experience about end-of-life care provided an irrefutable learning opportunity for nurses themselves and a team usually works together and shares experiences together for patients’ benefits (Johnson and Gray, 2018; McConnell and Porte, 2017). According to the nurses, by providing end-of-life care, they were inspired to face death and cherish life which means every effort should be paid back (Liu and Chiang, 2017). Meanwhile, nurses can also use their own experience to make life convenient, such as supporting the families, managing their children's symptoms, and providing personalized care and activities to make life easier (McConnell and Porte, 2017). What’s more, because of their contact with end-of-life patients, the nurses have developed a quantity of meaningful but practical insights (Johnson and Gray, 2018). Although surrounded by busy work every day, nurses claimed that their enthusiasm for
nursing as a caring profession was revitalized by the deep gratitude of patients and their families (Tse et al., 2016). Generally, the nurses said they will reflect on the meaning of life and death, prepare for their own death and motivate themselves to do some things, for example, nurses cherish the family and life when death relates to the family (Liu and Chiang, 2017; Tse et al., 2016).

4 Discussion

4.1 Main result
The results of this study suggest that nurses’ experience of end-of-life care can be synthesized in five categories, and they are challenge, dilemma, cognition, nursing care and rewarding. During end-of-life care, challenges and dilemmas were inevitable, and nursing care often constituted a large part of the experience of end-of-life care. The nurse usually got some physical or psychological rewarding after the nursing intervention. Patients, family members, colleagues and organization supports also played an important role in end-of-life care.

4.2 Results discussion

4.2.1 Discussion of synthesized findings
The results showed us five categories, which are challenge, dilemma, cognition, nursing care and rewarding. All of them were brought out for discussion. The challenge that nurses and the work team are facing during end-of-life care due to lack of formal or informal support is aligned with the conditions of Swanson’s theory of caring (Alligood, 2014). The challenges nurses faced included the fact that they often did not know how to properly communicate with patients, and lack of relevant experience and knowledge or educations in taking care of end-of-life patients and interpersonal communication.
(Johnson and Gray, 2013; Kisorio and Langley, 2016; McConnell and Porte, 2017; Ong et al., 2017; Ranse et al., 2012). “Hospice care is rarely included in nursing education, with more than half of practicing nurses saying they believe their hospice education is inadequate, this finding is consistent with the other studies” (as cited in Dickinson, 2006, pp. 165). The nurse witnessed events that patients and their families feel sensitive and vulnerable, including deaths (D’Antonio, 2017). Nurses rarely receive formal or informal emotional support and only could express their emotions through tears (Thompson, 2007). Increasing end-of-life care education for nurses can foster the ability for nurses to face death squarely and give them more opportunities to reflect on the problem (D’Antonio, 2017), because this D’Antonio’s paper researched the relationship between end-of-life care and education, it paid more attention to the influence of end-of-life care education on nurses in all aspects, including nursing work and life emotion.

Dilemma that described by nurses in the selected articles stemmed from ineffective medical treatment and establishing relationships with the patient's family, which is aligned with the conditions of Swanson's theory of caring (Alligood, 2014) and Ruland’s and Moore’s Peaceful End-of-life Theory (Alligood, 2014). Patients often lived with no dignity before dying, and the treatments they received, such as intubation and blood drawing, were not what they really wanted to accept. The helplessness of nurses comes from the incomprehension of doctors and their families (Grech et al., 2018; Kisorio and Langley, 2016; Liu and Chiang, 2017; Ong et al., 2017; Tse et al., 2016). Most patients have a high degree of pain, but the medical staff do not pay too much attention to the pain and symptoms control, resulting in patient eventually died of pain (Puchalski and Ferrell, 2010).

Cognition occurs when people try to understand the meaning of something in the other person's life. This theme aligned with the conditions of Swanson's theory of caring and one of major concepts - knowing (Alligood, 2014). When the nurse face to patients who have already at the stage of end-of-life, they realize that what patients need more is to improve their quality of life (Ong et al., 2017). At the same time, many studies have
shown that improving the quality of life of patients in end-of-life care is extremely important (Lu et al., 2017; Evans et al., 2019). Therefore, the nurses need policy implementation, empowerment, emotional and organizational support, and education to provide end-of-life care.

Nursing care based on end-of-life patients' demands for respect and physiological satisfaction is aligned with Swanson's theory of caring - doing for (Alligood, 2014) and Ruland and Moore’s peaceful end-of-life theory (Alligood, 2014). Nurses not only need to satisfy their demands in regard to environmental, daily physical, mental and medical needs, but also need to respect them (Holmberg et al., 2018; Johnson and Gray, 2013; Kisorio and Langley, 2016; Ranse et al., 2012; Tse et al., 2016). The view about respecting the patients in the final stages was supported by multiple study findings of patients’ and relatives' view (Östlun et al., 2019; Johnston et al., 2017). In addition, in our review, the family support was also one of the nursing care (Kisorio and Langley, 2016; Ranse et al., 2012; Tse et al., 2016). The family members also play an important role in end-of-life care, and Noome et al’s review supports this view (Noome et al., 2016).

Rewarding will arise when the nursing measures are implemented in end-of-life care. This synthesized finding is aligned with the conditions of Swanson's theory of caring and enabling (Alligood, 2014). It shows that nurses gradually have an understanding of end-of-life care in this process and accumulate experience for future work (Johnson and Gray, 2018; McConnell and Porte, 2017). At the same time, not only can the nurse receive the gratitude from the patient and the family members, but also can the nurse get inspiration about life and death and cherish life (Liu and Chiang, 2017; Tse et al., 2016). In van der Wath and du Toit’s research (2015) of nursing students, the participants’ elaboration on the values of death and dying supports the same views.

4.2.2 Discussion of the selected articles’ data collection methods
Qualitative research has two main data collection methods, which are interviews and observations. The interview method is the process of asking questions and getting answers. The observation method uses text recording, recording, video recording and other methods to record the daily activities as research materials. The analysis of the material provided the answer the researchers needed. Qualitative data collection methods such as individual in-depth interviews and field observations have increased the understanding of the human experience (Polit and Beck 2012).

All the 9 selected articles in this present literature review conducted face-to-face interviews with the participants (Grech et al., 2018; Holmberg et al., 2018; Johnson and Gray, 2013; Kisorio and Langley, 2016; Liu and Chiang, 2017; McConnell and Porte, 2017; Ong et al., 2017; Ranse et al., 2012; Tse et al., 2016). For further qualitative analysis, this method of data collection is a wise choice to collect descriptive data (Polit and Beck, 2012). In 2 of the selected articles, focus-group interview was adopted to communicate with participants (Kisorio and Langley, 2016; Liu and Chiang, 2017). In focus-group interview, a group of participants is assembled for a discussion according to a written set of questions or topics covered by researches (Polit and Beck, 2012). Focus group meetings are carefully planned discussions that use group dynamics to obtain a wealth of information in an economical manner (Polit and Beck, 2012). In 7 of the selected articles, semi-structured interview were chosen to talk with participants (Grech et al., 2018; Holmberg et al., 2018; Johnson and Gray, 2013; McConnell and Porte, 2017; Ong et al., 2017; Ranse et al., 2012; Tse et al., 2016). In the semi-structured interview, the researchers prepared an interview guide which included a list of areas or questions to the participants and encourage them to talk freely in their own words, which ensured that the researchers will have all the information they need and the participants will be free to provide as many illustrations and interpretations as possible (Polit and Beck, 2012).

Six of the included articles in the literature review, data were reread and transcribed in data collection (Grech et al., 2018; Holmberg et al., 2018; Kisorio and Langley, 2016; Ong et al., 2017; Ranse et al., 2012). According to Polit & Beck (2012), this is a
strength as presenting the collected data clearly and objectively. Three articles used the recorded and transcribed approaches (Liu and Chiang, 2017; McConnell and Porte, 2017; Tse et al., 2016). According to Polit & Beck (2012), this is a strength as making the data collected more accurate. This literature review included studies from different countries including Malta, US, South Africa, Taiwan China, Ireland, Singapore, Australia and China. The study's credibility was bolstered by research in different countries around the world, where end-of-life care was a global problem, and different area’s medical standards were various.

4.3 Methods discussion

In order to improve the reliability of the results, the authors conducted searches in a great database; MedLine, which helped to strengthen the results of the present review (Polit and Beck 2012). The authors used MeSH terms, TIAB and Thesaurus, and used the Boolean operator ‘AND’ and ‘OR’ to combine search terms, as well as free text search for more relevant article results (Polit and Beck, 2012).

According to Polit and Beck (2012), the authors of this study used clear and specific inclusion and exclusion criteria, which strengthens the usability of the study. One of the criteria selected by the author was that the article must be written in English, which may be regarded both as a strength and a limitation. The limitation is that English is not the authors’ first language, which means a risk of misinterpretation and misunderstanding may have occurred. In addition, the articles should have been published between 2008-12-01 and 2018-12-31 in order to limit the outcome of the search. This may result in the authors missing studies that were published at an earlier date, which is the limitation of present literature review. However, the exclusion of articles over a decade ensures a more advanced and modern outcome, which can also be seen as a strength (Polit and Beck, 2012). What’s more, the articles must be provided free of charge to university of Gävle, which may be seen as a limitation because the author may have missed relevant article due to lack of resources.

The authors read the nine articles carefully and repeatedly , and the two authors read them independently to avoid them influence each other’s understanding of the text and
looking for more useful information, it was recommended by Polit and Beck (2012). The aim of the literature review was to describe nurses’ experience of caring for end-of-life patient, and the results were consistent with the aim. The authors discussed, analyzed and summarized the collected data, and finally obtained the research results. Each article in the study was approved by the ethics committee. In the process of literature search, the authors adopted the method of limiting keywords, title, year and language to make a quick browse, which also might resulted in many more meaningful articles were not included. Doing the study systematically is according to Polit and Beck’s (2012) recommendations and documented each step of the process to ensure the study is efficient and reproducible.

4.4 Clinical implications for nursing

The results of this study indicated that it was important to understand the factors that influenced nurses' experience of end-of-life care. It affected not only the physical and mental health of nurses, but also the development of end-of-life care. Knowing the difficulties that nurses faced in end-of-life care was critical to the development of end-of-life care, which meant patients could be better cared for, free from pain, and able to go through their final stages of life with dignity. Nurses are recommended to get more training in end-of-life care so that expertise can be a support. At the same time, when encountering a difficult problem, nurses should be actively to seek help from an experienced nurse or head nurse, which can be skills or psychological support.

4.5 Suggestions for future research

In the comprehensive literature review, the authors found that few articles could fully answer the research questions of this study, especially in China. Moreover, the concept of end-of-life care in countries around the world was severely inadequate. With the increasingly serious aging of the population, the importance of end-of-life care in contemporary medical treatment is becoming increasingly prominent, so it is necessary to explore the experience of nurses in end-of-life care.
Our review described the experience of nurses in end-of-life care and summarized the difficulties and inspirations which the nurses encountered in end-of-life care. But we haven't researched how to alleviate the difficulties that nurses face in end-of-life care. So what can we do in the future is to alleviate the difficulties that nurses faced in end-of-life care, and evaluate the effectiveness of these interventions. It provides guidance for future intervention research.

4.6 Conclusions

In the process of end-of-life care, the nurses experienced challenges, including communication difficulties, lack of experience, lack of professional support and so on, as well as dilemmas. However, through the implementation of nursing care, the nurses had rewards, such as experience, gratitude of patients and their families. In order to further develop end-of-life care, the nurses must strengthen their knowledge and skills related to end-of-life care, enhance the awareness of end-of-life care and constantly improve their level from the aspects of psychology, professional technology, comprehensive ability to deal with problems, master excellent operation technology and nursing theory knowledge. In addition, it is also important to improve the corresponding health regulations and increase the overall social support.
References


21


Karlsson M., Kasen A. & Wa¨ rna˚ furu C., (2016). Reflecting on one’s own death: The existential questions that nurses face during end-of-life care. Palliative and Supportive Care, 15, 158–167


related to the interaction between patient, family and professional: an integrative review. *Scandinavian Journal of Caring Science*, 30, 645-661


## APPNDIX 1

### Table 2. Overview of selected articles

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Study code</th>
<th>Title</th>
<th>Design (possibly approach)</th>
<th>Participants</th>
<th>Data collection method(s)</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grech &amp; Depares &amp; Scerri Malta (2018)</td>
<td>a</td>
<td>Nurses’ experiences providing end-of-life care to adults with hematologic malignancies</td>
<td>Descriptive design</td>
<td>5 registered nurses, all females, aged from 25 to 55 years and had more than 1 years working experience.</td>
<td>2 Semi-structured interviews, the first lasted 75 minutes, the second lasted between 15 minutes and half an hour.</td>
<td>Inductive analysis</td>
</tr>
<tr>
<td>Holmberg &amp; Hellström &amp; Österling Sweden (2018)</td>
<td>b</td>
<td>End-of-life care in a nursing home: Assistant nurses’ perspectives</td>
<td>Descriptive design</td>
<td>7 assistant nurses, all had formal high school education and a minimum of 3 years of work experience.</td>
<td>Individual interviews, lasted between 34- 64 min. Interview questions were used.</td>
<td>Inductive qualitative content analysis</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Study Number</td>
<td>Title</td>
<td>Research Design</td>
<td>Sample Characteristics</td>
<td>Data Collection Method</td>
<td>Data Analysis</td>
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<tr>
<td>Johnson &amp; Gray, US (2013)</td>
<td>c</td>
<td>Understanding nurses’ experiences of providing end-of-life care in the US hospital setting</td>
<td>Descriptive design Qualitative approach</td>
<td>13 registered nurses, 12 females and 1 males, aged over 25 years old.</td>
<td>Individual interview. The interviews lasted 60-90 minutes. Interview questions were used.</td>
<td>Interpretative analysis</td>
</tr>
<tr>
<td>Kisorio L C, Langley G C, South Africa (2016)</td>
<td>d</td>
<td>Intensive care nurses’ experiences of end-of-life care</td>
<td>Exploratory design Qualitative approach</td>
<td>24 registered nurses, 2 male and 22 female, had more than 6 months’ working experience.</td>
<td>Group interviews, discussions, lasted between 1-1.5 hours. Interview questions were used.</td>
<td>Comparative analysis</td>
</tr>
<tr>
<td>Liu Y.C &amp; Chiang H.H, Taiwan (2017)</td>
<td>e</td>
<td>From vulnerability to passion in the end-of-life care: The lived experience of nurses</td>
<td>Descriptive design Qualitative approach</td>
<td>13 registered nurses, 13 females, with an average age of 38.4, had an average of 12.6 years working experience.</td>
<td>Group interview, lasted between 90 -120 min. Interview questions were used.</td>
<td>Interpretative phenomenological analysis</td>
</tr>
<tr>
<td>Authors</td>
<td>Country</td>
<td>Sample Size</td>
<td>Description</td>
<td>Methodology</td>
<td>Analysis Method</td>
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<tr>
<td>McConnell T &amp; Porte S. Ireland (2017)</td>
<td>Ireland</td>
<td>15 registered nurses</td>
<td>The experience of providing end of life care at a children’s hospice: a qualitative study</td>
<td>Descriptive design Qualitative approach</td>
<td>12 semi-structured individual interviews, lasted between 30 - 45 min, and a focus group interview lasted approximately 60 min. Inductive analysis</td>
<td></td>
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<tr>
<td>Ong K.K, Ting K.C &amp; Chow Y.L. Singapore (2017)</td>
<td>Singapore</td>
<td>10 registered nurses, 8 females and 2 males, from 23 to 42 years, all had 2– 13 years working experience.</td>
<td>The trajectory of experience of critical care nurses in providing end-of-life care: A qualitative descriptive study</td>
<td>Descriptive design Qualitative approach</td>
<td>Purposive sampling. Individual interview, a semistructured interview, lasted between 31 - 77 min. Interview questions were used. Inductive analysis</td>
<td></td>
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<tr>
<td>Ranse k, Yates P &amp; Coyer F. Australia (2012)</td>
<td>Australia</td>
<td>5 registered nurses, all female registered nurses from one hospital.</td>
<td>End-of-life care in the intensive care setting: A descriptive exploratory qualitative study of</td>
<td>Exploratory design Qualitative approach</td>
<td>Semi-structured interview, lasted between 13 to 72 min. Interview questions were used. Inductive analysis</td>
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</tbody>
</table>
Tse K.W & Hung S. U & Pang M.C. China (2016)

Emergency nurses’ perceptions of providing end-of-life care in a Hong Kong emergency department: a qualitative study

Descriptive design
Qualitative approach

16 registered nurses, all had at least 6 months experience in providing end-of-life care in an emergency department

Semi-structured, face-to-face interviews. Interview questions were used.

Inductive analysis

APPNDIX 2

Table 3. Overview of selected articles’ aims and main results

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Study code</th>
<th>Aim</th>
<th>results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grech A, Depares J</td>
<td>a</td>
<td>to explore the experiences of</td>
<td>1. Battling Against Medical Futility</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Abstract</td>
<td></td>
</tr>
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<td>-----------------------------------------------</td>
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</tr>
</tbody>
</table>
| Scerri J Malta (2018)                         | Nurses providing end-of-life care to patients with hematologic malignancies, in a hematology oncology setting, in an acute general hospital. | - Ineffective treatment prevents patients from dying with dignity  
- Ineffective surveys increase patient pain  
- Ineffective communication between doctors and nurses  
2. Struggling With the Emotional Burden of Care (Hospice care often leaves nurses feeling miserable and frustrated in every way) |
| Holmberg B, Hellstrom I & Osterlind J Sweden (2018) | To describe assistant nurses’ perspectives of providing care to older persons at the end of life in a nursing home. | 1. Death a natural part of life (neither reflection nor preparation.)  
2. The older person’s well-being  
- The older person as a person (wish to provide a care characterized by respect for the older persons lived lives and personal needs, with a focus upon their well-being. Helping the older persons to cherish daily enjoyments)  
- Adapt the tempo of care.  
- Having the will but not the ability. (Limitations in staffing forced them to prioritize, resulting in them not always being able to stay close to a dying older person.)  
3. Care in the moment of death  
- A silent care (When death approached, avoid irrelevant conversations.) |
| Johnson S.C & Gray D.P. US(2013) | c to explore nurses’ perspectives on the phenomenon of end-of-life care within the hospital setting. | - A dignified farewell (respect the dead person)  
1. Confronting challenges  
- Experiencing struggle (witness suffering of patients, family members, and fellow team members; provide futile care or treatment; lack of knowledge or skill to address patient care; lack of understanding about complex human interactions; differences in perspectives over care choices or interprofessional team dynamics)  
- Encountering emotional consequences (influence by nurses’ overwhelming sense of “accountability” for patient care outcomes; physical demands of nursing coupled with emotional demands of end-of-life care or conflict can also take a toll upon the nurse)  
2. Coming to understand end-of-life care  
- Opening to learning experiences (Personal experience offered an irrefutable learning opportunity; the vital need for professional education, training, and support)  
- Cultivating insights (As a result of their experiences with dying patients, participants cultivated numerous meaningful yet practical insights)  
3. Transforming the understanding of end-of-life care into nursing practice  
- Making connections (These connections evolved through a genuine interest in details about their patients’ lives)  
- Respecting choice (listening; respect patients’ choices for emotional well-being; respect choices for physical well-being) |
| Kisorio L C & Langley G C. South Africa (2016) | d | Explore intensive care nurses’ experiences of end-of-life care in adult intensive care units. | 1. Difficulties nurse experience (regarding psychological and emotional challenges, it’s painful, touching, traumatic, heartbreaking, depressing, draining, disturbing and stressful.)
2. Discussion and decision making (the nurses would give views and advocate for the patient if necessary.)
3. Support for patients (spiritual leader, ward environment, encouraging families to be present at the patient’s bedside )
4. Support for families(Respecting the patient’s and families’ cultural practices and rituals)
5. Support for nurses (Training, prevent nurses’ being emotionally drained, delegate appropriately and give some time to adjust after death and before the next admission. ) |
| Liu Y.C & Chiang H.H. Taiwan (2017) | e | To elucidates how end-of-life nurses interpret their care experience and how they transform their experience and mindset. | 1. Suffering with
   - Witnessing a patient experiencing a painful death (nurses experience emotional suffering.)
   - The inability to answer questions about death (nurses fear to talk about death in front of dying patients and their families.)
   - Disenfranchised grief (these emotions influence nurses’ inner selves and outer behaviours.)
2. Being authentic |
McConnel T & Porte S. Ireland (2017)  |  
--- |  
**To explore the impact of providing end-of-life care to children on staff within a hospice setting, how they cope, and draw recommendations for improving staff wellbeing, thereby improving the quality of paediatric care for**  

|  |  
|---|---|
|  | **1. Rewarding experiences**  
- Making a difference (support the families, manage their child’s symptoms, and provide individualised care and activities make time become easier.)  
- We’re all in this together (a team work working and sharing experiences together for that child’s benefit.)  

|  | **2. Challenges**  
- Communication with families (afraid of saying the wrong thing)  
- Managing their own grief (nurses couldn’t just keep building grief up and not letting any of that out.)  

|  | **3. Self-illuminating**  
- Detecting hidden personal agendas (arise a nurse’s deep feelings associated with deceased family members.)  
- Separation anxiety from a dying patient (long - term care makes nurses have strong feelings for patients.)  
- Remembering the dead (remembering the dead provide deeper meaning to end-of-life care.)

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|  | **- Preparing for their own death (reflect on death in nurses’ own lives.)**  
- Self-writing (inspire nurses to do something that reflects on their lives)  
- Giving and taking (nurses can be inspired by these experiences.)  

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- Separation anxiety from a dying patient (long - term care makes nurses have strong feelings for patients.)  
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|  |  
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|  | **- Preparing for their own death (reflect on death in nurses’ own lives.)**  
- Self-writing (inspire nurses to do something that reflects on their lives)  
- Giving and taking (nurses can be inspired by these experiences.)  

|  |  
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both children and their families.

3. Recommendations

- Self-care and building resilience (having an outlet outside of work in order to maintain energy for both their work and home life.)
- Peer support (can talk openly with co-workers without worry about being breaking confidentiality.)
- Organisational support – open doors and sticky buns (leadership provide a safe space to share experience.)
- Ongoing education and training in communication skills (learn how to communicate and draw experience from more experienced staff)
- Dissemination of specialist skills and experience

g
To understand the perceptions of critical care nurses towards providing end-of-life care.

1. Culture of care
- The professional perspective (maximum support embodied critical care and end-of-life care was generally only considered after it had been administered; ensure a pain-free and comfortable dying process; maintain the dignity of dying patients; reduce pain and increase comfort for patients; focus on family members’ psychological support; nurses communicate with family members only about the current care plan; nurses translate medical jargon into a simpler language.)
- The family perspective (family members also perceived critical care as maximum support and anticipated curative care.)

2. Tension
- Lack of autonomy (the power imbalance between doctors and nurses; nurse-family communication is restricted.)

- Suboptimality of end-of-life care (end-of-life care has been described as a sensitive subject; lack of time.)

- Under-preparedness (insufficient education initiatives.)

3. Meaning of life and death

- Emotional meaning of life and death (observe the suffering of patients and feel uncomfortable; emotional connection, dramatic reactions from family members and the social context of patients and family members affect nurses’ emotion.)

- Philosophical meaning of life and death (critical care disrupted the notion of comfort at the last phase of life; nurses value quality over quantity of life.)

4. Coming to terms

- Necessity (coping; need to control their emotions.)

- Active coping (seek training and guidance; Share the feelings and experiences)

- Passive coping (enter into a state of passivity)

- Adaptation (develop methods; build rapport;)

| Ranse k, Yates P & Coyer F. | The purpose of this study was to explore the end-of-
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<tr>
<td>h</td>
<td>Beliefs about end-of-life care (the value and the complexity of end-of-life care was not always recognised by their nursing colleagues.)</td>
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</table>
- Emotional intensity (as nurse frequent exposure to grief and suffering, emotional support is needed.)  
- Organisational support (available to guide end-of-life care.)  
- Uncertainty and ambiguity (the uncertainty and ambiguity surrounding patient prognosis and end-of-life decision making in this setting.)  
3. Facilitating end-of-life care  
- Providing comfort care (included bathing, hair care, mouth care, pressure area care, spiritual care, and the administration of analgesics, sedatives and antimucolytics.)  
- Modifying the environment (create an intimate and peaceful setting, and Removing clinical equipment)  
- Facilitating the family’s experience (encouraging the family to sit, talk to and touch the patient.) |
| Tse K.W, Hung S. U & Pang M.C. China (2016) | To understand emergency nurses’ perceptions regarding the provision of end-of-life care in the emergency department. | 1. Doing good for the dying patients  
- Estimating the Duration of Stay and end-of-life Care(avoid controversial and invasive treatment)  
- Promoting Desirable Locations for end-of-life Care( peaceful environment, religious rituals)  
- Providing Comfort and Care to Meet the Needs of end-of-life Patients(using various interventions, such as paregoric, Use drugs effectively )  
2. Facilitating family engagement and involvement |
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<td>4. Expressing ambiguity toward resource deployment.</td>
<td>- Manpower constraint and service priority in an emergency context(insufficient manpower in the emergency department.)</td>
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<td>- Effectiveness of resource utilization in emergency contexts(whether it can provides service to multiple end-of-life patients at one time)</td>
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APPENDIX 3

Table 4. Main findings of selected articles’ result.
<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-cATEGORIES</th>
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<tbody>
<tr>
<td>Challenge</td>
<td>(c1) Confronting challenges</td>
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<tr>
<td></td>
<td>- Experiencing struggle (witness suffering of patients, family members, and fellow team members; provide futile care or treatment; lack of knowledge or skill to address patient care; lack of understanding about complex human interactions; differences in perspectives over care choices or interprofessional team dynamics)</td>
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<tr>
<td></td>
<td>- Encountering emotional consequences (influence by nurses’ overwhelming sense of “accountability” for patient care outcomes; physical demands of nursing coupled with emotional demands of end-of-life care or conflict can also take a toll upon the nurse)</td>
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<tr>
<td></td>
<td>(d5) Support for nurses (Training, prevent nurses’ being emotionally drained, delegate appropriately and give some time to adjust after death and before the next admission. )</td>
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<tr>
<td></td>
<td>(f2) Challenges</td>
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<tr>
<td></td>
<td>- Communication with families (afraid of saying the wrong thing)</td>
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<td></td>
<td>- Managing their own grief(nurses couldn’t just keep building grief up and not letting any of that out.</td>
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<td></td>
<td>- Balancing complex respite care alongside end-of-life care.</td>
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<td></td>
<td>(f3) Recommendations</td>
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<td>- Self-care and building resilience (having an outlet outside of work in order to maintain energy for both their work and home life.)</td>
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- Peer support (can talk openly with co-workers without worry about being breaking confidentiality.)

- Organisational support – open doors and sticky buns (leadership provide a safe space to share experience.)

- Ongoing education and training in communication skills (learn how to communication and draw experience from more experienced staff)

- Dissemination of specialist skills and experience

(g1) Culture of care

- The professional perspective (maximum support embodied critical care and end-of-life care was generally only considered after it had been administered; ensure a pain-free and comfortable dying process; maintain the dignity of dying patients; reduce pain and increase comfort for patients; focus on family members’ psychological support; nurses communicate with family members only about the current care plan; nurses translate medical jargon into a simpler language.)

- The family perspective (family members also perceived critical care as maximum support and anticipated curative care.)

(g4) Coming to terms

- Necessity (coping; need to control their emotions.)

- Active coping (seek training and guidance; Share the feelings and experiences)
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<thead>
<tr>
<th>Dilemma</th>
<th>(a1) Battling Against Medical Futility</th>
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<tbody>
<tr>
<td></td>
<td>- Ineffective treatment prevents patients from dying with dignity</td>
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<td></td>
<td>- Ineffective examinations increase patient pain</td>
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<td></td>
<td>- Ineffective communication between doctors and nurses</td>
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<td></td>
<td>(a2) Struggling With the Emotional Burden of Care(Hospice care often leaves nurses feeling miserable and frustrated in every way)</td>
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<td></td>
<td>(d1) Difficulties nurse experience (regarding psychological and emotional challenges, it’s painful, touching, traumatic, heartbreaking, depressing, draining, disturbing and stressful.)</td>
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<tr>
<td></td>
<td>(e1) Suffering with</td>
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<tr>
<td>- Witnessing a patient experiencing a painful death (nurses experience emotional suffering.)</td>
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<tr>
<td>- The inability to answer questions about death (nurses fear to talk about death in front of dying patients and their families.)</td>
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<tr>
<td>- Disenfranchised grief (these emotions influence nurses’ inner selves and outer behaviours.)</td>
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<tr>
<td>(e2) Being authentic</td>
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<tr>
<td>- Detecting hidden personal agendas (arise a nurse's deep feelings associated with deceased family members.)</td>
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- Effectiveness of resource utilization in emergency contexts (whether it can provide service to multiple end-of-life patients at one time)

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<th>cognition</th>
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<tr>
<th>nursing care</th>
<th>(b1) Death a natural part of life (neither reflection nor preparation.)</th>
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<tbody>
<tr>
<td></td>
<td>(b2) The older person’s well-being</td>
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<td>- The older person as a person (wish to provide a care characterized by respect for the older persons lived lives and personal needs, with a focus upon their well-being. Helping the older persons to cherish daily enjoyments)</td>
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<td></td>
<td>- Adapt the tempo of care.</td>
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</tbody>
</table>
Care in the moment of death
- A silent care (When death approached, avoid irrelevant conversations.)
- A dignified farewell (respect the dead person)

Transforming the understanding of end-of-life care into nursing practice
- Making connections (These connections evolved through a genuine interest in details about their patients’ lives)
- Respecting choice (listening; respect patients’ choices for emotional well-being; respect choices for physical well-being)
- Offering meaningful support (communicating presence, care, and acceptance; responding honestly and compassionately)
- Embracing the work (become more effective in integrating care and achieving meaningful outcomes)

Discussion and decision making (the nurses would give views and advocate for the patient if necessary.)

Support for patients (spiritual leader, ward environment, encouraging families to be present at the patient’s bedside)

Support for families (Respecting the patient’s and families’ cultural practices and rituals)

Facilitating end-of-life care
- Providing comfort care (included bathing, hair care, mouth care, pressure area care, spiritual care, and the administration of analgesics, sedatives and antimucolytics.)

- Modifying the environment (create an intimate and peaceful setting, and Removing clinical equipment)

- Facilitating the family’s experience (encouraging the family to sit, talk to and touch the patient.)

(i1) Doing good for the dying patients

- Estimating the Duration of Stay and end-of-life Care(avoid controversial and invasive treatment)

- Promoting Desirable Locations for end-of-life Care(peaceful environment, religious rituals)

- Providing Comfort and Care to Meet the Needs of end-of-life Patients(using various interventions, such as paregoric, Use drugs effectively)

(i2) Facilitating family engagement and involvement

- Realizing family involvement in choosing intervention options

- Supporting the family in expressing their concern and love to the end-of-life Patient

- Balancing family’s needs and patient’s interests and dignity while dying during the final farewell

rewarding

(c2) Coming to understand end-of-life care
- Opening to learning experiences (Personal experience offered an irrefutable learning opportunity: the vital need for professional education, training, and support)

- Cultivating insights (As a result of their experiences with dying patients, participants cultivated numerous meaningful yet practical insights)

(e3) Self-illuminating
- Preparing for their own death (reflect on death in nurses’ own lives.)
- Self-writing (inspire nurses to do something that reflects on their lives)
- Giving and taking (nurses can be inspired by these experiences.)

(f1) Rewarding experiences
- Making a difference (support the families, manage their child’s symptoms, and provide individualised care and activities make time become easier.)
- We’re all in this together (a team work working and sharing experiences together for that child’s benefit.)

(i3) Enhancing personal growth and professionalism
- Reflecting on the meaning of life and death (death attach to family, make nurses treasure family and life.)
- Revitalizing participants’ passion for nursing as a caring profession