

## REVIEWS

# The attitude of providing good death from intensive care nurses: A meta-synthesis of the literature

Liu Siyu<sup>1</sup>, Makiko Kondo\*<sup>2</sup>

<sup>1</sup>Nursing Department, The First Affiliated Hospital of Dalian Medical University, Dalian, China

<sup>2</sup>Graduate School of Health Sciences, Okayama University, Okayama, Japan

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## ABSTRACT

The purpose of this article is to explore the attitude of Intensive Care Unit (ICU) nurses of good death and to improve the quality of death of dying patients in ICU. The authors conducted a literature search from databases for published, English-language, peer-reviewed reports of qualitative studies that focused on attitude of ICU nurses of providing good death from different cultures during 2009-2018. 13 studies met eligibility criteria with the following two questions: A. "What are the obstacles to realize good death in ICU?" B. "How to help ICU dying patients to get good death?". According to these questions, we grouped all results. Finally, 5 categories each answered Research Question A(RQ-A), and 5 indicated RQ-B. The following four factors that can promote the good death of ICU dying patients: 1) Legalizing and standardizing "good death" in ICU by providing education, physical and mental support for nurses; 2) Gaining trust of family and seeking consistency of important decisions; 3) Creating a physical and cooperative environment of ICU that benefits dying patients; 4) Giving priority to satisfy physical and mental needs of dying patients and their families, leaving no regrets.

**Key Words:** Good death, ICU nurse, Literature review, End-of-life care, Peaceful death

## 1. INTRODUCTION

Good death, as the ultimate goal of palliative care, is also gaining attention. In 1972, Weisman<sup>[1]</sup> firstly put forward the concept of "good death". The definition proposed by the American institute of medicine<sup>[2]</sup> in 1997 is widely used now, that is, good death means that the patient and his/her family are free from pain and discomfort, and the end-stage decision is basically in line with the wishes of the patient and his/her family, and consistent with clinical practice, cultural and ethical standards. Recently, there are more and more researches of good death, including the attitude of nurses. Good death can be realized by nursing support, Advanced

Medical Care Plan and so on, which need further study.

Generally, the goal of ICU care is not to provide good death. Some dying patients have to spend their last days in the ICU although technological and medicine advances. And the environment is not the as good as the hospice care institution to realize good death. Dying at ICU means that a final farewell will happen at a high technological environment with little or no privacy. Critically ill patients in ICUs may experience negative feelings, such as loneliness and pain, in such unfamiliar place without family members' accompany.<sup>[3]</sup> Working in such department also makes staffs feel stressful both physically and emotionally, especially nurses.

\*Correspondence: Makiko Kondo; Email: [mkondo@cc.okayama-u.ac.jp](mailto:mkondo@cc.okayama-u.ac.jp); Address: Graduate School of Health Sciences, Okayama University 2-5-1 Shikata, Kita-ku, Okayama 700-8558, Japan.

As we all know, the quality of care provided by nurses is important to satisfy relatives and dying patients in ICU. And improvements in care are relatively easy compared with big changes in national policies and the health care system. So, if the patient has to spend the last days of his or her life in the ICU where generally is not an ideal place to die, we can improve care quality to help dying patient get a good death. Experienced ICU nurses have their own ideas about how to help patients achieve good death. It is necessary to integrate nurses' experience to realize good death in ICU.

Qualitative research provides important information about the experience and expectations of the health care profession and requires critical evaluation and synthesis.<sup>[4]</sup> The meta-synthesis method is one such method. Thus, we use meta-synthesis to obtain evidence-based practices that integrate and leverage the best available information to assist ICU nurses in developing strategies and interventions for end-of-life care.

### **Purpose**

To clarify the attitude of ICU nurses of good death and to improve the quality of death of dying patients in ICU.

## **2. METHODS**

### **2.1 Research design**

A qualitative and inductive methodology is utilized in the paper.<sup>[5]</sup> Meta-synthesis is a process of in-depth data integration, in which original research results are collected to explain various research results, and new explanations are generated by summarizing according to their meanings. The integrated results more comprehensively reflect the commonality among various studies, making the results more extensive and becoming the empirical basis for evidence-based practices.<sup>[4]</sup>

### **2.2 Inclusion/exclusion criteria for selecting literature**

#### **2.2.1 Inclusion criteria**

The PICO model recommended by the Australian JBI evidence-based health care center was used to guide the formulation of inclusion and exclusion criteria.<sup>[6]</sup> P is population and refers to the research object; PI is phenomenon of interest, referring to the research content; CO is context and refers to the situation.

- (1) Subjects: nurses working in ICU wards.
- (2) Phenomena of interest: ICU nurses' attitude of good death while caring for dying patients.
- (3) Context: ICU nurses take care of dying patients in the ward.
- (4) Research method: qualitative research, which includes a variety of qualitative research literature using phe-

nomenology, grounded theory, ethnography and descriptive analysis.

#### **2.2.2 Exclusion criteria**

- (1) The age of dying patients who receive care is less than 18 years old.
- (2) Articles concentrate on specific methods such as euthanasia, Advanced Care Planning and so on.
- (3) Papers are written without English language.

### **2.3 Procedure of gathering and selecting literature**

#### **2.3.1 The database**

CINAHL, Medline, PubMed, PsycINFO and Web of Science databases were searched to find relevant articles.

#### **2.3.2 Procedure of searching and selecting literature to meet the inclusion/exclusion**

Firstly, we searched for papers published in 10 years through the databases. One decade is generally the period selected in review articles. To get papers as much as possible that meet the criteria, keywords such as "good death", "critical care", "end-of-life care", "nurse", and "qualitative research" were used. We got the preliminary data after the deduplication.

Secondly, we read the title and abstract and then excluded articles. In the step, nurses' country of citizenship and religion are not limited. Because only by understanding different attitude of different countries, cultures and religions, can we better reach a balance between reality and ideal of "good death". Because the special patient populations, such as the Neonatal Intensive Care Unit (NICU), can lead to bias, we excluded them. Original articles are the majority of the type of papers, which can guarantee the quality of the research, excluding conference proceedings, technical materials, and interpretive articles for beginners.

Thirdly, full articles were carefully read, then decided whether they were included.

#### **2.3.3 Literature quality assessment**

Both researcher evaluated literatures if: 1) the research methods are consistent with the stated philosophical views, research questions, data collection methods, data analysis and expression methods, 2) clarify the potential impact of the researcher's beliefs and values on the study and result interpretation, 3) expound the influence of the researcher on the research and the influence of the research on the researcher, 4) fully represents the meaning of the participants' statements, 5) it conforms to the current ethical standards and has the research ethics approval certificate recognized by academic institutions, 6) the conclusion of the study comes from the analysis and interpretation of the data. Also, we insured if the studies included rich information in the results

to help us develop new categories and if they clarified our two research purposes. Again, papers that did not meet these criteria were excluded.

All these steps were done by the first author and were supervised by the second author.

**2.4 Integration of the data in the literature**

**2.4.1 Outline of the selected literature**

Table 1 presented the basic information of the selected studies, including nurses’ working experience, nation and method of data gathering and analysis.

**Table 1.** An outline of the selected research studies

Number	Nurses’ working experience	Nation	Method	
			Data gathering	Analysis methods
#1	Unknown	Iran	Semi-structured interview	Inductive coding approach
#2	Junior and senior registered	USA	Semi-structured interview	Inductive coding approach
#3	2-20 years	UK	Semi-structured interview	Interpretative phenomenological analysis
#4	At least 6 months	Brazil, Israel, Germany, UK, Palestine	Semi-structured interview	Grounded Theory
#5	2 years to 30 years	USA	In-depth dialogical phenomenological interviews	Hermeneutra approach
#6	10-20 years	Thailand	In-depth telephone interviews	Grounded theory
#7	At least 6 months	Thailand	Semi-structured Interview	Van Manen’s approach
#8	More than three years	Sweden	Semi-structured interview	Conventional content analysis
#9	At least 2 years	UK	Semi-structured interview	Thematic content analysis
#10	2 to 21 years	South Africa	Focus group discussion	Verbatim transcription
#11	More than 12 months	Australia	Semi-structured interviews	Thematic analysis
#12	6 months to 30 years	UK and Israel: Judaism	Focus group and individual interviews	Qualitative thematic analysis
#13	At least 1 year	Netherlands: Catholicism	Semi-structured interviews	Kwalitan

**2.4.2 Integration of data and development of new concepts**

Integrating the selected literature and making clear the two research purposes are the aim of this phase of the study. Take RQ-B as an example: “How to help ICU dying patients to get good death?” Firstly, the results of the selected literature were carefully analyzed and descriptions pertaining to this purpose were identified. Secondly, the descriptions were extracted and one sentence codes that illuminated the aim of research were developed. Codes that have similar meaning were sublimated to create lower categories. Thirdly, the content of each lower category must meet the research purpose. Fourthly, sub-categories will be developed from similar lower categories by repeating the above steps, and then categories are developed from similar sub-categories. Finally, for RQ-B we create a category name or label.

This process was also used in RQ-A. The first author executed all steps and the second author was the supervisor.

**3. RESULTS**

**3.1 Outline of the selected literature**

First of all, we gained 293 studies from the database. Secondly, the number of papers was narrowed down to 116 through reading the titles and abstracts. Finally, after reading and examining the full-text of the articles, we identified 13 studies that met the inclusion and exclusion criterions.<sup>[7-19]</sup>

**3.2 Meta-synthesis about the two research questions**

12 studies of the 13 studies related to RQ-A (#1, #2, #3, #4, #5, #7, #8, #9, #10, #11, #12 and #13), A. “What are obstacles to realize good death in ICU?” A total of 40 codes were created from these 12 studies, which were integrated into the following 5 categories (see Appendix 1): A-1. Although ICU nurses attach great importance to the care for end-of-life patients, this is contrary to the purpose of the ICU, and they need to bear the pressure of social law, public opinion, morality and their own religious beliefs, thus leading to the excessive treatment of patients. A-2. ICU nurses do not

receive formal and effective guidance, training and policy support, and are unable to take good care of end-of-life patients and their families. A-3. In the face of frequent and sudden deaths, ICU nurses are emotionally exhausted and have no time and energy to provide different care due to the shortage of nursing staff and heavy workload. A-4. In the face of death, families and patients cannot make wise and correct decisions. A-5. The particularity of the human and material resources environment in ICU is not conducive to the communication between patients and their families and the development of hospice care.

Further, all of the 13 studies addressed RQ-B, “How to help ICU dying patients to get good death?”. From these 13 studies we gained 76 codes, and identified the following 5 categories through carefully reading the articles (see Appendix 2): B-1. Providing formal, effective education guidance and emotional support and adequate nursing time to ICU nurses, the patients and their family also need education. B-2. Strengthening cooperation with doctors and multi-disciplinary teams, eliminating discrimination between

medical staff to reduce tension of ICU working and create a sense of security. B-3. Providing care opportunities to family members before the end of life through timely identifying deaths and arranging time and space for visits and farewells to ensure family members have no regrets. B-4. Providing priority care to end-of-life patients through improving the environment in the ICU and providing planned and timely care as well as maintaining patient comfort. B-5. Sincerely understanding and helping the family members to win the trust of the family members, conveying correct and true information so as to accept the death mutually to actively seek consistency in the decision to withdraw treatment.

#### 4. DISCUSSION

##### 4.1 Attitude of ICU nurses to help dying patients to get good death

We identified 4 categories each related to RQ-A and RQ-B. The attitude (situation and care strategies) for caring for the dying patients at ICU was obtained through integrating all the categories (see Table 2).

**Table 2.** The attitude of providing good death from intensive care nurses

Attitude that help to get good death	Findings related to Research Question A to B
1) Legalizing and standardizing “good death” in the ICU by providing education policies and physical and mental support for nurses.	A-1 Although ICU nurses value hospice care for patients, it is difficult to carry it out for subjective and objective reasons.
	A-2 ICU nurses lack formal education and policy support to care for dying patients and their families.
	A-3 ICU nurses do not have extra time or energy to provide specific care for emotional and workload reasons.
2) Gaining trust of family and seeking consistency of important decisions.	B-1 To provide humanized emotional support and educational training for ICU nurses as well as family members and patients.
	A-4 In the face of death, families and patients always cannot make wise and correct decisions.
3) Creating a physical and cooperative environment of ICU that benefits dying patients.	B-5 Mutually accepting the fact of death, winning the trust of family members to actively seek consistency in treatment decisions.
	A-5 The collaborative and physical environment of the ICU is not conducive to the care of dying patients.
4) Giving priority to satisfy physical and mental needs of dying patients in ICU and their families, leaving no regrets.	B-2 Creating a suitable working environment.
	B-3 Providing care opportunities with family members before death through timely identifying deaths and arranging time and space for visits and farewells to ensure family members have no regrets.
	B-4 Valuing terminal patients and their families, so that they are physically and mentally satisfied.

##### 4.1.1 Legalizing and standardizing “good death” in the ICU by providing education policies and physical and mental support for nurses

A-1. Although ICU nurses value end-of-life care for patients, it is difficult to carry it out for subjective and objective reasons. A-3. ICU nurses do not have extra time or energy to

provide specific care for emotional and workload reasons. These two categories showed that most ICU nurses hope dying patients to get good death, but both subjective and objective reasons hinder the supply of high-quality end-of-life care for ICU dying patients. Subjectively, first is that nurses’ emotional workload is too large which has not been paid

much attention to. While death is a common occurrence in the ICU, an increase in accidental deaths and the number of dying patients, and the active involvement of grieving family members all create a strong sense of grief and loss for nurses. Secondly, the physical workload of ICU is large and the staff is short, which leads to the lack of time and energy to provide different care. Another reason is objective reason. Firstly, related law is imperfect, nurse's behavior lacks of legal protection. Secondly, social ethics influence ICU nurses to provide different kinds of care for the dying patients. The purpose of the ICU is to save lives, which is paradoxical with "good death". When nurses remove mechanical ventilation from dying patient, they will feel they were killing the patients. Subjective and objective reasons for nurses are not easy to try to provide different care.

A-2. ICU nurses lack formal education and policy support to care for dying patients and their families. B-1. To provide humanized emotional support and educational training for ICU nurses, the education of family members and patients is also essential. These two points indicated that education and policy support on end-of-life care needed to be provided to ICU nurses, patients and family members, as well as noticed the psychological problems of nurses in the ICU. ICU nurses' comfort level, knowledge and skills in caring for dying patients and families is highly connected with the quality of death. But at present most ICU staff barely access to advanced knowledge.

Firstly, subjectively increasing the possibility of "good death" in ICU. ICU nurses and patients and their families should develop right attitude: every dying patient has the right to get good death in ICU through care. For nurses, providing education and emotional support is essential. Education and training can be provided both online and offline. Regularly attending academic conferences offline and case sharing also are important. It is recommended that formal support strategies be implemented, such as the establishment of a network of partners for new and junior staff, and that regular briefing and critical reflection sessions be conducted by social workers or external consultants.<sup>[9]</sup> For emotional support, prevention is most significant. Regular psychological lectures and tests to find the psychological state of nurses. Humanized nurse's care object: A nurse, for example, who has just experienced the loss of a loved one, tries not to immediately arrange the nurse to care for a seriously ill patient. Or developing more targeted emotional support methods to satisfy nurses.<sup>[13]</sup> For instance, research has shown that "Sacred Pause" can make ICU staff feel the environment of teamwork, increase happiness and satisfaction, and reduce sadness and compassion fatigue. The method commemorates and acknowledges the loss of life and the team's efforts to

save the patient.<sup>[20]</sup> When the nurse has related psychological problems, to stop loss in time, and to reasonable arrange their nursing patients and nursing time. Asking professional psychology expert to help. As for patients and family, nurse can also hold related lectures on a regular basis, hand out leaflets, or broadcast the correct view of death through the network. What is more, reasonably arranging nursing personnel and nursing workload. For example, a nurse should be arranged fewer other works and set aside enough time and energy to take care of dying patient.

Secondly, from the objective aspects. Developing targeted guidelines and policies. To make clear legal policy to provide for non-resuscitation and other end-of-life decisions. Making proper guidelines then making full use of these guidelines through giving some supportive programme, which could have more positive effect on the stick to the guidelines, and family satisfaction.

In a word, ICU nurses should use their inner and outer strength to let dying patients get "good death".

#### **4.1.2 Gaining trust of family and seeking consistency of important decisions**

A-4. In the face of death, families and patients cannot make wise and correct decisions. This category suggested that decisions that are appropriate for dying patients are difficult to make. Firstly, patients cannot speak to express themselves. Secondly, family members are limited to medical knowledge, whose emotional stress and unrealistic expectations also prevent them from making rational decisions.<sup>[17]</sup>

For nurses, ICU is a department where to chase active treatment, death is treated as failure.<sup>[7]</sup> Most nurses are afraid of joining in making such important decisions. For example, delaying the withdrawal of treatment created moral questioning to nurses.

B-5. Mutually accepting the fact of death, winning the trust of family members to actively seek consistency in treatment decisions. This classification indicated that ICU nurses have responsibility to help patients and their families make the right decisions. First, to help them accept death. We should convey sufficient, truthful and understandable information to patients and their families. The information includes the context of the ICU, the actual state of the patient, the medical and care plan, what might happen to the dying patient, what might be done in last stage, what the pros and cons of doing that, and what the appropriate recommendations based on the nurse's own experience. What is more, to choose the right way and skills of communication: first, actively participating in family meetings, accompanying doctors to communicate with families. To listen, supplement, explain

or clarify the information, and see if the observer and patient's response is clear. When communicating with family members, we should use structured communication methods, such as "value" memorization, which includes active listening, expressing empathy, and making supportive statements around not giving up and making decisions. Then, the timing of communication is important. Communication should be conducted when the family members are calm, and EOL willingness of the patient should be discussed before the patient's condition worsens or even before the patient is admitted to the hospital.<sup>[21]</sup>

Secondly, ICU nurses should fully understand, guide and support the family members, and establish a good relationship with the family members and patients. Nurses need to understand the individual needs of different families with empathy. For example, the use of sedatives, whether a separate room should be provided at the end of life, practical suggestions for cremation after death.<sup>[22]</sup> Finally, ICU nurses should advocate for patients and assist families and doctors in making the right decisions. And trying to seek consistency between patient and physician decisions based on nurses' own experience and expertise. However, if decisions are inconsistent, seek the support and assistance of the ethics committee.<sup>[23]</sup>

#### **4.1.3 Creating a physical and cooperative environment of ICU that benefits dying patients**

A-5. The collaborative and physical environment of the ICU is not conducive to the care of dying patients. This category showed that the ICU environment is not conducive to the implementation of good death. Firstly, the physical environment of ICU: the ICU is full of machines and noise, the environment is complex, the space is small, and most rooms are shared, there is no available single room, so patients' privacy can only be protected by the bed curtain. In such environment, there is no privacy. This also increases the distance between patients and their families. The second is the cooperative environment. ICU lacking of communication between doctors and nurses is common especially in critical end-of-life decisions,<sup>[9]</sup> nurses feel excluded most of the time. At the same time, nurses are less likely to communicate, let alone collaborate, with doctors and other specialists. From the point of view of physical and cooperative environment, ICU is not conducive to the realization of dying patients.

B-2. Creating an equal, cooperative and safe working environment. This category indicated that changing the environment can contribute to the realization of good death. The good death in ICU is characterized by quiet, well-ventilated patients surrounded by close relatives in a separate room.<sup>[11]</sup> A strong sense of camaraderie helps nurses deal with and

maintain emotional stability while caring for a dying patient, while creating a safe atmosphere for staff to help patients and their families feel at ease.<sup>[14]</sup> Firstly, on the premise of understanding the wishes of patients and their families, we need to arrange appropriate rooms, turn off unnecessary instruments, reduce the noise of operation, pull up the curtain, and if conditions permit, we can also provide a single room for family members and patients to say goodbye.<sup>[19]</sup> For example, nurses working in ICUs recommended a room was elaborately decorated, allowing close relatives to light candles and spend hours with the body if they wish.<sup>[11]</sup>

Secondly, interdisciplinary meetings should be held frequently for information sharing and discussion. The first is to ensure the rationality of the decision: within 72 hours after admission of high-risk patients, the attending physician can lead an interdisciplinary meeting to formulate treatment and care plans according to the goals and expectations of patients and their families.<sup>[21]</sup> In addition, meetings were also held irregularly during the patient's hospitalization to discuss and make corresponding decisions on the patient's condition changes. The second is to ensure that information is shared: end-of-life cases can be collected and knowledge of medical experience shared on a regular basis, thereby standardizing medical judgment and care. A pre-meeting between disciplines is required to reach consensus before a family meeting is important. Finally, to eliminate the gap between the disciplines, strengthen cooperation. For instance, integration of APNs into a palliative care team for case finding so as to relieve the pressure of nurses.<sup>[24]</sup>

#### **4.1.4 Giving priority to satisfy physical and mental needs of dying patients in ICU and their families, leaving no regrets**

B-3. Providing care opportunities with family members before death through timely identifying deaths and arranging time and space for visits and farewells to ensure family members have no regrets. It suggests that families and patients need stronger bonds before patients' death, which is the same as Rieko Kondo's<sup>[25]</sup> research. Due to the fear of infection, families always cannot be included in the care of patients and can only visit at a fixed time. They cannot see the patient for the last time which is cruel to both the patient and the family. Thus, ICU nurse need to strengthen the connection of family member and patient. First of all, using experience and monitoring indicators and warnings to identify early signs of death. At early stage, creating positive memories and encouraging families to touch and talk with patients to increase the intimacy of them.<sup>[12,16]</sup> Besides, families can be more actively involved in the care of their loved one. On arriving of death, arranging visitation time suitably and ensuring family and patient see each for the last glance through appropriately

using equipment and medication.<sup>[11]</sup> Family members of dying patients can be allowed to be present during rescue, and nurses are responsible for supporting family members.

B-4. Valuing terminal patients and their families, so that they are physically and mentally satisfied. The category highlights the significance of satisfying the family members and patients physically and mentally. First of all, we should give greater weight to the terminal patients so that they won't feel lonely. In ICU, patients are lonely because they cannot be accompanied by their families all the time, while nurses are always with them. Therefore, we should take care of patients just like their family members. In addition, most patients in the terminal stage are unconscious and their conditions change rapidly. Nurses should pay more attention to their needs and give priority to their care. Family members also need to focus more on the real needs of patients, rather than operation of the machine.<sup>[12]</sup>

Secondly, we should provide a complete and continuous care with the patients and their families.<sup>[7]</sup> According to the needs of them, to make a reasonable nursing plan in time, and constantly re-evaluate the patients and adjust the plan appropriately.<sup>[19]</sup> For example, the EOL care plan was a useful tool for formalizing frequently discussed but undocumented issues which provides a structure for clearly identifying responsibilities and alerting people to certain aspects of care that need to be addressed after the start of the EOL care plan.<sup>[26]</sup> Care of the body should be continued after the death of the patient, and emotional support should be extended to the family, such as attending funerals and conducting follow-up visit.

Finally, trying to meet the physical and mental needs of patients and their families in the ICU environment. The first is to make sure the patient is comfortable. This is completed by not performing invasive procedures, keeping the body clean, comfortable, breathing smoothly and pain-free.<sup>[17]</sup> Secondly, the customs and rituals of different religious cultures should be respected. Nurses should assist family members and patients to carry out religious rituals.

#### **4.2 The connection between different traditional culture and religions**

In China, because of the imprisonment of traditional culture: traditional views on life and death and filial piety which call out to do everything possible to save life, it is a taboo to talk about death in front of dying patient. The traditional view of filial piety coupled with the fact that the patient's religious traditions were not valued, most dying patients are overtreated and die with poor quality in ICU. Besides, ICU nurses have not formed a correct view of death. Most ICU

nurses even have death anxiety. ICU nurses are not active in end-of-life care. Moreover, basic care is done well for patients in the ICU, but mental care is inadequate. For nurses without religious beliefs, they seldom participate in patients' religious rituals. Most of the time, they allow some simple chanting and other rituals, but considering the special circumstances of the ICU, some religious rituals will be prohibited because they will affect other patients. In a word, the situation China faced is not so desirable.

Based on different cultural traditions and religions, we find that different cultures and religions are closely related to the degree of realization of good death.

Firstly, different cultural backgrounds lead to the extent to which ICU nurses are involved in end-of-life care. Due to different cultural backgrounds, most ICU nurses join in end-of-life care in different degrees, some directly involve in end-of-life decisions. For example, in a European study, the majority indicated direct involvement in end-of-life care, 73.4% reported active involvement in the decision-making process.<sup>[27]</sup>

Secondly, some religious beliefs promote the realization of good death. Religion provides spiritual relief to patients and their families. "For Muslims, there is a belief that it is a good thing if they die in Allah's arms." Then the nurses arranged patients' families to guide the dying patients to say commandments and read the Quran to the dying patients.<sup>[18]</sup> Thai Buddhists believed that the dying persons will not have a good death when their families are crying near the dying persons. Crying relatives were invited to go outside and were supported by the nurses.<sup>[19]</sup> In addition, some religions require patients to keep clean and comfortable. For Thai Muslims, they paid high attention to body cleaning and if the body was cleaned like this the deceased would pass away peacefully.

#### **4.3 Enlightenment to Chinese critical care practice**

Therefore, through this literature review, the experience and measures of ICU nurses in other countries in assisting patients with getting good death can be consulted.

Firstly, nurses should establish the correct concept: through the quality of care, terminal patients in the ICU can also get good death, which requires education and emotional support for ICU nurses. For education, through a variety of online and offline education methods, head nurses should provide more opportunities for nurses to learn, such as attending academic conferences, regular case discussion and sharing, and special lectures. At the same time, according to the actual needs of nurses to provide rich learning content: the right attitude facing death, the development of hospice care in the

ICU, how to communicate with the family and participate in the medical decision-making. According to the actual needs of family members, the education of patients and family members can be carried out through holding relevant lectures on a regular basis and distributing publicity materials, or through the network such as WeChat to convey correct views of death to family members. For emotional aspect, head nurse should always pay attention to the nurse's emotions, especially to prevention, regularly assess the psychological state of nurses, hold psychological lectures. Once nurse's negative feelings appear, the head nurse should timely alter nursing object and workload and converse with nurses to solve problems.

Secondly, Chinese nurses should attach importance to satisfy family members and patients psychologically and try not to leave any regrets. Firstly, more company from medical staffs should be provided with the patients and their families to prevent them from feeling lonely. Besides, providing flexible visiting time with family members and letting them participate in the care of patients at the last time are also important. In addition, a reasonable nursing plan should strengthen mental care on the basis of good basic nursing. Satisfying patients' religious rituals and cultural customs and letting them and their families have no spiritual regrets. Arranging nurses with the same religious beliefs to help patients is better.

Thirdly, in terms of policies, China should closely follow the pace of international development and issue guidelines and policies suited to Chinese national conditions. Laws such as withdrawal from treatment and Advance Care Planning should be enforced. Guidelines and workload should also base on the actual situation of each hospital. Allowing nurses have time and energy to provide specific care.

Fourthly, nurses should pay high attention to family members, understand the needs of family members comprehensively through active and effective communication, help family

members in practical problems, establish a good relationship, convey sufficient and true information. Actively seeking consistency with families of important medical decisions depending on patients' actual situation.

Finally, creating the right ICU cooperation atmosphere and good physical environment. Trying to arrange rooms according to the wishes of family members and patients. If possible, suitable single rooms should be provided to ensure silence and privacy. Working with doctors and members of other disciplines, the head nurse taking the lead in joining doctors' shifts and family meetings. Maintaining consistent information with doctor. Nurses can also work with social workers and home nurses to reduce the workload.

#### 4.4 Limitation

The included studies have heterogeneity in the living environment, ethnic and cultural background of the nurses, which may affect the interpretation of the findings. Hence, readers must think about their own countries' particularity. Nevertheless, looking after dying people in ICU is a general requirement and the four core findings of this study may have broad applications.

## 5. CONCLUSIONS

Good death is the ultimate goal of end-of-life care and dying patients have the right and need to get a peaceful death even in ICU where saving lives is the goal. However, through this study, we found that nurses believed that the quality of death of patients in the ICU was not high because of various obstacles. Nurses felt that innovation and reform were needed to make good death being a standard of care in ICU wards. However, in order to achieve good death of patients, only the efforts of nursing are not enough, we also need to improve the social, economic system and other aspects, so that the good death in the ICU is possible to achieve.

## CONFLICTS OF INTEREST DISCLOSURE

The authors declare they have no conflicts of interest.

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