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Coping strategies used by nurses in dealing with patient death and dying

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Description

Nurses are affected by patient death and dying on a regular basis. Nurses, however, encounter challenges to cope with it. Education is one way of preparing nurses to face these challenges. The aim of this study is to present the coping strategies used by nurses in dealing with patient death and dying and to determine which are found most helpful. The purpose of this study is to provide information that can be used as a resource for nursing students at Jyväskylä University of Applied Sciences and that might help facilitate the improvement of the subject in the curriculum.

A literature review was chosen as the method of analysis in this study. The following databases were used to search for and obtain data: Cinahl, Elite, Pubmed and Science Direct in addition to manual search. The sixteen articles which were found were analyzed thematically. Three themes emerged from the reviewed articles: the factors affecting death perception, coping process and examined educational models. Work settings, previous experience and culture were the factors influencing death perception. Distancing was found to be the first strategy sought by nurses, while seeking support from colleagues was the most used. EOLc education that adapted to nursing students' individual needs and their anticipated future work settings was emphasized to be the solution for better preparing these students to deal and cope with patient death and dying.

Miscellanous

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1 Introduction

Nurses deal with patient death and dying and its aftermath on a regular basis, which has a considerable impact on their work and personal life (Gerow, Conejo, Alonzo, Davis, Rodgers & Domian 20110, 122). Resources that better help nurses to deal with patient death and dying are lacking (ibid.; Calleja 2007; Brunelli 2005). Some research suggests that more investigations need to be conducted to acquire a comprehensive picture of how nurses respond to patient death and dying as well as the coping strategies available to help them (ibid., 128).

It is not common to include courses on death and dying in nursing curriculums (Jonas, Simpson, Pilkington, MacDonald & McMahon 2013, 2). Patient death and dying may impact nurses adversely, producing feelings such as depression and guilt (Martins, Chaves & Campos 2014, 172; Gerow, Conejo, Alonzo, Davis, Rodgers & Domian 2010, 123; Shorter & Stayt 2010, 160). Some nurses reported their unpreparedness when dealing with patient death and dying, attributing this to having received insufficient education (Alvaro 2009, 29).

The aim of this study is to present the coping strategies used by nurses in dealing with patient death and dying and to determine which are found most helpful. The purpose of this study is to provide information that can be used as a resource for nursing students at Jyväskylä University of Applied Sciences and that might help facilitate the improvement of the subject in the curriculum. A literature review was chosen as the method of analysis.

2 Death in the context of nursing

2.1 Death and dying

Death is an unavoidable phenomenon. The moment a human being is born, s/he is certain to die. Death may be unpredictable, occurring in the absence of chronic illness or advanced age. (Stillion & Attig 2014, 6-7.)

The definition of death has evolved greatly and can range from the stoppage of the circulatory and respiratory systems to ''brain death,'' which refers to the irreversible cessation of brain function (Zeller 2008, 452). However, the definition of death, of when an organism dies, is still a subject of bioethics. Medical and technological developments have contributed significantly to the prolongation of human life. For instance, the extensive use of life-support machines in the care of critically ill patients was not possible in early medical history. (Thomas 2010, 100, 106.)

It is crucial for nurses to be able to recognize the physical indicators of death when it approaches, since such recognition allows the nurse to provide the best care (Werff, Paans & Nieweg 2012, 143). Some of these indicators are fatigue, pain, breathing difficulties, dyspnea, delirium, confusion and altered gastrointestinal function (ibid., 145,146). However, there are other signs which, although less obvious, might be detectable by experienced nurses, such as withdrawal, refusing food or drink and consistent requests to see family members and beloved ones. (Sahelberg-Blom, Hårsmar & Österlind 2013, 22, 23).

2.2   Nursing the dying patient

Nursing is a profession that deals with humans, thus making patients the essence and focus of practice in nursing (Kim 2015, 21). One of the most important aspects of nursing care is ensuring that a patient's needs are provided for unto death, and that the patient experiences a serene death (ibid., 3).

Health-care professionals previously considered their inability to save a patient's life as a failure. A more comprehensive understanding of what it means to care for an individual across the life-span, however, has since developed, with a focus on ensuring a peaceful death. (Watts 2009, 4, 7.) Palliative care encompasses this principle with a shift from soothing or inhibiting the death of patients to an emphasis on an improvement in the patient's quality of life, a goal which may be attainable through the deterrence and alleviation of distress prior to death. (Philip 2009, 4.) Holistic care is a critical component of nursing. It demands physical, emotional and spiritual presence. It is necessary in order to ensure that the caring process leads to a positive outcome (Dossey, Keegan & Guzzetta 2005, 6).

In providing holistic care nurses go beyond merely tending to the patient's physical needs. Active listening is part of the holistic approach. As described by nurses in the study by Iranmanesh, Häggstörm, Axelsson & Sävenstedt (2009, 246), active listening is silent listening, and developing and demonstrating an awareness of the patients' "situation and wishes," which comforts patients.

2.3   Patient death impact on nurses

Nurses encounter patient death at work regularly (McCourt, Power & Glackin 2013, 510). According to McCourt, Power & Glacking (2013, 510); Goe et al 2013 in United Kingdom (U.K.) '' hospital was the commonest place

of death, with 48% of people with cancer ding in hospital''. Upon the death of a patient, nurses may experience contradictory feelings of sadness, guilt, depression, helplessness, frustration, as well as the need to remain focused on their other patients (Martins, Chaves & Campos 2014, 172; Gerow, Conejo, Alonzo, Davis, Rodgers & Domian 2010, 123; Shorter & Stayt 2010, 160).

Even though patient death is frequently experienced by nurses working in all types of wards in the hospital, for example, palliative care, acute care, surgical ward and elderly care, the effect of patient death on nurses has been studied less than its effect on family members (Gerow et al 2010, 122; Brunelli, 2005; Calleja, 2007).

3   Coping strategies within nursing

The word "cope" can be traced back to the sixteenth century, at which time it meant "a coup, a blow, or the shock of combat." Freud´s writing on defense-mechanisms sparked an interest in coping. Defense-mechanisms associated with the psychoanalytical school of thought are denial, intellectualization, projection and repression. (Lazarus & Lazarus 2005, 53.) It was not, however, until the 1960´s and 1970´s that the concept began to be used in psychological circles, where it referred to the effort surrounding the management of the "stresses of everyday living." (ibid.)

Coping strategies are ways of thinking and behaving adopted to reduce the difficulty experienced in a given situation, whether this difficulty is internal or external (Martins, Chaves & Campos 2014, 177). They have been categorized into two main types: problem-focused coping and emotion-focused coping. An individual using the problem focused coping focuses on what s/he can do to change the undesirable circumstances, while an individual using the

emotion focused coping concerns his/her self solely with managing his/her "emotional distress". In both forms of coping the emphasis is on relief of emotional distress, the difference residing in the method of relieving the distress. Emotion-focused coping strategies, unlike problem-focused coping strategies, do not have as their aim any alteration of the outside environment. Where a problem-focused coping strategy would be used to remove a given stimulus, an emotion-focused coping strategy would be used to change one's response to that stimulus. (Lazarus & Lazarus 2005, 57-58.) In the majority of cases both kinds of strategies are used (ibid., 58).

Utilizing coping strategies may help nurses avoid the exhaustion and depersonalization that may arise as a result of exposure to stress. Nurses encounter many emotionally charged situations, the most intense of which is patient death. (Martins, Chaves & Campos 2014, 177.) Martins, Chaves and Campos (2014, 175) used the following coping strategies in their study of how nurses cope with caring for terminally-ill patients: self-control, seeking social-support, escape/avoidance, planned resolution of the problem, positive re-evaluation, assumed responsibility, confrontational coping and distancing.

The following coping strategies are categorized according to whether they belong to the problem-focused or emotion-focused coping group. Problem-focused coping includes planful problem solving, confrontation and social-support while emotion-focused coping includes distancing, escape/avoidance, self-control, positive reappraisal and accepting responsibilities. (Lim, Bogossian & Ahern 2010, 255.)

3.1 Problem focused coping

Planful problem solving is an intentional effort to analyze and solve the problem (Glidden,Billings & Jobe, 2006, 951; Folkman & Lazarus 1988b). While "Confrontational styles are characterized as being more controlling, competi-

tive and extroverted" (Vedhara, Miles, Wetherell, Dawe, Searle, Tallon, Cullumm, Day, Dayan, Drake, Price, Tarlton, Weinman & Campbell 20110, 1593). Expressions of anger and an unwillingness to adapt are manifestations of this aggressive form of coping, which is more often used by men (Ribiero, Pompeo, Pino, Ribiero 2015, 220, 221). Confrontational styles might be seen as well in "Unwillingness to adapt is an example of not accepting one's environment, which is an element of problem-focused coping strategies" (Lazarus & Lazarus 2005, 57-58). These forms of coping are based on refusing the pain resulted from certain experience and therefore trying to change the environment instead of changing, for example, from the inside.

Social support is generated from human interaction which also considered as a form of problem focused coping. It is sought from friends, family, and co-workers. Social support is seen as a separate component that facilitates coping. (Lin, Probst & Hsu 2010, 2344, 2345.) Seeking support from others presents an active form of finding a solution for a problem.

3.2 Emotion focused coping

Emotion-focused coping strategies are attitude-oriented. They concern themselves with how one feels about a given stimulus. (Lazarus & Lazarus 2005, 57-58.) As such, they are sometimes not even considered to be coping strategies. For example, self-control is considered both a coping strategy and a personality trait which, when possessed, allows an individual to cope more effectively. The more self-control an individual has, the greater his or her ability to defer gratification. (Martin, Chaves & Campos 2014, 175; Boals, van Dellen & Banks 2011, 1049-1050.)

Escape means a disengagement of the problem (Antunes-Alves, Thompson, Kramer & Drapeau 2014, 96). It is associated with wishful thinking and behavior meant to avoid the problem at hand (Glidden, Billings & Jobe 2006,

951). Avoidance can be expressed in a cognitive, behavioral and emotional way. The meanings of avoidance and escape overlapped. Emotional avoidance, like escape, entailed an attempt to evade the painful feelings associated with the event. (Boeschen, Koss, Figuerdo & Coan 2008, 213; Glidden, Billings & Jobe 2006, 951.) The meanings were so similar, in fact, that in Glidden, Koss, Figuerdo and Coan grouped them under one category: Escape-avoidance (ibid.).

Distancing is a distraction oriented form of coping (Nicholls, Polman, Levy & Blackhouse 2008, 1185). By using this coping method one tries to forget the painful event (Bormann & Carrico 2009, 76).

Positive reappraisal is an active coping strategy rather than an avoidant one. As an active coping strategy, it does not incorporate denial of the stressful situation. In addition, positive reappraisal allows the possibility of re-exposing oneself to the same stressor in the future. (Garland, Gaylord & Park 2009, 37, 38.)

Accepting responsibility, another form of emotion focused coping, is admitting one's own contribution to the problem, with the intention of ensuring that things are done in the proper way (Glidden, Billings & Jobe 2006, 951; Folkman & Lazarus 1988b). This means that an individual considers a challenging experience as a result of his/her own actions therefore, s/he takes responsibility of managing it in a way of showing acceptance of having such experience.

4 Death and dying in nursing education

Many studies highlight the importance of education as a means of preparing nurses to deal with patient death and dying. Education of the individual is a "social, moral, cultural and spiritual" endeavor. "It is the development of the

power of adaptation to an ever-changing social environment." (Pachauri 2005, 17.)

One model for end of life care (EOLc) education is the Liverpool pathway. The Liverpool care pathway (LCP) was the first EOLc pathway launched in England with the intention of rendering suitable and evidenced-based management to patients at the last stage of life in a terminal setting. One main aim of the Liverpool pathway is to provide the best individualized care to patients at the terminal stage of life. It was introduced into nursing settings to maximize the quality of EOLc that patients receive, and therefore allowing them to experience an individualized and serene death. (Walker & Reid 2010; Parsons et al. 2012, Stocker & Close 2013; Venkatasalu, Whiting & Cairnduff 2015, 2109.)

Different gaps existed in education for EOLc. One of these was inadequate education for the provision of quality EOLc. Nurses showed an inadequate knowledge of EOLc principles and strategies, therefore adequate EOLc education was needed. Providing quality EOLc education might lead to advancement in the nursing services received by nursing home residents in their EOLc stage. (Whittaker, Kernohan, Hasson, Howard & McLaughlin 2006, 508.) A study done in Iran to examine nursing student's attitudes toward caring for dying patients before and after receiving EOLc education revealed the positive effects of such education (Jafari Rafiei, Nassehi, Soleimani, Arab & Noormohammadi 2015, 193, 194).

Another gap was in the time allotted to the subject in the curriculum. Nursing students were willing to participate in end-of-life education, however, the time given to the subject was insufficient. More extensive EOLc education is necessary if student nurses are to be able to use multiple strategies in the provision of EOLc. (Dickinson 2007, 719-720.)

Educational measures, however, to prepare nurses for death and dying were not universally implemented in nursing studies. Adequate education on "death and dying" was a rarity. The majority of intensive care (ICU) nurses reported that their previous education did not sufficiently equip them with the needed skills related to EOLc despite its necessity in ICU settings. (Alvaro 2009, 29.)

The need to prepare nursing students to deal with death and dying was pointed out by Msiska, Smith and Fawcett (2014, 47). The same issue was discussed by Jafari and his colleagues (2015, 196) with the conclusion that it was necessary to provide undergraduate nursing students with an educational program about EOLc. The study advocated more research testing the benefits of such education (ibid.).

The Canadian Association of Schools of Nursing (CASN) found that palliative care programs in Canada did not offer sufficient hands-on training in EOLc. The CASN intended to try and to integrate "palliative care training into undergraduate nursing programs". (Vogel 2011, 418.)

5   Aims and purposes

The aim of this study is to present the coping strategies used by nurses in dealing with patient death and dying and to determine which are found most helpful. The purpose of this study is to provide information that can be used as a resource for nursing students at Jyväskylä University of Applied Sciences and that might help facilitate the improvement of the subject in the curriculum.

This study involves two research questions:

1. What are the coping strategies used by nurses when dealing with patient death and dying?

2. What recommendations for dealing with patient death and dying are given the greatest emphasis in the research?

6 Implementation of the study

6.1 Literature review

The literature review serves as collector, investigator and interpreter of existing knowledge in specific topic. The literature review in the healthcare sector examines existing knowledge in order to assess the progression of a phenomenon. Furthermore, the literature review serves to generate further research in a particular topic to fill the gap of unanswered questions brought up by previous research. (Saks & Allsop 2007, 33.) Identifying the conceptual and theoretical approaches taken by different authors is the first step in understanding the literature and influences the structure of the report (Machi & McEvoy 2009, 4; Saks & Allsop 2007, 33-34).

Literature review is important because it summarizes the bulk of information available on a specific research topic by integrating and analyzing the information into a complete structure reducing the need of reviewing the sources individually. It helps to provide evidence-based fact that is systematic and can be reviewed in order to provide an academic judgment that is based on all relevant sources rather that a small piece of information. Literature review is also important because it encourages the evolution of new insights by the re-analyses of results obtained in a previous research. (Aveyard 2010, 7-8.) Literature review is also helpful because it ensures that researches about health can be viewed as within its context and differentiated from other researches so that

its impact on health can be systematically evaluated. Reviewing the literature elicits a complete image which may remain unraveled if only one piece of information was to be used (ibid., 10).

In a literature review the reviewer critiques the evolution of the concepts, theories, empirical research, methodology, and methods surrounding a given subject (Jones 2008, 33-34). This critique involves the assessment, analysis and synthesis "of previous research," so as to find its relevance to the present context. The works collected in a literature review should be seen in light of the conceptual and theoretical approach of their authors. (ibid., 34.) The authors have found that the literature review is the most suitable method for achieving the aims of this work.

6.2 Literature search

A systematic approach was needed, and was employed in this study by the use of inclusion and exclusion criteria. Such criteria strengthened the study (Aveyard 2010, 17). The purpose of the inclusion and exclusion criteria is to obtain generalized and relevant articles by narrowing the focus of the search (ibid., 19). Literature met inclusion criteria (table 1) if it was current (2011 to 2016), relevant (answered the research questions), peer reviewed, was written in English and was full-text available via JAMK library. The authors chose the five-year time span as the amount of data that has been produced was great. Articles which did not meet the above inclusion criteria were excluded.

Table 1: Inclusion criteria

Inclusion criteria
Relevant (answer the research questions)

In the time span (2011-2016)
English language
Full text available via library
Peer reviewed

Boolean logic, that is, usage of key words connected by "and," "or" and "not," is commonly used when entering queries into a search engine. (ibid., 41). The following keywords were used in the Boolean-search: palliative, terminal, coping-mechanism, coping-strategy, patient-death, nursing, education and end-of-life-care. As a first step the authors selected the databases CINAHL, Elite, PubMed and Science Direct. The Boolean tools "and", " * " and "or" were used to connect the search engine queries. A total of 16 articles were finally selected for thematic analysis; 14 articles resulted from the search process while 2 articles were selected based on manual search (Appendix 1). After the articles had been selected by title (Table 2), they were filtered based on the words found in their abstracts.

Table 2: search process (Repetitive results were excluded from followed searches)

Keywords	Database	Search results	chosen by title	chosen by abstract	Articles selected
nurs* AND coping strategies OR coping mechanism*	CINAHL	9	7	6	6
	Elite	10	1	1	0

AND palliative care OR end of life care	PubMed	20	2	1	0
	Science Direct	6	1	0	0
nurs* AND educa-tion* AND coping* AND terminal care OR palliative care OR patient death OR end of life care	CINAHL	22	9	9	6
	Elite	20	3	2	2
	PubMed	50	3	2	0
	Science Direct	1	0	0	0
Total number of articles selected through databases					14
Final number of articles selected (+manual search)					16

6.3 Data analysis

Qualitative data analysis intends to create a logical meaning to the bountiful, different and frequently nonnumeric type of data that accumulates in the course of research (Averill 2014; De Chesnay 2014, 1). The purpose of data analysis is to provide a summary of the reviewed literature into sizeable quantity and the clarification of results. Data analysis provides an avenue for the interpretation of findings and gives knowledge on the basis on why a specific type of research gave distinct results from the research obtained from a similar research and how the findings are influenced by the method of data collection. (Aveyard 2010, 124).

Thematic analysis entails finding reappearing themes amongst data, examining classifications of the themes and observing the similarities and differences

that occur between and within these themes (Saks & Allsop 2006, 124). Thematic analysis is a strategy used in the identification, examination and recounting of themes (Braun & Clarke 2006, 79). Conducting thematic analysis has enormous importance for instance, the method of analysis is flexible and can lead to unexpected insights, as well as highlighting the comparison and contrast among data (ibid., 97).

Thematic analysis consists of four steps with the first step being "familiarization with the transcripts" which involves reading and or listening to the data available and providing a summary to it. The second step involves establishing a coding structure. The third step deals with categorizing the main concept of the data into defined codes. The final step in thematic analysis consists of putting the codes that are similar into one group. (Machi & McEvoy 2009, 36; Saks & Allsop 2007, 124; Braun and Clarke 2006, 86.)

Coding means differentiating categories in data and assigning tags and names. It is the initial stage of data analysis and is followed by the establishment of categories and themes. Coding divides data into workable parts. (Gerrish & Lacey 2013, 432; Holloway & Wheeler 2013, 286.) Initial coding, which is also known as open coding, is a type of coding used in thematic analysis and it involves assigning names to a particular set of data and these codes could be in words, expressions or other bulk of data. In search writing, a large number of codes are eventually reduced to represent a concept which denotes a meaning. At the end of the coding process, authors combine the codes that have same meaning into a same phenomenon. (ibid., 287.)
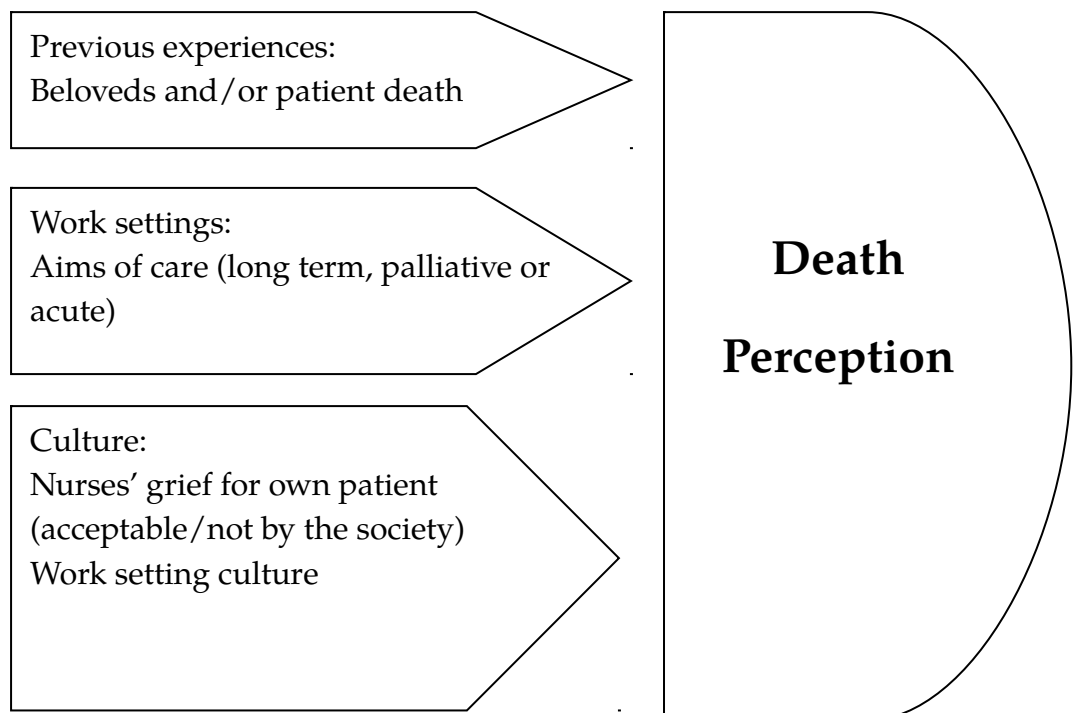
7 Results

Three themes emerged from the analysis of the reviewed articles. The first was the factors which influence death perception, the second was the coping processes used by nurses in dealing with patient death and dying and the third was about the importance of specifically tailoring education in a way which might be most beneficial to the nurse.

7.1 Factors affecting death perception among healthcare professionals

The following sections presented the three factors that were found affecting death perception among nurses (Figure 1).

1. Figure 1: Factors influencing death perception among healthcare staff

Previous experiences:
Beloveds and/or patient death

Work settings:
Aims of care (long term, palliative or acute)

Culture:
Nurses' grief for own patient (acceptable/not by the society)
Work setting culture

Death

Perception

7.1.1 Previous experience

How previous experience influenced death-perception depended on the type
of experience. Some of the early encounters nurses had with patient death be-
came educational, while others became sources of distress.
(Zyga, Malliarou, Lavdaniti, Athanasoupoulou & Sarafis 2011 in Nia, Lehto,
Ebadi & Peyrovi 2015, 5-6.) Providing terminal care was perceived as an edu-
cational experience because it helped nurses to make informed choices con-
cerning the EOLc they would receive. One nurse, for example, in the study
conducted by Mak, Chiang and Chui (2013, 427) referred to how witnessing
invasive procedures used on terminal patients helped her to make the decision
not to allow such procedures to be used on herself or her family. Reflection on
the loss of loved ones might also help to shape perception of death. An in-
stance, in which this might happen is by comparing the "patients' dying pro-
cesses" with that of loved ones (ibid., 427.)

In addition to reflecting on the previous experience of nurses, the amount of
experience has also been found to influence death perception. Junior nurses,
for example, showed less willingness to deal with dying patients (Abdel-
Khalek & Tomas-Sabado 2005 in Nia, Lehto, Ebadi & Peyrovi 2015, 4). In addi-
tion, less work experience was associated with a more negative attitude when
it came to caring for dying patients (Lange, Thom & Kline 2008; Matsui &
Braun 2010; Braun, Gordon & Uziely 2010; Iranmanesh, Dargahi & Ab-
baszadeh 2008 in ibid., 4-5). One reason for the association between less work-
experience and negative attitudes might be that junior nurses were less satis-
fied than senior nurses with what they believed were obstacles to good care
(Mak, Chiang & Chui 2013, 426-427). Such an attitude might have been im-
proved by seeking support from colleagues (ibid., 426).

Unlike the relationship between previous experience and death perception, the relationship between age and death perception was not consistent. Some studies showed a positive correlation between older age and death anxiety, and others a negative one. In one study conducted on palliative care nurses, for example, the nurses who were older demonstrated greater death anxiety. (Halliday & Boughton, 2008 in Nia, Lehto, Ebadi & Peyrovi 2015, 5.) In another study comparing Egyptian and Spanish nurses, younger age was associated with greater death anxiety. (Abdel Khalek & Tomas-Sabado 2005 in Nia, Lehto, Ebadi & Peyrovi 2014, 4.)

7.1.2 Work settings

The impact of death on nurses in an acute-care setting was different from that in a palliative-care setting for two reasons. The first one had to do with the essence of the nursing care provided and the second with the timing of death. The essence of nursing care in an acute care setting is to save lives, while in a palliative care setting it is to provide the patients with comfort and dignity and prepare them for impending death. In the acute care setting, nurses did not have as much time to prepare for patient death, because the trajectory of death tended to be more rapid. In the palliative care setting, on the other hand, the impact of death on nurses had to do with witnessing invasive treatments, while in the long-term care setting it had to do with the relationship built with the elderly patient. (de Araujo, de Silva & Franciso, 2004 in Mak, Chiang & Chui, 2013, 428.)

In a study done on nurses working in an intensive care unit (ICU) in Brazil, success was identified as saving lives (de Araujo, de Silva & Franciso 2004 in Mak, Chiang & Chui 2013, 428). Since, in an acute-care setting patient death had the tendency to be unexpected and sudden, family members might have been more likely to project their anger onto acute care nurses, making acute

care nursing more challenging. Nurses described their emotional responses to patient-death in an acute-care setting as intense, and complained of somatic-symptoms, such as insomnia. Feelings of guilt also arose for what some nurses perceived as their own insensitive behavior. Nurses working in such a setting were required, under time-pressure, to adhere to a strict series of tasks, from which it was difficult to take time out and adopt a more caring, supportive role. Words such as "helplessness," "insufficiency," and "disappointment" were used to described how nurses felt about their ability to comfort the relatives of the recently deceased. (Mak, Chiang & Chui 2013, 425 – 427.)

Despite the potential stress involved in working in an acute-care setting, positive experiences were also reported. These experiences were related to the belief by nurses that they had played a "positive supportive role." Chatting with the patient and fulfilling patient's wishes for "non-routine or exceptional care," were viewed as means of providing positive support. The satisfaction nurses took from the provision of such support seemed to have to do with the belief that they had done their best to provide comfort, dignity and intimacy to the patients and their loved ones. (Mak, Chiang &Chui 2013, 427.)

Unlike palliative-care nurses, nurses working in an acute-care setting may have had difficulty recognizing when to begin providing EOLc (Mak, Chiang & Chui 2013, 429). Adequate time to provide suitable care after realization that the case is terminal tended to contribute to a more positive experience (ibid., 428). In order to become comfortable with providing EOLc, ICU nurses had to challenge their definition of success. More experienced ICU nurses, however, those who have worked many years in the field, understood better when it was appropriate to begin providing EOLc. ICU nurses felt that being in a highly professional team helped facilitate this understanding. (Berlado, Almeida & Bocchi 2015, 708.)

7.1.3 Culture

Culture intersected with previous experience and work setting to help shape how nurses responded to and perceived death. In this study, using the word culture refers to the impact that local differences had on how an individual perceived and responded to death. Instances of the relationship between country and coping style could be seen in the difference between United States (U.S.) and United Kingdom (U.K). Nurses in the UK were unwilling to seek formal support, since they viewed it as implying that they could not handle their emotions. Nurses in the U.S. on the other hand, expressed willingness to use formal support. (McCreight 2004 in Wilson & Kirshbaum 2011, 562.)

Culture also played a role in the coping strategies used by nurses in Hong Kong. There appeared to be a link between avoidance and cultural patterns. (Yang and McIlfatrick, 2001 in Mak, Chiang & Chui 2013, 429.) In a study of acute-care nurses in Hong Kong, avoidance of caring for the dying patient was used by some nurses as a way of bringing one's feelings under control. (Mak, Chiang & Chui 2013, 427). Escaping, another coping strategy employed, was used to prevent unplanned outbursts of emotion, such as crying or appearing overwhelmed in front of the patient or his family. (de araujo et. al 2004 in Mak, Chiang & Chui 2013, 429). Culture, in addition to being a local phenomenon, may also manifest itself within a given profession. Each work setting had its own standard that shaped how health-care staff should express the pain they feel concerning patient death. (Roper & Shapira 2000; Hutshinson 1984 in Wilson & Kirshbaum 2011, 561.)

7.2 Coping process

From a review of the articles it appeared that the types of coping strategy, as well as their uses were related to time and place (Table 3).

Table 3: Coping process and strategies within each section

Coping process	Strategies within each section
1 Distancing	Distancing Compartmentalization
2 Coping strategies at work	Seeking support from colleagues Momentarily regrouping Interchanging tasks Taking short break Using Humor
3 Coping strategies outside work	Seeking support from family members Distancing by taking days off Perceiving death as part of life Religious practice Changing life style or dietary regimen

With respect to time, it was found that distancing tended to be used immediately upon realization by the nurse that the patient was dying. It was the only coping strategy that a nurse could engage in independently. It was also the only coping strategy whose defining feature was when it occurred, as opposed to where or with whom. With respect to place, nurses tended to use certain coping strategies within the work environment and others outside of work. The coping strategies which occurred in relation to time were covered under the first sub-heading, while the coping strategies occurred in relation to place were covered under the second and third sub-heading.

7.2.1   Distancing: the first coping strategy

Distancing was defined as a distraction oriented form of coping (Nicholls, Polman, Levy & Blackhouse 2008, 1185). In using this coping method one tried to forget the painful event (Bormann & Carrico 2009, 76). This method, as reported by nurses, helped them to focus on their work and to care for their patients in a professional manner (Barrere & Durkin 2014, 42). Moreover, it helped nurses to protect themselves from being too involved emotionally with patients and their families (Mak, Chiang & Chui 2013, 427). Compartmentalization, which was also a form of distancing, also occurred as part of a two-step coping strategy. The first step of this coping strategy was compartmentalization, and the second was problem-focused coping. Compartmentalization was used to consciously block the experience of pediatric patient death, only to deal with it later by means of problem-focused coping. (Forster & Hafiz 2015, 296.) Nurses used compartmentalization "in order to maintain a professional outward demeanor, and continue to perform their caring role" (Gerow et al., 2010; Badger, 2005 in ibid).

Distancing was also seen as a quick way to deal with undesirable emotions resulting from the processes of caring for a dying patient. Distancing was described by oncology nurses as something which took place "one minute at a time.'' (Ko & Kiser-Larson 2016, 161.) Switching off might have also been considered a form of distancing. It was defined as not fretting excessively about caring for a dying or deceased patient after the work-day ended. Switching off was believed to improve performance at work. (Tunnah, Jones & Johnstone 2012, 287.) The importance of letting go of the emotion, sadness and intensity of the experience of caring for dying patients was also emphasized, with the caveat that one should let go as much as they can without letting go entirely (Melvin 2012, 609).

Some nurses linked distancing to work experience, explaining that they had learned this distancing only after frequent exposure to death and dying. These nurses perceived distancing as a strategy that a nurse acquired over time and as the primary phase of an effective multi-phase coping strategy. Moreover, they found distancing to be a decision which should be made once a patient´s case was determined by the doctor to be terminal or the Do-Not-Resuscitate (DNR) order was given. (Beraldo, Almeida & Bocchi 2015, 708.)

Distancing was found to be one of the lesser used coping styles by Portuguese nurses in acute care settings. The same study concluded that distancing has a link to using self-control, which was found to be the most used coping style amongst the nurses in the same study. (Laranejeira 2011, 1759-1760.) Self-control is the capacity of the nurse to direct and frame her emotions and is associated with lower death anxiety (Aradilla-Herrero, Tomás-Sábado & Gómez-Benito 2012 in Nia, Lehto, Ebadi & Peyrovi 2015, 5).

7.2.2 Coping strategies used in workplace

The most prevalent coping strategy used by nurses at work was seeking support from colleagues. One reason why nurses sought support from their colleagues was due to their shared experience of patient death and dying (Barrere & Durkin dying 2015, 42; Forster & Hafiz 2015, 295; Hildebrandt 2012, 604). Examples of support from colleagues were chatting with colleagues, sharing one's feelings over the lunch hour, as well as "mixing" with colleagues in the department (Tunnah Jones & Johnstone 2012, 288). Most support sought was informal support, which entailed sharing feelings with colleagues (Barrere & Durkin 2015, 42). Peer support was another term used in the reviewed articles to refer to seeking support from colleagues (Forster & Hafiz 2015, 295; Macpherson 2008 in Hildebrandt 2012, 604).

Support provided by colleagues was seen by nurses as a way of improving both the well-being of professionals and their job satisfaction (Wilson & Kirshbaum 2011, 562). Nurses described the value of support from colleagues as helping them to find emotional balance or "locate themselves" (Harris, Flowers & Noble 2011, 10). For example, in a study done on nurses working with terminal hemorrhage patients, all the participants sought support from colleagues (ibid., 10). Along similar lines, most oncology nurses used support as a way to cope with workload and death and dying (Ko & Kiser-Larson 2016, 161). Similar findings were reported by Forster and Hafiz (2015, 295) and Hildebrandt (2012, 604).

In a study done by Mak, Chiang and Chui (2013, 428), acute care nurses in China found that sharing with colleagues and supporting each other with "positive words" was helpful. Seeking support from colleagues was reported to be a temporary relief from stress at work in the study conducted by Barrere and Durkin (2014, 42) where the authors examined the experiences of newly graduated nurses one year after their participation in the End-of-life Nursing Education Consortium (ELNEC). Nursing students found it beneficial to seek such support, as Edo-Gual, Tomás-Sábado Bardallo-Porras and Monfte-Royo (2014, 3506-3507) reported in their study. Laranjeira (2011, 1759) reported that seeking support from colleagues was the third-most-used coping strategy of Portuguese nurses.

Some of the reviewed articles highlighted the benefits of seeking support from experienced staff. This benefit was obtained not only by sharing experiences and emotions, but also by working within a more experienced team. This type of coping was seen to be of great benefit for nursing students in their clinical practice (Edo-Gual, Tomás-Sábado, Bardallo-Porras & Monforte-Royo 2014, 3506). A similar impression was stated by Fessick (2007) in Wilson & Kirshbaum (2011, 562), where oncology staff attended an educational session dur-

ing a retreat conducted by participants in the same field. This type of retreat had the corollary benefit of strengthening intra-professional relationships. From a different angle, ICU nurses perceived working with experienced staff as a form of support in the Berlado, de Almeida and Bocchi study (2015, 708).

Support provided by colleagues may have had harmful effects as well. The "shock and devastation" felt at the death of a pediatric patient, for example, might have been intensified by "sharing and recounting the experience". In another word sharing many times the sad and painful experience related to the death of a pediatric patient might as well bring up the feelings resulted earlier from that exact experience. (Forster & Hafiz 2015, 295.) Support from colleagues sometimes actually increased the stress level of nurses whose stress levels were already high (Button 2008 in ibid.).

Another type of support was formal support, which was provided by the institution itself. Chaplain services (religious-based services) and the services provided by healthcare institutions, for instance, have been found to reduce stress. (Ko & Kiser-Larson 2016, 162.) In the study conducted by Harris, Flowers and Noble (2011, 10) most of the peer support took place informally, as situations arose, as opposed to unstructured debriefing sessions. Although nurses expressed a desire for formal support, it was not widely available, and its inclusion into the workplace was thus recommended by the authors of some of the reviewed articles (ibid.).

Planful problem solving was the second-most used coping strategy among both oncology nurses in the Ko & Kiser-Larson (2016, 161) study and Portuguese nurses working in acute-care in the Laranjeira (2011, 1759) study. In the latter study, planful problem solving was understood to be the use of both problem solving and planning to maintain control in otherwise difficult situations (ibid., 1760). The depiction of planful problem solving was consistent with that of the study conducted by Harris, Flowers and Noble (2011, 10.) on

how nurses coped with terminal hemorrhage patients. Planful problem solving was understood as planning on how to handle the situation properly. In the case of terminal hemorrhages, for example, this took the form of "prior planning and discussion" of who would be responsible for what procedure when a terminal hemorrhage occurred (ibid.). Rotating assignments, which entailed changing the responsibilities of the staff at intervals to lessen the time that a given nurse had to spend with dying patients, was another form of planful problem solving (Barrere & Durkin 2014, 42).

In addition to coping strategies which aimed to change the situation or seek support from others, another coping strategy used in the workplace was the avoidance of painful stimuli. Momentarily regrouping was a form of escape which nurses used to temporarily disengage from the problem. It involved taking a short break in a private place, such as a bathroom, to decompress. (Barerre & Durkin 2014, 42.) Another form of escape was leaving the workplace altogether. One nurse in the study conducted by Melvin (2012, 608) left palliative care to protect themselves from being consumed by the pain of caring for dying patients.

Not only did nurses cope by taking action, they also attempted to change the way they responded emotionally to the world around them. Using humor was one example of this. Humor was found to be helpful for oncology nurses and seen as a resource for relaxation. (Ko & Kiser-Larson 2016, 161.) Also ''Gallows humor'' was used by nurses as a quick coping strategy to lighten the drama involved in the care of dying patients, in the Barrere & Durkin (2014, 42) study.

7.2.3   Coping strategies used outside of the workplace

Support, the most prevalent coping strategy, was also sought outside of the workplace. Spouses and supportive partners were specifically mentioned.

From the articles reviewed a picture emerged of the supportive role of the family. While support from colleagues often consisted of sharing similar experiences, family members played the role of confidants by listening to the concerns of the nurses. (Ko & Kiser-Larson 2016, 161; Forster & Hafiz, 295; Barrere & Durkin 2015, 42; Tunnah, Jones & Johnstone 2012, 288.)

As with support, distancing was used inside and outside of the workplace. It was a useful tool in the mitigation of suffering of nurses after being exposed to patient death. One way in which distancing might have been used outside of the workplace was in the nurse's attempt to create a calm environment in which he or she could do enjoyable things. Enjoyable things were going on holiday or taking days off work, "watching television, listening to music and attending craft lessons." (Mak, Chiang & Chui 2013, 428; Tunnah, Jones & Johnstone 2012, 287.) For example, one acute care nurse stated that she went on holiday to distance herself from her job, citing this method as a way of helping her to recuperate. (Mak, Chiang & Chui study 2013, 428.) While planful problem solving coping strategy outside of the work extended beyond recreation, it also included adhering to a healthy dietary regimen, and maintaining a healthy lifestyle (Ko & Kiser-Larson 2016, 161; Tunnah, Jones & Johnstone 2012, 287).

Normalizing and accepting death and religious practice are cognitive processes that might take place over extended periods of time, and therefore are not strictly tied to the workplace. Normalizing and accepting death and dying was referred to as a way of being "realistic and rational" by seeing death as part of life. (Ko & Kiser-Larson 2016, 161; Mak, Chiang & Chui study 2013, 428.) Moreover, nursing students, through the normalization and acceptance of death, were inspired to make the decision to live a more fulfilled life, as reported by Edo-Gual, Tomás-Sábado, Bardallo-Porras and Monforte-Royo

(2014, 3506) in their study on death anxiety amongst Egyptian and Spanish nursing students.

Religious practice was seen as a source of power, giving nurses the strength to continue caring for dying patients, as expressed by a nurse in the study conducted by Mak, Chiang & Chui (2013, 428). Oncology nurses used prayer as a means of self-care. (Ko & Kiser-Larson 2016, 161). In addition to expressions of organized religion, relying on spiritual beliefs and emphasizing the positive were some of the ways that health professionals coped with the death of a pediatric patient (Forster & Hafiz 2015, 295).

7.3   End of life care education and examined models

This chapter endeavored to cover the different educational programs presented in the reviewed articles, as well as the impact of those programs on participating nursing students, programs not only different in structure, but in how effective they were judged to be by the nursing students. In order to be prepared to deliver EOLc, nurses should be equipped with both clinical skills and adequate coping strategies.

The presence or absence of education might be one of the keys to determining whether a particular experience with death was harmful or beneficial to the nurse. For example, the more palliative care experience nurses had, the less anxious about death they tended to be. (Zyga, Malliarou, Lavdaniti et. al 2011 in Nia, Lehto, Ebadi & Peyrovi 2015, 5-6.)

In a study done by Venkatasalu, Kelleher and Hua Shao (2015, 182-183) education in the form of simulation was found to be helpful in various ways. For example, it helped nursing students to respond to the dying patient with appropriate nursing techniques, such as documentation and communication. It also seemed to increase their confidence, reduce anxiety and contribute to emo-

tional preparedness. In the opinion of one nursing student, however, a seminar-based discussion carried out with her personal tutor might have been of greater benefit when it came to being emotionally prepared (Venkatasalu, Kelleher & Hua Shao 2015, 183.) Simulation did not give students a good idea of what it would be like to actually encounter patient death. A previous study also found that the setting of the simulation was not reflective of what nursing students would encounter as nurses in real life and thus was not beneficial to them (Leavy, Vanderhoff & Ravert 2011,9).

A similar opinion emerged from the Barrere and Durkin (2014, 41) study, that only by experiencing the actual situation itself would they come to understand the meaning of caring for a dying patient. While the simulation method did not adequately capture the reality of death, imagining that one's death was imminent gave the nursing students a glimpse of the potential grief and suffering associated with death. The nursing students in the workshop conducted by Liu, Su, Chen, Chiang, Wang and Tzeng (2011, 859-860) reported positive results, which might have had to do with the student's own hypothetical death being subject of the workshop. The workshop consisted of three steps: writing a goodbye letter, writing one's own epitaph and a group discussion (ibid., 858). Imagination and reflective activities represented good opportunities for participants to recognize emotions, acknowledge them as normal and share them, all of which helped them deal with death and dying (ibid., 859-860).

An EOLc education which was general might not meet the needs of the nursing students. Moreover, educational programs were criticized for leaning too h eavily on theory and for inadequately addressing the specific difficulties encountered in certain nursing specialties (Harris, Flowers & Nobel 2011, 11). For example, according to the nurses from Harris, Flowers and Nobel (2011, 11) study, while some received palliative care education, they did not receive any

education on to cope with the chaos of terminal hemorrhage. The topic of terminal haemorrhages did arise in the course of their studies, but it was not in conjunction with how to cope with such an experience. Conte (2011); Brown & Wood (2009) in Hildebrandt (2012, 604) did not only emphasize on the importance of EOLc education's contents, but also drew attention to the need of continually updating the oncology nurses' EOLc skills.

Understanding how nurses responded to death was one of the requisites to build an educational program that ensures quality care for dying patients. An educational program that might help in molding nurses' perceptions about death could be an effective way of reducing death anxiety, thus improving the care received by dying patients. A review of the studies revealed the importance of including within death and dying education the following components: self-care and support seeking, effective coping, EOLc legislation and communication with the dying patient. Although all the educational styles examined within the reviewed articles incorporated a theoretical aspect, a reduction in death anxiety appeared to be more closely related to non-theoretical components, such as interactive activities, discussion sessions as well as less-traditional approaches, for example, art therapy. (King & Lee 2014;
S Potash, Hy Ho, Chan et al. 2014; Claxaton-Oldfield, Crain & Claxaton-Old-field 2007; Mooney 2005; Hegedus, Zana & Szabó 2008 in Nia, Lehto Ebadi & Peyrovi 2015, 6.)

8   Discussion

8.1   Ethical consideration, validity and reliability

The standards which should guide research if it is to be ethical are as follows: consent of participants, safety of participants, participants' right to withdraw,

transparency of findings and social responsibility (Furseth & Everett 2013, 15). The standards of consent, safety and right of withdrawal of participants, transparency of findings and social responsibility were all met in the articles reviewed in this study. Transparency in this case means making "the results of...research known." (ibid.). The norm of social responsibility implies that the research should "benefit society, either directly or indirectly" (ibid., 10). The authors, in publishing their study in the JAMK library data-base, are making their results known to the JAMK students and JAMK staff.

Reliability implies that the same findings will be obtained when the same methods are used to analyze the same studies (Saks & Allsop 2007, 179-180). It is concerned with the trustworthiness of the data collected and the thoroughness of the collection process (Furseth & Everett 2013, 108). Triangulation is one way of testing for reliability. Triangulation is gathering data from various sources which are concerned with the same issue. (Greetham 2014, 194.) Moreover inclusion and exclusion criteria strengthen the study (Aveyard 2010, 17). In this study the criteria of triangulation was fulfilled in that various databases were used to gather adequate and current information to answer the research questions.

Another way of testing for reliability is through the continual process of analysis and interpretation (ibid.). In this study findings and interpretations were double checked. The purpose behind this was to help the authors of this study distinguish their thoughts from the thoughts of the authors of the reviewed articles and therefore avoid plagiarism. This also prevented misinterpretation, fabrication and falsification of data. Clear use of in text citation was also used to avoid plagiarism. (ibid., 356.) The research process was also made explicit to make it easier to repeat the research and verify the findings. Moreover, the opinions of the authors in the reviewed articles were presented accurately and the data gathered were not misrepresented.

In order for data to be considered valid they should serve to answer the questions posed by the researchers (Furseth & Everett 2013, 109). For research to be considered valid the tools of analysis should be suitable for analyzing the data in question (Saks & Allsop 2007, 180). Validity is also correlated with credibility. Credibility is affected by many factors:" research methods used, findings and outcomes of research, the reputation of researchers, the status of the funding body and the peer review process." (ibid., 306.) The themes of the results in this study were not predefined, but rather emerged during the analysis of the material. This resulted in the data being consistent with the questions posed. The method of research, data collection and analyzing were thoroughly presented in addition to assisted information tables which render the study as possible as valid and credible.

The limitations of the study were that the articles used were all in English and only free full access articles obtained from the JAMK library. In addition, a narrow spectrum of countries was covered. The reviewed articles were done in nine different countries: U.S. (5), U.K. (4), Brazil (1), Spain (1), Australia (1), Portugal (1), Taiwan (1), China (1) and Iran (1). Covering such a small portion of the world, the results obtained do not represent a global view.

8.2   Discussion of the study results

The aim of this study was to, through a review of the literature, discover the coping strategies used by nurses in dealing with patient death and dying. This was to contribute to the resources available for nursing students at Jyväskylä University of Applied Sciences. The study was done with the goal of attracting attention of the JAMK nursing school to the importance of proper education regarding coping with death and dying, thus enriching the content of the subject in the curriculum.

The previous experiences of nurses caring for dying patients was considered to have an impact on them in various ways, for example, on how they reflected on their own death or the death of their loved ones or their willingness to care for dying patients. Moreover, experience caring for the dying patient might have caused distress, or it might have been educational. The relationship between the quantity of experience and the attitude of the nurse was somewhat clear, but the relationship between the kind of experience and attitude of the nurse remained unexplored. (Abdel-Khalek & Tomas-Sabado 2005 in Nia, Lehto, Ebadi & Peyrovi 2015, 4.) It appeared that the kind of experience had some effect on the nurse. For example, witnessing invasive procedures performed on dying patients might have made nurses reconsider permitting such procedures to be used on themselves or their loved ones. The relationships between previous experience of caring for dying patients and the distress felt by a nurse were less clear. Some experiences were sources of distress, but the degree to which that distress was determined by the personality and attitude of the nurse, as opposed to some pattern of experience, remained to be answered. (Zyga, Malliarou, Lavdaniti, Athanasoupilou & Sarafis 2011 in Nia, Lehto, Ebadi & Peyrovi 2015, 5-6.)

Work-setting helped to determine the nurse-patient relationship as well as whether the nurse would have sufficient time to prepare for patient death. The nurse-patient relationships found in palliative-care settings, for example, tended to be more intimate than those in acute-care settings, which were short and impersonal. The reason that patient death and dying had an impact on nurses in home care settings was because nurses had the opportunity to establish a relationship with their patients in such settings (Marcella & Kelley 2015, 9). There came a time in the care of a dying patient when adequate care ceased to be preservation of life and became provision of comfort. Whether a nurse had the opportunity to make the transition from providing care to preserve

life into provision of comfort depended, at least in part, on the setting in which s/he worked.

Culture, as it appeared in the reviewed articles, seemed to be an international and intra-professional phenomenon. International in the sense that nurses in different countries had different preferences when it came to coping strategies, and intra-professional in the sense that within the nursing profession itself, work-setting seemed to help determine what expressions of grief were considered appropriate. (Roper & Shapira 2000; Hutshinson 1984 in Mak, Chiang & Chui 2013, 427-429; de Araujo et. al 2004; Yang & McIlfatrick, 2001; Wilson and Kirshbaum 2011, 561.)

The results showed that distancing was described by the nurses from the different articles in different terms. Although caring for the dying patient required emotional engagement, nurses still needed to protect their own emotions. Timing was of particular importance in the use of distancing. The reason was that distancing seemed to be especially effective in balancing one's emotions and maintaining professionalism, both of which were important to nursing dying patients. The role of distancing in protecting one's emotions and behaving professionally was emphasized by Ingebretsen and Sagbakken (2016, 5). Distancing was also used regardless of timing and work environment, however more emphasis was given to its importance once a nurse encountered patient death and dying.

The results revealed that the most commonly used coping strategy was seeking support from colleagues. Nurses not only received emotional support when they sought support from colleagues, but also acquired new knowledge and skills related to practical management of caring for dying patient. While certain coping strategies could be said to exist either inside or outside of the workplace, others were more difficult to categorize, such as religion and the

normalization of death. (Ko & Kiser-Larson 2016, 161; Mak, Chiang & Chui study 2013, 428.)

Coping strategies used in the workplace were seeking support, planful problem solving, avoidance, escape and using humor. Nurses sharing the same experience and same work environment might have been the reason behind the fact that seeking support was the most used coping strategy. Perhaps, support from colleagues was the most used because nurses could better empathize with other nurses when it came to caring for dying patients. Moreover, sharing experiences might have resulted in gaining new knowledge and skills. Nevertheless, this type of coping strategy might have had harmful effects. For example, the individual from whom a nurse sought support might have perceived death differently, thus erecting barriers to the shared experience. In doing so a nurse might have inadvertently harmed one of his or her colleagues by talking about how s/he felt about patient death. Thus, sharing experiences about death and dying among nurses should be done carefully, respecting different points of view.

Similar coping strategies occurred inside and outside of the workplace. The forms they took, however, were different. Family, for example, like nursing colleagues, participated in the coping process by offering support, but the way in which they provided support was different. Unable to share similar experiences, the value of a family member resided in his or her willingness to listen. (Ko & Kiser-Larson 2016, 161; Forster& Hafiz, 295; Tunnah, Jones & Johnstone 2012, 288, Barrere & Durkin 2015, 42). Among the various types of religious coping strategies, praying was found to be the most commonly used in the study done by Ekedahl and Wengström (2010, 535). This finding helped illuminate why it was the only religious practice encountered within the reviewed articles.

As important as theoretical knowledge of EOLc was, it could not substitute knowledge based on real-life experience developed over time. Abstract or hypothetical understanding might have had its merit, but only in a real-life situation were nurses able to develop the skills needed in EOLc. Simulation was not able to capture the range of emotions that were usually felt by the dying person and his or her relatives. The purpose of simulation education was to improve performance or clinical competency (Waldner & Olson, 2007, 4). Moreover, it was the termination of real life that triggered actual reactions from nurses.

Data from the research above indicated that adequate EOLc training required a very broad-based skill acquisition, including both theoretical and real-life experience. Although practical experience could be gained on the job, acquiring it during the nursing training and under the supervision of a more experienced nurse facilitated the learning process. The nurses involved in this supervision should be well informed on the specific aspects of the training, including precise coping strategies.

This kind of diversified training seemed not only to contribute to the provision of adequate EOLc, but also to improve the psychological wellbeing of the nurses. The educational models in the reviewed articles represented different approaches in dealing with death and dying. In addition, according to Carlson, Wann-Hansson and Pilhammar (2009, 525) the differences between students should be taken into consideration.

8.3 Conclusion and recommendations

Nurses who shared the same experience were at an advantage when it came to understanding one another. Support from colleagues not only helped emotionally but was also a means of enhancing nursing skills and knowledge. When coping with patient death and dying, distancing was the most readily

used strategy to protect oneself emotionally. Since EOLc education based solely on theory was considered insufficient, there was a need to include practical approaches.

The authors recommended that education should take into consideration students' own perception about death and dying, previous experiences and their future work-settings to better equip them to deal and cope with patient death and dying.

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Appendix 1

Author, date & place	Aims	Methodology, Data collection and analysis	Key results
Barrere, C. & Durkin, A. 2014 United States	to explore the lived experiences of recent graduates who received ELNEC education content in their nursing programs and who cared for a dying patient within the first year of clinical practice.	Qualitative: Phenomenological descriptive methodology. Open ended semi structured questions were used, thematic analysis	Four themes emerged: facilitating a good death, realizing intrinsic rewards, learning through impressionable experiences, and maintaining balance
Berlado, L. M., de Almeida, D. V. & Bocchi, S. C. M. 2015 Brazil	to understand nurse technicians' experience with caring for the death of terminal patients in ICUs and to configure a theoretical model	Qualitative study with theoretical saturation when analyzing the 10th non-directive interview. analysis following the methodological reference steps of the Data Grounded Theory.	the acceptance of death as a therapeutic and intervenient component - emerged from the comparison of the Sub-processes: when the nurse does not feel prepared for caring for death, accepting death as a therapeutic phenomenon and developing coping strategies.
Edo-Gual, M., Tomas-Sabado. J., Bardallo-Porras, D., Monforte-Royo, C. 2014. Spain	To explore nursing students' experiences of death and dying in clinical practice.	Qualitative Semi-structured interviews and analyzed using Colaizzi's seven-step procedure.	The central theme was the enormous impact the encounter with death had, while the other themes were a response to and/or modulators of this impact.
Forster, E. & Hafiz, A. 2015. Australia	Examine the perceptions of health professionals regarding bereavement support	Qualitative 10 Interviewed participants (doctors, nurses and social-	Education and clinical simulation may help prepare health-professionals cope with feelings of loss

	concerning the pediatric-patient death	workers). Thematic analysis	experienced when caring for dying children. These coping skills are developed by most health-professionals through their own experience.
Harris, D.G., Flowers, S., Noble, S.IR. 2011. South West Wales. United Kingdom	To examine and consider both the coping strategies and support mechanisms that nurse's use in managing terminal haemorrhages.	Qualitative analysis 11 nurses Nurse's working in the fields of palliative care and oncology were recruited by means of purposive sampling. Interpretative phenomenological analysis was used to analyze data.	Despite the potential trauma of witnessing a terminal haemorrhage, there were some positive aspects to the experience. These had to do with the value of peer support, and the usefulness of going on subconscious autopilot.
Hildenbrandt, L. 2012. United States of America	Through the identification of coping strategies motivate nurses to participate in grief resolution	Literature review Search conducted using CINAHL, MEDLINE, and pubmed. Thematic analysis.	Limited number of articles. Emphasis on the experience of pediatric oncology nurses (pediatric oncology nurses experiencing additional stressors)
Ko, W., Kiser-Larson, N. 2016. United states of America	To identify stress levels and stressful factors of Nurses working in Oncology staff nurses in outpatient units.	Descriptive, cross-sectional design 40 Participants and analyzed using descriptive statistical analyses.	The three most frequently used coping behaviors were verbalizing, exercising or relaxing, and taking time for self.
Laranjeira, A.C. 2011. Portugal	To clarify the association between perceived stress in work and the types of coping strategies used by Portuguese Nurses	Descriptive correlational design 102 registered Nurses analyzed using Statistical Product and Service Solutions for Windows version 15	The most frequently used coping strategy was self-controlling, Planful problem solving, distancing and escape-avoidance, indicating that those who were more distressed showed lower levels in mentioned coping subscales.
Leavy, D.J., Van-	To assess students views on the benefits	Qualitative 176 Nursing stu-	Participants wished for longer debriefing time.

derhoff, C. J., Ravert, K.P. 2011. United States	of participating in stimulated codes scenerios in which a patient dies and the effectiveness of the debriefing sessions and processing emotios related to the laboratory experience	dents Six-item survey data collection and analyzed using descriptive statistics.	-Simulation did not feel like real-life situation. Participants felt prepared for critical care.
Liu,Y. C. , Su, P.Y., Chen, C. H., Chiang, H. H., Wang, K. Y. & Tzeng, W. C. 2011 Taiwan	set up a workshop to allow both students and faculty to explore students' beliefs and perceptions of life and death and to improve nursing curriculum design at a university in Taiwan.	Interpretive qualitative methodology used, 20 nursing students participated in a workshop, reflective sessions Thematic analysis	Students can learn their fear of death and possible emotional reactions towards dying patients through self reflection during a workshop on life-and-death issues
Mak,Y. W., Chiang, V. C. L. & Chui, W. T. 2013 China	aimed to explore the experiences and perceptions of nurses caring for dying patients and their families in the acute medical admission setting	A qualitative interpretive descriptive methodology was used to explore the experiences and perceptions of 15 nurses recruited via purposive sampling from three acute medical wards of a hospital in Hong Kong. Semi-structured interview and thematic analysis	Four themes were derived from the findings: lack of preparedness for patients' deaths, reflecting on their own nursing roles for dying patients, reflecting on the meaning of death and their personal experiences of the death of their own family members, and coping with caring for dying patients
Melvin, C.S. 2012. United States of America	To examine the pervasiveness of compassion fatigue in hospice and palliative care nurses, its consequence, as well as the coping strategies used by hospice and	Descriptive qualitative 6 nurses Semi-structured interviews Thematic analysis	Healthy coping strategies, including boundary setting, were used by nurses to improve their experiences in the workplace. By learning more about professional compassion fatigue, nurses become bet-

	palliative nurses.		ter at identifying it in themselves and therefore more prepared to take action.
Nia, H. M., Lehto, R. H., Ebadi, A. & Peyrovi, H. 2015 Iran	To study death anxiety and how healthcare professionals deal with it putting into account the cultural aspect.	A literature review using CINAHL, ScienceDirect, PubMed and PsychInfo, articles from 2000 in English amongst 38 were chosen. Inclusion and exclusion criteria were used, quantitative studies and qualitative were chosen and reviewed by two authors.	Shedding the light on the quality of death education in relation to death anxiety level among nurses.
Tunnah, K., Jones, A.,Johnstone, R. 2012. North West Wales. United Kingdom	Exploration of the feelings and experiences of home-hospice nurses and identification of key stressors	Qualitative. Ten hospice at home nurses and one nursing assistant. Semi-structured interview which lasted 45 minutes at maximum.	Researchers "encouraged the use of clinical supervision, attendance at multidisciplinary meetings, stress awareness training and raising awareness of the role of hospice at home nurses in primary care."
Venkatasalu, M.R., Kelleher, M., Hua Shao, C. 2015. United Kingdom	The design and implementation of high-fidelity simulation teaching, as well as the assessment of its effectiveness on first year nursing students experiencing their first patient death, compared to the effectiveness of classroom-based end-of-life care teaching.	Qualitative 12 first-year nursing students interviewed. Qualitative phenomenography. Data analyzed using framework analysis.	Classroom based EoLC and simulation-based EoLC were both considered helpful in that they both increased students' knowledge. When it came to improving practical skills and a better emotional experience, however, EoLC was more effective.
Wilson, J. & Kirsh-	Investigate how patient death affect	A literature review using CINAHL,	Themes arising from the literature review included:

baum, M. 2011 United Kingdom	nurses in hospital environment	Medline and PyschInfo, articles in English and no limitation on date, amongst 17 were chosen Thematic analysis	the theoretical context; the emotional impact; the culture of the healthcare setting; staff 's previous life experiences; and support available for healthcare staff.