Stress and Coping Methods of Nurses

Caring for Dying Patients- A literature Review

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Abstract:

As the population ages and the increasing number of diseases, the need for Palliative Care also increases. Nurses play an important role in caring for palliative care patients to enjoy longer quality life or hospice patients whose lives nearing death. Their role is challenging. Similar to emergency rooms and internal medicine wards, they face distress, and the role takes a toll on them. Factors that affect nurses at work are the results of patients' death and dying as well as how they perceive death. These hinder them to cope with their professional demand but with correct coping methods, level of death anxiety decreases and performance in palliative care improves. This literature review suggests that coping strategies can be used by both healthcare professionals dealing with palliative care patients.

The literature review is composed of thirty (30) articles published from 2013-2023 from three different scientific databases. These peer reviewed articles studied different coping methods of nurses dealing with palliative care. CINAHL and Science Direct provided most of the articles used followed by PubMed.

Keywords: coping methods, end-of-life care, oncology, palliative care, hospice care

Contents

1. Introduction

According to the World Health Organization, the aging population, and the rising number of diseases either non-transmissible or transmissible, the need for palliative care constantly grows. Yearly, an estimated 56.8 million people need palliative care being 25,7 million people are in their end-of-life. WHO further states that palliative care and, by extension, hospice care is a multi-professional care industry whose aim is to support dying patients and their family. Through this, admissions to hospitals and health care facilities are decreased. *In health care professional teams, there are physicians, nurses, support workers, paramedics, pharmacists, physiotherapists and even volunteers* (World Health Organization [WHO], 2020).

Hospice care comes from the word "*hospes"* meaning "a guest travelling or a host for travelers". In the 11th century, crusaders were believed to have provided places for people with incurable diseases. In 1967, Cicely Saunders, a British nurse and social worker developed the first modern hospice. She pioneered the principles of today's hospice care which include *(1) the concept of "total pain," - physical, spiritual, and psychological discomfort; (2) the proper use of opioids for patients with physical pain; and (3) attention to the needs of family members and friends who provide care for the dying*. Few years later, Balfour Mound, a doctor from Canada first used the word "palliative care" in relation to providing treatments with the purpose of relieving symptoms. It comes from Latin word *"palliare"* meaning "to cloak or cover up" symptoms without curing it. Both Palliative and hospice care are interrelated. Hospice being a part of a wider approach in managing symptoms known as Palliative Care.

2. Background

Palliative care improves the quality of life of patients and their families that suffer from life-threatening diseases. This approach prevents and relieves suffering of patients from life-threatening illnesses. Palliative care approach includes early identification, correct assessment and treatment of pain and other problems to relieve the pressure of these patients and their families. This can be physical, psychosocial, or even spiritual. The caring process goes beyond the care of the physical symptoms. This approach is person- centered care provided by integrated health services. They work as a team to support patients and their families. With this integrated health care approach practical needs such as psychosocial needs are addressed and, if needed, patients and their families get the best care they need for their active life until the end of life. (World Health Organization [WHO], 2020).

The World Health Organization (WHO) recognizes palliative care as a human right to health. The National Institute of Aging (2021) describes palliative care as a meaning of enhancing a person's actual care and doing so refocuses the care on the quality of life for the person itself and their families. The palliative care patient receives specialized care for their symptoms from the disease they suffer from, or they receive it alongside their current treatment path.

Hospice care is an option that a patient can choose at the end of life because the illness of a person is so severe, or the patient chooses not to undergo treatment. Hospice care has increased as an option if the patient is at the end of life. It is concentrated on the care, comfort, and quality of life of a person who is at the end of life due to illness. The patient is aware that treatment is not attempted anymore, and the disease process is no longer slowed down. In comparison to palliative care where patients are provided with care and support to maintain quality life until death, hospice care concentrates on the last few months of a person's life from which a physician believes that there is six months or less to live if the illness continues to proceed. It can provide meaningful care and the last moments with family. Hospice is an extension of palliative care (National Institute of Aging, 2021). Therefore, in the rest of this review, the terms palliative care (PC) and hospice care (HC) are used interchangeably. End-of-life care (EOLC) was also used from time to time.

The focus of this literature review is to find coping methods to stressors being encountered by nurses at work dealing with Palliative Care (PC) or Hospice Care (HC) and why these problems emerge.

3. Theoretical Framework

The theory that has been used for this study is the Theory of Stress and Coping by Lazarus and Folkman.

There is no hard definition of stress, but Lazarus and Folkman (1984) suggested that stress is a phenomenon in the adaptation to a new situation in humans and animals. Stress has not one starting point, but it has many variabilities and processes. It has been seen as the reaction on a stimulation. These stress stimuli are often through to events that happen to a person but can also come from the person within, for example hunger. Lazarus and Folkman (1984) discuss three major stressors: major changes that affect huge amount of people, major changes that affect one or a few people and changes that only touch the individual. With major changes that influence a huge number of people huge events is often described as natural catastrophes or war. Major changes that affect one or a few people are for example death of a family member and getting fired from work, but divorce or birth can also be for one person a major change. Also, day to day stress stimuli that are less dramatic can also lead to stress in people.

There are three broad dimensions of stress. Stress may be defined as something outside the person that stimulates the person somehow and will have an individual response from the person to that stimulus. This response is then considered stress and is called the stimulus- based model. The response-based model focuses on the individual's physiological response to an external stimulant. This response compromises stress and therefore is called the response-based model. The third and last way to look at stress is with the transactional model of stress. This model highlights the interaction between the environment and the person who experiences the situation. The result of this interaction leads to stress if the person feels to have no impact on the situation (Lazarus and Folkman (1984), cited in Bailey & Clarke, 1989).

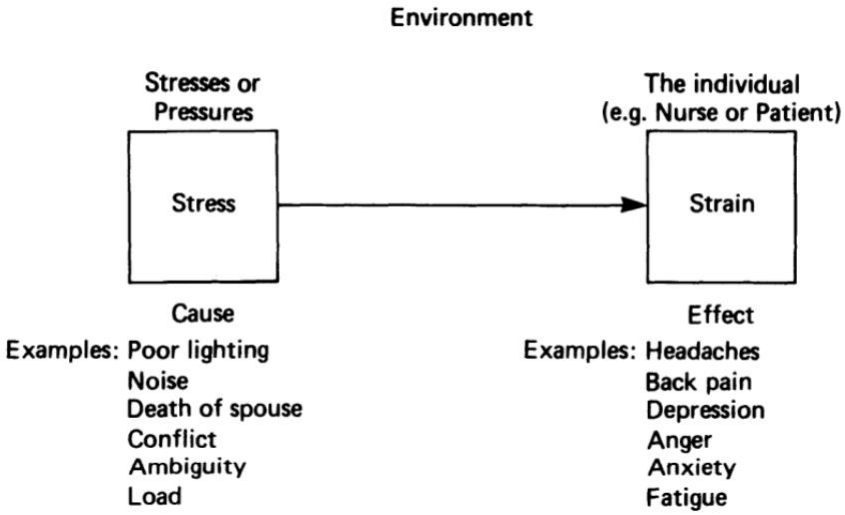

Figure 1. Stimulus-based model of stress (Lazarus and Folkman (1984), cited in Bailey & Clarke, 1989).

Lazarus and Folkman's theory refer to two processes: cognitive appraisal and coping. In cognitive appraisal, individuals assess an encounter whether it is relevant to their well-being. When individuals face challenges, they evaluate these situations as either harmful or non-harmful (primary appraisal). After this phase, they appraise whether they have enough resources to cope with the challenge (secondary appraisal). If they do not have enough resources to counter the posed challenges, they are highly likely to use emotion-focused coping strategies such as distancing, escape-avoidance, and seeking social support. However, if individuals have sufficient resources, they develop problem-focused coping strategies such as problem analysis and action planning. Secondary appraisal then determines what kind of coping strategies a person uses because coping depends on the resources available to the person and the limitations of the use of these resources for the specific encounter. There are a lot of categories, but Lazarus and Folkman have described four major categories: Health and energy, Positive beliefs, Problem solving and social skills (competencies) and Social and material resources (Lazarus & Folkman, 1984).

Health and energy are among the most pervasive resources in that they are relevant to coping in many, if not all, stressful encounters. A person who is frail, sick, tired, or otherwise debilitated has less energy to spend on coping than a healthy, robust person. The important role played by physical well-being is particularly evident in enduring problems and in stressful transactions demanding extreme mobilization (Lazarus & Folkman, 1984).

Viewing oneself positively can also be regarded as a very important psychological resource for coping. Included in this category are those general and specific beliefs that serve as a basis for hope and sustain coping efforts in the face of the most adverse conditions. Hope can be encouraged by the generalized belief that outcomes are controllable, one that has the power to affect such outcomes, that a particular person (e.g., a doctor) or program (e.g., treatment) is efficacious, or by positive beliefs about justice, free will, or God. Hope can exist only when such beliefs make a positive outcome seem possible, if not probable. (Lazarus & Folkman, 1984).

Problem-solving skills (competencies) include the ability to search for information, analyze situations for the purpose of identifying the problem to generate alternative courses of action, weigh alternative courses of action, weigh alternatives with respect to desired or anticipated outcomes, and select and implement an appropriate plan of action. They are also important resources for coping. Such general, abstract skills are ultimately expressed in specific acts, such as changing a flat tire, presenting oneself to a prospective employer, preparing for an examination, and so on (Lazarus & Folkman, 1984).

Social skills are an important coping resource because of the pervasive role of social functioning in human adaptation. They refer to the ability to communicate and behave with others in ways that are socially appropriate and effective. Social skills facilitate problem-solving in conjunction with other people, increase the likelihood of being able to enlist their cooperation or support, and in general give the individual greater control over social interactions (Lazarus & Folkman, 1984).

Having people from whom one receives emotional, informational, and/or tangible support has been receiving growing attention as a coping resource in stress research, behavioral medicine, and social epidemiology. Material resources refers to money and the goods and services that money can buy. This obvious resource is rarely mentioned in discussions of coping. Although its importance is implied in discussions of the strong relationships that are found among economic status, stress, and adaptation. People with money, especially if they have the skills to use it effectively, generally fare much better than those without. Obviously, monetary resources greatly increase the coping options in almost any stressful transaction; they provide easier and often more effective access to legal, medical, financial, and other professional assistance. Simply having money, even if it is not drawn upon, may reduce the person's

vulnerability to threats and in this way also facilitate effective coping (Lazarus & Folkman, 1984).

Lazarus and Folkman (1984) define coping as '*constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person'.* Coping is divided into two: problem- focused, and emotion-focused. Emotional focused coping are actions to minimize emotional discomfort in a person with a stressful encounter. These actions are avoidance, minimization, distancing, selective attention, positive competition and forcing positive value from negative events. Problem focused coping is aimed at changing the stressor. This aim is done in steps. The first step is defining the problem and then continuing with generating alternative solutions, weighing the alternatives in terms of their costs and benefits, choosing the best possible option and acting.

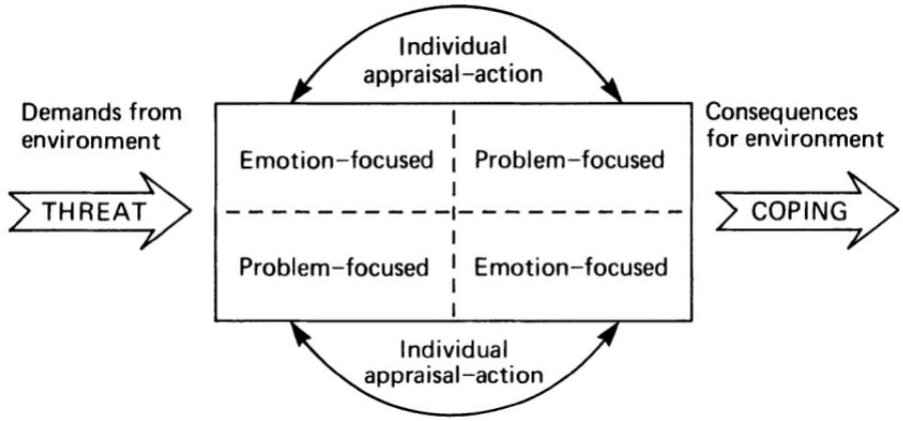

Figure 1. Coping dimensions window (Lazarus and Folkman (1984), cited in Bailey & Clarke, 1989).

4. Aim and Objectives of the Study

The aim of this study is to explore the stressful factors that nurses experience in relation to death of patients in palliative care and what kind of coping methods they apply.

To meet the aim, these questions have been formulated:

Questions:

1. What are the nurses' experiences in the process of patients' death and dying in palliative/hospice care settings?

2. What are the nurses' coping methods when caring for patients in palliative care?

5. Methodology

A literature review was chosen for this study to describe the stress factors that nurses experience when facing patients' death and the coping strategies related to these stress factors in palliative care settings. The literature review utilized a deductive approach, and the collected data is systematically done by means of content analysis.

1.1 Data Collection

A systematic search was conducted from March to April 2023. The time period chosen for publications was the years between 2013 and 2023. Literature that are over ten years old were not included. A literature search in PubMed, Cinahl, Sage and Science Direct were used.

E-journals are also provided by the latter. Inclusions and exclusions were used.

Table 1. Inclusion and exclusion criteria

Inclusion criteria	**Exclusion criteria**
Free full texts	Experiences of nurses in emergency care
Peer reviewed; Journal literature	Non-journal literature
Publication years between 2013 to 2023	Publications 2012 and older
Palliative care/hospice care/end-of-life care	sudden death
nurses' experiences	doctors'/ physicians' experiences
nurses' coping	doctors'/patients or their relatives' coping
Nurses in PC/EOLC	Nurses not in PC/EOLC
English written literature	Non-English written literature

From all the mentioned databases, the same search words were used: *coping with death* AND *nurse* AND *palliative care or hospice care*. From CINAHL there were 1 099 hits, PubMEd had 211 hits, Sage had the most hits of 2 775, Science Direct had 1 473 and from manual search were 9. There was a total of 5 567 hits but after using some inclusion and exclusion criteria (see figure3 below) e.g. free full text, peer reviewed, academic journals, 2013-2023 publications and English as the literature language, hits were narrowed down dramatically to 98. These 98 literatures were further screened down. Titles which were closely related to the researchers' aim were selected and their abstract sections were read. The result was 45 hits and down to final 30 after reading the free texts (see flowchart below, *figure 3*).

For the list of these 30 related articles containing their country of origins, methods used, sample size and the study findings (see table 2 in Appendix).

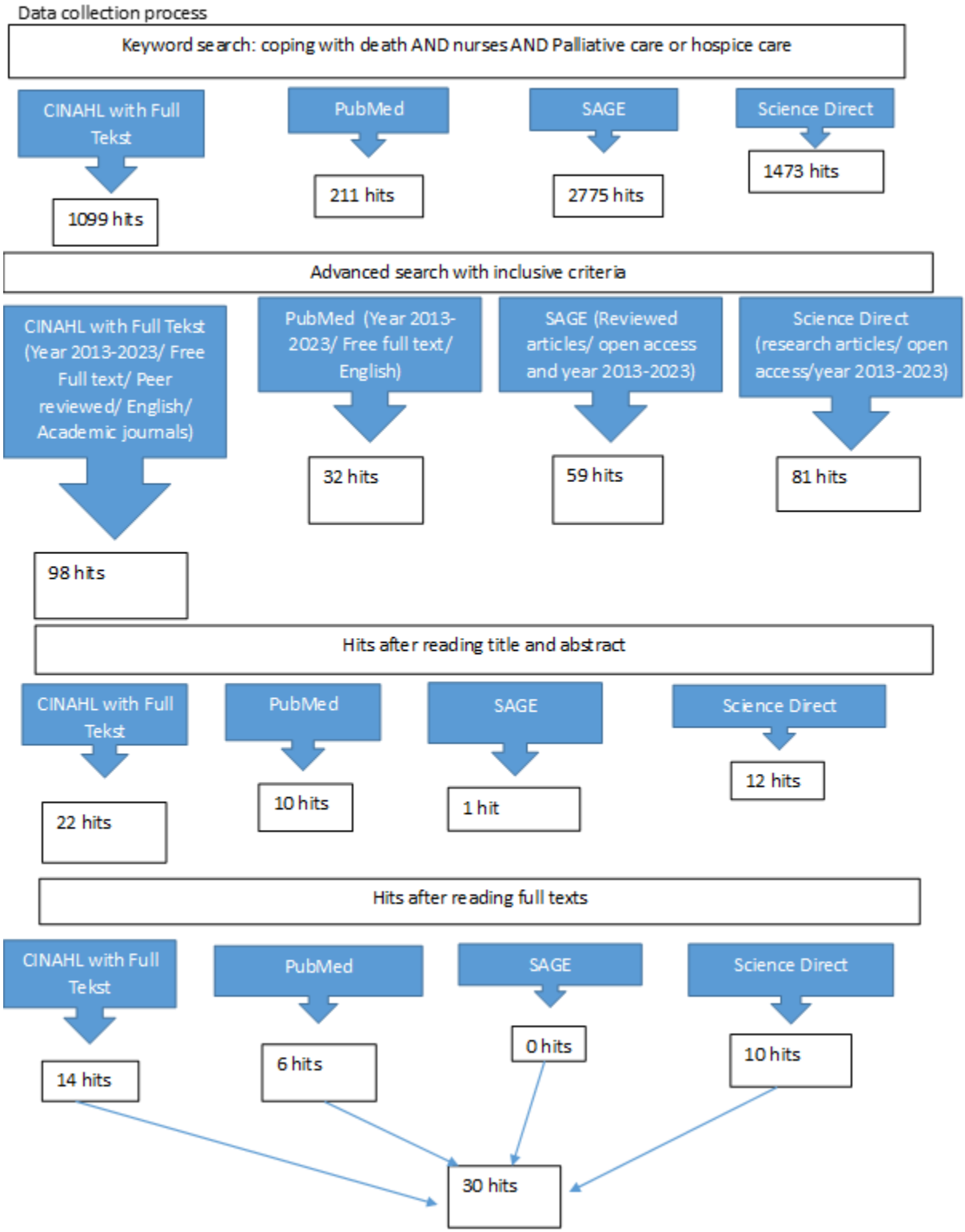

Figure 3. Flowchart: Data collection

1.2 Data Analysis

Inductive content analysis (Elo & Kyngäs, 2008) is the organization of qualitative data that is extracted from the found data. In this process, open coding creating, categories and abstraction are being created. Open coding means that words are highlighted in the text when reading. The text is then read through again and as many headings are written down as necessary in the context of the study. Then the highlighted headings are collected in the coding sheets. From this point, the researchers can then freely create categories. According to Elo & Kyngäs (2008), if there is little knowledge about an existing phenomenon, an inductive approach is recommended. It starts from drawing codes to be observed then later be categorized and made into general statements. On the other hand, a deductive approach is the opposite of which this literature review used. Themes and main categories were drawn from existing literature. The research then continued by searching codes from different studies or research to fill these sub-categories. Two themes were drawn "nurses' stressful factors" and "nurses' coping strategies. The goal was to collect recent information of nurses' experiences in Palliative Care and their coping strategies in dealing with death and dying patients.

During the process, a coding sheet was developed to make mind maps (physical sheets) and digital sheets to store copied and pasted keywords to easily access them later for data analysis (WORD-document). Units of analysis refer to the numbered articles where the codes were retrieved.

Table 3. List of Categories and sub-categories

Themes	**Nurses' Stressful Factors**		**Nurses' coping Methods**	
Categories	**Distress**	**Experience with Death**	**Emotion-based**	**Problem focused**
Sub-categories	Burnout Compassion fatigue Death anxiety Occupational stress Guilt and anger Difficult hospice family members	Negative perceptions of death Fear of death No previous experience in EOLC Young age/ being a novice nurse Religious and cultural beliefs about death	Distancing Escape avoidance Self-control Seeking social support Positive re-appraisal Accepting responsibility	Confrontive coping Planful problem-solving
Units of Analysis	1,2,5,8,10,12,13	16,19,21,25,27,28	1,2,3,4,6,7,8,9,10,11,12,14,15,16,17,18,19	20,21,23,24,25,26,29

1.3 Ethical considerations

The researchers followed Arcada's Writing Guidelines in producing academic writing. Proper citations were used to recognize and give credits to authors' work. The majority in the search process and data analysis was the use of primary sources. Paraphrasing was also practiced avoiding plagiarism as much as possible. Moreso, the researchers were from time to time guided by the principles of Responsible Conduct of Research (RCR) of the Finnish National Board on Research Integrity TENK which are *integrity, meticulousness, accuracy in conducting research, and in recording, presenting, and evaluating the research results*. During the whole research process, the researchers in their best ability conducted, collected, and presented results in a non-biased manner. Case studies that do not represent the whole community were on the researchers' decision to not include them for analysis. As an example, one of the case studies answers the research questions but after a thorough investigation, it was found that there were only four participants involved. Out of the four, two were patients and two were family members who are nurses. It surely is not enough to represent the whole community where the study took place. According to the American Nurses Association (2001) and American Psychological Association (1982), *"Nurses who critique published studies, review research for conduct in their agencies, or assist with data collection for study have an ethical responsibility to determine whether the rights of the research subjects are protected". These include self-determination, privacy, anonymity and confidentiality, and fair treatment. Self-determination is violated when there is deception or misrepresentation of subjects.* Thus, transparency in searching and fairness in presenting collected data and results were considered. Lastly, the authors of this paper also went for group counselling to be guided by proper academic writing/ research and practice peer reviewing with other student researchers.

6. Results

In this chapter, thirty (30) articles were analysed. Different coping methods of nurses emerged based from their different stressful factors. The themes and subcategories from table 3 are used as a guideline to form the results of this review.

1.4 Nurses' Stressful Factors

Nurse distress refers to stress that hinders nurses from coping with their professional demands either organizational, relational, emotional, personal, moral, spiritual, and ethical aspects (2). It leads to a higher possibility of committing errors at the workplace and a high rate of staff turnover (2,11).

Compassion fatigue can occur in the nurse because of patient death, trauma, or unexpected outcome. Nurses in oncology suffer higher risk of burnout due to emotional exhaustion and there is longing to shift work to non-related oncology nursing (25, 17). Encountering death anxiety and burnout affects their ability to build interpersonal relationships, retain job satisfaction and maintain quality of patient care (26). Some health professionals can recognize burnout symptoms (21) but with others the emotional toll of working with death and dying took them. High level of it including moral distress was felt heightened by the COVID-19 pandemic when all was often busy but there was no time to execute any interventions (23).

Occupational stress has also been reported as one of those regular experiences of oncology nurses (13) which are caused by death and dying in end-of-life-care (28). Costeira et. al. (2022) found that novice nurses who have less professional experience showed higher levels of workplace stress (5). Guilt and anger due to feeling of unable to fulfil one's nursing roles is experienced by nurses who are inadequate in managing death and dying situations and powerlessness to alleviate patients' suffering especially in children-related suffering and death because they are more traumatic compared to adults' or the elderly's' (25).

Lehto et. al. (2020) further noted that family members of the palliative patients pose distress to nurses in non-hospital care settings (21). Security related concerns were huge-sized dogs,

furious relatives, their hesitation to cooperate with patients' education needs. Added to negative experiences are family conflicts and their absence during patients' death (12). Nurses have also been expected to provide psychosocial care (24). Results showed that discussion about the development of disease was most frequently given but long-term problems in families emerged to be difficult for nurses (24).

Negative perception of death hinders nurses to acquire adequate knowledge or training in EOLC and limit their experience in supporting palliative care (10,28). On the other hand, those with positive perceptions of death have decreased level of fear regarding death or death anxiety (28). Findings reveal (10) that positive perceptions and attitude are in correlation with an improved performance in palliative care. The study also revealed that nurses with younger age or fewer years of experience notably showed lower performance compared to older or those with acquired many years of experience. The results presented novice nurses being more psychologically burdened to the death and dying process, thus, leading to more negative attitudes about hospice care. Without EOLC training and long years of experience, nurses develop a feeling of inadequacy and helplessness (20). In another study, religious belief contributed to attitudes in relation to death and care for palliative patients. Culture also influenced health professionals. It dictates how they perceive death which challenged them how they deal with EOLC especially in a culture that considers discussion about death is a taboo (16). International nursing students in China faced hindrances from learning EOLC skills due to the country's control of perceived behavior, attitudes, and norms (30).

Fear of death will cause a nurse to avoid supporting PC patients and their families leading to negative impact on patient care (1, 15).

1.5 Nurses' Coping Methods

Stressors identified to affect nurses in palliative care settings are death, dying and suffering of their patients. (13). The following have been reportedly helpful in coping with these job demands.

Distance and Escape- Avoidance. One of the coping strategies of nurses to deal with stressful work due to patients' death and suffering is getting away or going on a travel (13). Disconnecting from work has a positive effect on health workers' personal time. Drawing boundaries from professional life and personal time such as avoiding checking emails or work phones are essential skills for fighting burnout, one of the impacts of caring for dying patients to health workers. In home care settings with palliative care patients, wind-shielding has been reported to be effective. It is a way for staff to spend some time in their car and take some breaths prior to the next home care visit (21). Another way of coping is compartmentalization (7), a combination of emotion-focused and problem-focused coping. It is blocking off ones' feelings for a short period of time (emotion-based coping) and later finding solutions how to address the experience, so it does not result to being a stressor (problem-problem-focused coping). Relaxation and music with aromatherapy and warm drinks are also effective. In palliative care ward, Klitzman et. al. (2022) mentioned that nursing staff come and go during their breaks to a relaxation space to talk about e.g., their traumatic patient care experience or if the ward has had tough days (23). This kind of ritual refreshes the soul. It helps nurses cope with grief and patients' death. Enjoying hobbies (14) is one way to manage stressors e.g., knitting which is a stress-reducing activity. Study shows that those who have been in knitting intervention have less compassion fatigue and lower burnout results. Another study revealed similar result (3) that nurses' activeness in physical exercises showed lower levels of stress, and burnout compared to their lesser active counterparts. They also have better mental health and quality of life. Holistic practices such as meditation, music, relaxation, yoga, and tai chi are self-based strategies that help nurses' self-heal and refreshen themselves.

Additionally, healthcare workers in palliative care who work part time and have more independence in schedules showed better response to avoid burnout. When burnout symptoms start to appear, they take advantage of their time flexibility to deal with it. Health professionals were able to notice their own burnout symptoms (3).

Empathy from workmates, family and friends (8) is one way of coping with distress related to EOLC situations. Garten et. al. (2021) showed in their study (8) that distress to nurses caused by hospice care were common in German Palliative Intensive Care Unit (PICU). Contributing factors were reportedly due to lack of clearly set and agreed therapeutic goals. The interventions they rated highest as very helpful in coping were team support, and discussions before and after patients' death. Support within the team circle (7) allows each professional to share their own experiences. It gives everyone a sense of positivity, knowledge, and time to reflect on their shared practice, coping strategies and improve individual confidence. In situations where a nurse does not get enough feedback from dying patients or if he or she lacks proper education in PC, consultation with peers helps. Bam and Naidoo (2014) showed in their study (20) that social network in the care team allows collaboration with multidisciplinary members to improve patient outcomes and allow nurses to be more compassionate, careful, and committed in handling their patients. Another choice is family support. It also provides grounds for health workers to share their experiences in caring for PC patients that resulted in better management of emotions and stress (7). In relation to this, some organizational strategies help nurses to manage grief and counter burnout and manage work-related stress. One way is via a hotline number (provided by their organization) that they can call to discuss grief counselling services. Monthly staff meetings focusing on grief support have also shown significance. Team members go through the list of patients who have passed away and take time to reflect on them. During meetings, employees were given lunches and other food as a sign of appreciation for their work contribution. (21).

Many nurses admit they are also human beings who fear death. One of the studies (16) reported that in order to combat this fear and negativity surrounding death, cultural resources are used. These are reciting holy words just after taking care of EOLC patients, putting apples at the ward station which signifies "safety" in Chinese, wearing red clothes or some amulets which means to drive away bad luck also in Chinese.

A recent study (2) concluded that palliative nurses are more spiritually oriented and have more positive views in life due to their exposure to death constantly. Their findings revealed that nurses turned anguish into positive attitudes. Those who are more optimistic and possess sufficient self-esteem are more contented both at work and in their personal lives. They also consider their work as a privilege, not a source of stress. Optimism and self-esteem lessen the effects of stress. Some nurses reported (16) they have had challenges in handling patients'

spiritual needs. But overtime as they accumulated experience, they developed strategies of dealing with patients about their spirituality. This in turn improves their personal growth. Resilience (17), which is related to endurance in palliative care is needed. It however requires repeated processes of transformational growth to achieve it but once sustained, it helps decrease burnout and compassion fatigue.

In cultures with death-avoidance and death-denial (16), nurses adopted a positive meaning of EOLC. They transform death avoidance by embracing a social value that elderly care is a worthwhile job and assisting them to a peaceful death is commendable action. These are considered a process of accumulating blessings. The capability to handle the challenges in hospice care is a skill that PC health workers must acquire (28). A similar study suggests (10) that positive perceptions towards death would be improved through continuous training programs concerning care for death and dying patients (awareness of death). Adopting other self-care strategies (30; 27) e.g., comforting dying patients, assisting them face unfinished business, participating in their funeral or memorial ceremonies and finally taking some time to rest to regain strength boosted nurses' self-strength and professional strength. It made them become more empowered and proficient in providing complete PC process.

In attending patients' funeral or death services, a nurse was not allowed to cry during the visit because there was a need to show emotional strength around family member of the deceased (21). Reportedly, nurses intentionally distance themselves from death while assisting in the process of dying to protect themselves. Work is left behind after returning home and forget about it temporarily to keep balance between daily lives and work (16). Additionally, nurses discarded their emotions as disconnection is a way of self-coping to be able to handle the next hospice care patients.

To deal with challenging situations, nurses have also developed strategies such as the use of ironic humor or a (6) or metaphor (16). The purpose is to counter the psychological stress of dealing with deaths of patients. When a patient has passed away, nurses mention the letter "D" to mean a patient is already dead. Similarly, the word "pack" means to put the patient in body bag and "gone down" means patient is already in the morgue. A metaphor "nurses in black" means nurses are in bad luck. This signifies a busy day for them, thus, they are to be prepared for any unexpected events during their shifts. Palliative staff who engage themselves in

constant exposure to death (2) were found to be more vigorous, emphatic, thoughtful and spiritual-oriented.

For the purpose of changing the person-environment realities behind non-positive emotions or stress, providing education about End-of-Life-Care showed an important role both through simulation and practical courses. (10,6,27). A study reported that many Outpatient Hemodialysis nurses do not undergo end-of-life education when they were first hired to work in hemodialysis departments. This results in psychological stress due to constant interaction with deaths. The study later evaluated nurses in the hemodialysis ward who were given educational courses regarding death anxiety and burnout have less emotional exhaustion. Providing EOLC education to new staff during orientation period has also improved patient care quality and has met the emotional and physical requirement terminally ill patients' care require (27). Furthermore, Tu, Shen and Lee (2022) found that it helps nurses who are new in the field transition to mature professionally when dealing with patient's death (16).

In Palliative Intensive Care Unit (PICU), in-service education was regarded as the most helpful which includes psychological and bereavement care (8). Other forms of learning emerged via seminars, conferences, simulations, and training programs. Simulations provided strong confirmation that nursing students just like nurses who have no previous exposure to palliative care obtain knowledge, communication and coping skills, self-confidence, and improved satisfaction to be more emotionally prepared, perform EOLC skills, learn to deal with anticipated loss and apply knowledge into practice (18,7). Conferences and seminars are other ways staff receive current information about EOLC and the opportunity to develop professionally (22,21). A study suggested that continuing training programs should be developed to hone nurses' perception of death as positive perception affects good EOL performance (10). However, Sanso et.al, (2015) found that spiritual training to cope with death was not supported by their study (19).

7. Discussion

Due to the aging population and increasing number of diseases, the need for palliative care also increases. The World Health Organization (2020) stated that even dying patients have the right to receive quality care (also their families) by alleviating their pain and suffering from life-threatening diseases. Nurses treat suffering patients with dignity and maintain ongoing care to provide quality life until death. Nurses' role is important because they make and implement nursing care plans for the patients. They also influence the quality of patients' care including their family members (Currow et al., 2020). However, not all nurses are ready to take the role. Some reasons are due to young age or less experience in caring for death and dying patients, culture, religion, and less education/ training in end-of-life care. Additionally, fear of death and attitude towards death have an impact in end-of-life care (Peters, L. et. al., 2013). Novice nurses' lack of knowledge in palliative care affects their attitude towards it (Tu, J., Shen, M., & Li, Z. 2022). Even newly qualified nurses showed inadequate nurse education to prepare them to deal with the process of dying and death of patients. Challenges in handling deaths of patients are also influenced by socio-cultural views (Tu, J., Shen, M., & Li, Z. 2022). There is high possibility that nurses with negative perceptions of death will experience limitations in providing support for palliative care while those that have positive perceptions have less fear of death and will suffer less stress due to patients' death (Hussein et. al., 2018). The effects of patients' death are frequently mentioned as stressors in clinical settings. This is most likely that perceptions of death differ from culture to culture, traditions, religion, and social values (cited in Park, H.J., 2022).

Nurses in palliative care settings, especially in cancer department repeatedly deal with different kinds of distress which include compassion fatigue, burnout, work-related stress, and moral stress. They are at higher risk for psychological distress due to build-up of nurse-patient relationship during care process and eventually patients die in their care (Davis, Lind & Sorensen, 2013). This leads to a higher incidence of resignation from work. Undergraduate nurses and even newly qualified nurses alike suffer the same as they are not prepared to provide end-of-life care. It is because many nursing students did not receive palliative care education during their studies.

Lazarus and Folkman (1984) identified the most common coping methods people use to respond to stressful situations. They are divided into two, emotional-based coping and problem-focused coping. Emotional-based coping are: distancing (detachment from stressful situations to minimize its effect), scape-avoidance (wishful thinking and behaviors to avoid confrontation of workplace stress), self-control (efforts used to manage one's own emotions and actions), and seeking social support (efforts used to get some information, emotional and tangible supports from other people), accepting responsibility (one's own recognition of solving a problem) and positive reappraisal (spirituality, having positive meaning to stressful demands and improving personal growth experience). Problem-focused coping are: confrontive coping (an effort sometimes hostile to change a situation) and planful problem-solving (efforts to change a situation including analytic approach

The Stress and Coping theory states that when individuals encounter challenging situations, their first step is to assess whether the situation is threatening or non-threatening. The next step is to identify whether they have the resources to respond or cope with that challenge. If there is a feeling of lack of ability or control to manage the challenge, an emotion-based coping is utilized such as distancing and avoidance or just thinking about the positivity behind those uncontrollable situations. However, if they do have the resources, problem-focused coping is used such as the analysis of the problem and planning of action to respond to it (Lazarus & Folkman, 1984). Nurses who have more years of exposure in palliative care are more able to put aside their feelings to do their job professionally. Not showing any emotional weakness in front of deceased patients is also one of their effective strategies. Death in most countries is in conjunction with sorrow. Thus, everyone is expected to be calm and watch their words not to offend anyone. But in other cultures, making jokes in times of death is considered acceptable. Nurses and other care professionals take advantage of it and use it as a way of coping. In contrast, those who are less experienced do not have enough ability to face it. Distancing from work e.g. going on holidays, doing hobbies and sharing experiences with either family or colleagues are their most common strategies. While sharing experiences to a spouse or family member about end-of-life care as a way of obtaining emotional support, there is a possibility of breach of confidentiality. Patients' information privacy may not be kept. In doing so, nurses should avoid using any identifiers such as patients' name, place of residence, next of kin etc.
The Coping Theory is important in palliative care or hospice care. A continuous sight of patients' death in these care facilities may bring stress to health workers and could affect the quality of care they give to palliative care patients and their families. With proper coping

methods, stressors are handled more effectively that could eventually lead to minimization of emotional discomfort and turning negative events to more meaningful values (Folkman and Lazarus, 1984).

8. Conclusion

The need for palliative care is growing. Despite this, nurses lack education and training about end-of-life care. This results in qualified nurses' unpreparedness in providing the right palliative care and in responding to dying patients. This literature review recommends nurses who are interested in Palliative Care to enroll in end-of-life-care courses. The event could give them a traumatizing experience if they have no previous exposure. Seminars, conferences, simulations and training for professionals help them in the transition. These will provide the knowledge and skills on how to manage pain and anticipated death, be more emotionally prepared and apply knowledge into practice. Studies showed that trainings prepared nurses on how to communicate well with dying patients including their families. Insufficient communication between them and the members of the multidisciplinary team would result in poor palliative care. The need for end-of-life care education is needed to be able to respond well to patients care. Nurses who received proper training and education on psychological and bereavement care as well as death anxiety improved their ability to provide palliative care, more emotionally prepared and developed professionally. This literature review suggests that this is also beneficial to nursing students going for practical training to the same care setting because it helps them to learn in the care process.

On the other hand, coping strategies differ from person to person. The strategies used by one nurse may not work with others. Each one must assess which coping methods work for them. End-of-life care (EOLC) could be a pre-coping that prepares nurses before embarking on palliative care e.g., providing EOLC during the work orientation helps them in the learning process on palliative care. Nurses who received proper training and education on psychological and bereavement care as well as death anxiety improved their ability to provide palliative care, more emotionally prepared and developed professionally (Lee & King, 2014).

1.6 Strengths and Limitations of the Study

The topic of this review has been studied globally. Thus, there is much information that can be retrieved from different sources. However, many of them are also in different languages. The abstract parts are in English, but the rest are in their original languages. Additionally, many interesting research based on their Abstract are chargeable with a fee. They are not available in free full text. Despite this, the required thirty (30) articles were successfully completed and were in free full text. In the search process, while using the same keywords, CINAHL and Science Direct showed most of the needed articles followed by PubMed. To get results from other databases, it required search words to be changed which goes against the qualitative research criteria. The writers of this literature review stuck to the plan of using the same search words in all four databases which resulted in one of them (Sage) providing zero hit.

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9. Appendix

Table 2. List of Articles

No.	Author/s	Title	Country/ year of study	Methods used	Sample size	Results/Findings
1.	Adalet ustuku & Zehra Eskime	The effect of death anxiety in nurses on their approach to dying patients: A cross-sectional study	2021, Turkey	Cross-sectional study	240 participants	Nurses experienced death anxiety (mild) and showed tolerable avoidance in relation to patients' death and dying in relation of age and years of experience
2.	Beatriz Moreno-Milan, Antonio Cano-Vindel, Pedro Lopez-Dóriga, Leonardo Adrián Medrano, William Breitbart	Meaning of work and personal protective factors among palliative care professionals	2019, Spain	Self-reported questionnaires (Quantitative study?)	189 participants	Healthcare professionals manage grief by developing life attitudes and by considering hospice care being a privilege.
3.	Bhibha M. Das and Brianna C. Adams	Nurses' physical activity exploratory study: Caring for you so you can care for others	2021, USA	Exploratory	62 participants	Physical activity intervention is beneficial towards nurses' mental, occupational health and patient health and safety
4.	Carol E. Kinley	Student nurses' end-of-life and post-mortem care self-efficacy: A descriptive study	2023, USA	Quantitative descriptive, cross-sectional design	498 participants	Nursing education and simulation about EOLC may improve student nurses' self-efficacy and help them overcome fear and anxiety related to deaths and dying of patients.
5.	Cristina Costeira , Filipa Ventura, Nelson Pais, Paulo Santos-Costa, Maria Anjos Dixe Ana Querido, and Carlos Laranjeira	Workplace Stress in Portuguese Oncology Nurses Delivering	2022, Portugal	Descriptive baseline study	32 participants	Novice nurses suffer higher levels of stress associated with palliative care.

		Palliative Care: A Pilot Study				
6.	Cynthia Barreré and Anne Durkin	Finding the Right Words: The Experience of New Nurses after ELNEC Education Integration into a BSN Curriculum	2014, USA	Open-ended semi-structured interview	12 participants	Assisting in good death, internalization of intrinsic rewards. Learning through experience and maintaining balance emerged as themes from the study.
7.	Elizabeth Forster & Alaa Hafiz	Pediatric death and dying: Exploring coping strategies of health professionals and perceptions of support provision	2015, Australia	Semi-structured interviewing	10 participants	Health carers develop skills in providing children and their families EOLC. Educational preparation clinical simulations about EOLC greatly affects undergraduate nursing students' responses in managing with loss of life.
8.	Garten L, Danke A, Reindl T., Prass A. and Bührer C.	End-of-life care related distress in the PICU and NICU: A cross-sectional survey in a German tertiary center	2021, Germany	Cross-sectional survey	73 participants	PICU and NICU nurses have differences in distress factors and coping. However, the study shows that there is no significant differences in their distress-related symptoms.
9.	Huang, Ching-Chi; Chen, Jih-Yuan; Chiang, Hsien-Hsien	The Transformation Process in Nurses Caring for Dying Patients	2016, Taiwan	Phenomenological approach, semi-structured interview	8 participants	Emotional suffering due to death of patients showed to be the main factor that transforms nurses' personal and professional selves.
10.	Hyo-Jin Park , Yun-Mi Lee , Mi Hwa Won, Sung-Jun Lim and Youn-Jung Son	Hospital Nurses' Perception of Death and Self-Reported Performance of End-of-Life Care: Mediating Role of	2020, South Korea	Descriptive cross-sectional research design	250 participants	Nurses' positive perceptions of death and attitudes regarding palliative care are associated with better performance in EOL care

		Attitude towards End-of-Life Care				
11.	Jiong Tu, Manxuan Shen and Ziying Li	When cultural values meet professional values: a qualitative study of Chinese nurses' attitudes and experiences concerning death	2022, China	Qualitative study	28 participants	Nurses showed attitudes towards patients' death from both personal and professional aspect. Three coping strategies emerged to cope with this professional and personal differences
12.	John G. Cagle, Kathleen T. Unroe, Morgan Bunting, Brittany L. Bernard, and Susan C. Miller	Caring for Dying Patients in the Nursing Home: Voices from Frontline Nursing Home Staff	2017, USA & Switzerland	Qualitative analysis using survey data	707 participants	Nurses and social workers who have over 5 years of experience in nursing homes reported the following experiences: positive experience (creating close bonds, good patient care, hospice care involvement, preparedness, and good communication. Negative ones are: care-related challenges, unacknowledged death, feeling helpless, uncertainty, non-presence of family, painful emotions and family discord.
13.	Lara Wahlberg, Anita Nirenberg, and Elizabeth Capezuti	Distress and Coping Self-Efficacy in Inpatient Oncology Nurses	2015, New York, USA	Cross-sectional survey design	163 participants	Participants demonstrated high levels of distress. Less stress has shown to those who have higher self-efficacy.
14.	Lindsay W. Anderson, Christina U. Gustavson	The Impact of a Knitting Intervention on Compassion Fatigue in Oncology Nurses	2016, USA	Mixed- method	39 participants	According to the results, the younger nurses (aged younger than 30 years) on the units experienced lower compassion satisfaction and higher burnout

						scores prior to the Project Knitwell intervention, and their scores improved after participating in the intervention, with higher reported compassion satisfaction and lower burnout scores.
15.	Louise Peters, Robyn Cant, Sheila Payne, Margaret O'Connor, Fiona McDermott, Kerry Hood, Julia Morphet, Kaori Shimoinaba	Emergency and palliative care nurses' levels of anxiety about death and coping with death: A questionnaire survey	2013, Australia	Mixed methods design	56 participants	Nurses are reported to have lower fear of death, death avoidance, escape acceptance and approach acceptance compared to emergency nurses. Both showed acceptance that death is a natural process.
16.	Maya Zumstein-Shahaa, Betty Ferrellb, Denice Economoub	Nurses' response to spiritual needs of cancer patients	2020, USA	Qualitative survey, thematic analysis	62 participants	Patients are reported to seek meaning in their illness and nurses have shown difficulties in providing support to their spirituality/ religion. However, overtime nurses have developed a way of talking about it with patients which eventually helped them to their personal growth.
17.	Mervyn Y.H. Koh, Allyn Y.M. Hum, Hwee Sing Khoo, Andy H.Y. Ho, Poh Heng Chong, Wah Ying Ong, Joseph Ong, Patricia S.H. Neo, and Woon Chai Yong	Burnout and Resilience After a Decade in Palliative Care: What Survivors Have to Teach Us. A Qualitative Study of Palliative Care Clinicians with More Than 10 Years of Experience	2020, Singapore	Qualitative study, semi-structured interviews	18 participants	Palliative care clinicians who stayed in palliative care for over a decade have achieved resilience via transformational growth. Struggles, mindset change, adaptation, self-awareness, reflection, and evolution also showed to be important factors.

18.	Munikumar Ramasamy Venkatasalu, Michael Kelleher and Chun Hua Shao	Reported clinical outcomes of high-fidelity simulation versus classroom-based end-of-life care education	2015, United Kingdom	Phenomeno-graphic methodological approach	12 participants	Simulation-based teaching of EOLC compared to seminar-based provides stronger evidence where students are more emotionally prepared and can perform EOLC skills.
19.	Noemı´ Sanso, Laura Galiana, Amparo Oliver, Antonio Pascual, Shane Sinclair, and Enric Benito	Palliative Care Professionals' Inner Life: Exploring the Relationships Among Awareness, Self-Care, and Compassion Satisfaction and Fatigue, Burnout, and Coping with Death	2015, Spain	A cross-sectional online survey	387 participants	Professional competence in coping with death includes self-care and awareness. However, the finding does not support spiritual training as a way to cope with patients' death and dying.
20.	Nokwanda E. Bam Joanne R. Naidoo Bam, N.E. & Naidoo, J.R.	Nurses' experiences in palliative care of terminally ill HIV patients in a level 1 district hospital	2014, South Africa	Phenomenology design, qualitative research	10 participants	Palliative care helps nurses to be conscious of their mortality, be more sensitive and compassionate to caring for PC patients
21.	Rebecca H. Lehto, Carrie Heeter, Jeffrey Forman, Tait Shanafelt, Arif Kamal, Patrick Miller and Michael Paletta	Hospice Employees' Perceptions of Their Work Environment: A Focus Group Perspective	2020, Switzerland	Focus group study	19 participants	Focus groups showed to be significant in discussing challenges at work including the relief of patients' suffering that could contribute to burnout to health workers.
22.	Roberta Rolland	Emergency Room Nurses Transitioning from Curative to End-Of-Life-Care	2016 New York, USA	Semi-structured interview	10 participants	EOLC education and peer support help nurses transition smoothly to end-of-life care work.

23.	Robert Klitzman, Jay Al-Hashimi, Gabrielle Di Sapia Natarelli, Elizaveta Garbuzova, Stephanie Sinnappan	How hospital chaplains develop and use rituals to address medical staff distress	2022, USA	Semi-structured interview, formal telephone interview,	21 participants	In addition to chaplains' taking part in religious activities with patients, they also create new kinds of rituals for staff which help them including patients' families to cope with death, sorrow, and other stresses.
24.	Sheng-Yu Fan, I-Mei Lin, Jyh-Gang Hsieh, and Chih-Jung Chang	Psychosocial Care Provided by Physicians and Nurses in Palliative Care: A Mixed Methods Study	2017, Taiwan	Mixed-method study	88 participants	From the study emerged the most common psychosocial care which is care plan and discussion regarding the progress of diseases. Professionals mostly needed were social workers, and clinical/ counseling psychologists.
25.	Shoni Davis, Bonnie Lind, Celeste Sorensen	A Comparison of Burnout Among Oncology Nurses Working in Adult and Pediatric Inpatient and Outpatient Settings	2013, USA	Observational, descriptive research	74 participants	Spirituality and colleague support are often used as coping. Participants with younger age have lower emotional exhaustion and higher in outpatient RNs.
26.	Valerie L. Lee & Anita H. King	Exploring Death Anxiety and Burnout Among Staff Members Who Work in Outpatient Hemodialysis Units	2014, USA	Statistical analysis used after pre- and post-intervention	21 participants	No previous knowledge and training about death and dying leads to higher risk of death anxiety and burnout among health caregivers
27.	Venke Ueland & Ellen Ramvie	Nurses' Process of "Becoming" When Working in the Context of	2018, Norway	Qualitative and Explorative hermeneutic design	22 participants	The focus-group interview provided nurses with deeper meaning of their existential life. Powerless feelings, creating bonds

		Death and Dying				of love, arousal of existential questions and seeking refuge and appreciation were four themes that emerged.
28.	Wallace Chi Ho Chan, Agnes Fong, Karen Lok Yi Wong, Doris Man Wah Tse, Kam Shing Lau, and Lai Ngor Chan	Impact of Death Work on Self: Existential and Emotional Challenges and Coping of Palliative Care Professionals	2015, Hong Kong	Thematic analysis, semi-structured interview	22 participants	Patients' death at work has been reported as the challenge that affects health workers personally and professionally. Emotional coping and self-reflection have been defined as a way of coping to this challenge.
29.	Xiaoyu Wu, Zhihuan Zhou, Yiheng Zhang, Xiaoyan Lin, Meng Zhang, Fulin Pu, Meifen Zhang	Factors Associated with Behaviors Toward End-of-life Care Among Chinese Oncology Nurses: A Cross-Sectional Study	2021, China	cross-sectional design	1 038 participants	Attitudes toward EOL care to patients is associated with sharing of experiences with colleagues, EOLC education, frequent exposure to palliative care, support from nurses with higher position and their perceived high level of support.
30.	Yanhui Wang, Ying Huang, Ruishuang Zheng, Xian Yue, Fengqi Dong	Intern nursing students' perceived barriers to providing end-of-life care for dying cancer patients in a death taboo cultural context: A qualitative study	2023, China	descriptive, qualitative study.	21 participants	Nursing students are hindered from providing EOLC to patients. Factors emerged were barriers-related attitudes, subjective norms, and perceived behavioral control.