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Attitudes and experiences related to the deaths of COVID-19 patients among nursing staff: A qualitative evidence synthesis

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Abstract

Aim: To identify and synthesize the experiences and attitudes of nursing staff regarding the deaths of COVID-19 patients.

Review Methods: A qualitative evidence synthesis was carried out, using Noblit and Hare's meta-ethnographic approach. The review protocol was listed in PROSPERO (CRD42022330928). Studies published from January 2020 to January 2022 that met the criteria were searched in PubMed, Web of Science, Scopus, CINAHL, CUIDEN and PsycInfo. A total of 12 articles were included.

Results: Thirty-three metaphors emerged, which were grouped into three main themes: Determining factors of care, Feelings about death and Strategies for coping with death. Nurses reported the high emotional toll, the absence of family and the lack of staff, protocol and training as determining factors. Furthermore, staff had doubts about the quality of care that COVID-19 patients received. As coping strategies, nurses developed avoidance behaviours towards COVID-19 patients, selective memories, resilience, and/or leaving the profession.

Conclusions: The difficulty in providing adequate nursing care and the high number of deaths has increased anxiety and stress among nurses. These factors, alongside their lived experiences of seeing patients suffering, many dying alone without family members, have had psychological repercussions on nursing staff.

Implications for the Profession and/or Patient Care: The results demonstrate a high emotional toll and doubts surrounding their caregiving role caused by the lack of professional training needed to face a pandemic. This research shows what has been learned for future pandemics and highlights basic components that could provide a foundation for coping interventions for healthcare professionals.

Impact

What Problem did the Study Address?

The challenges posed by COVID-19 patient deaths for nursing staff around the world and also by the pandemic circumstances in which those deaths occurred.

What were the Main Findings?

The high number of deceased patients who were isolated from family members, communication with family members and doubts surrounding care given during the pandemic have created feelings of fear, stress and anxiety, as well as obsessive thoughts that have changed nursing staff's perception of death due to COVID-19.

Where and on whom will the Research have an Impact?

Results will be useful for preparing for future pandemics, and for policymakers and health staff in supporting healthcare professionals by creating programmes to help them cope with the emotional toll they have felt after dealing with death in such unprecedented circumstances.

Reporting Method: The authors have adhered to the PRISMA guidelines and the eMERGe Reporting Guidance.

Patient or Public Contribution: No patient or public contribution.

KEYWORDS

attitude to death, COVID-19, death, life change events, nurses, qualitative research, qualitative synthesis

1 | INTRODUCTION

In December 2019, atypical pneumonia cases began to be reported in China's Wuhan region, caused by infection by a strain of coronavirus that was unheard of until that point. The rapid global spread of the virus and the severity of the symptoms it provoked, especially in people over the age of 65, made the World Health Organization declared a global pandemic situation on 11 March 2020 due to the new coronavirus disease 2019 (COVID-19) caused by SARS-CoV-2 (WHO, 2020a).

COVID-19 has been a huge challenge for healthcare systems across the world, especially those whose population includes a high percentage of people over 65 (Fernández Ibáñez et al., 2022). The first cases in Europe were detected in France in January 2020 (Stoecklin et al., 2020). In the first week of March 2020, COVID-19 spread rapidly throughout Europe, with new cases being detected in Italy, Germany and the United Kingdom. By 2 March 2020, Italy was the country with the highest number of cases (1689) and deaths (35) (WHO, 2020b). The virus then spread to countries in the Middle East such as Iran, Iraq and Lebanon (Steffens, 2020).

The rapid progression of pneumonia caused by COVID-19 and the high mortality rate of infected patients during the first waves led to healthcare providers being confronted with new circumstances regarding the care and deaths of these patients (Cardoso et al., 2021). SARS-CoV-2 has had a clear impact on worldwide reported deaths in comparison to other recent pandemics. As of 2 March 2020 in the present pandemic, 3043 COVID-19 associated deaths had already been reported (WHO, 2020b), whereas in the SARS-CoV pandemic of February 2003, 779 deaths were initially reported, with no new cases having been reported since 2004 (Centers for Disease Control and Prevention, 2017).

Health systems became overwhelmed, prompting the development of new protocols in healthcare institutions, such as increasing the number of beds at several levels of care and employing staff with little to no experience in departments (Galanis et al., 2021; Mota Romero et al., 2022; Sahebi et al., 2021). The changes in healthcare units as a result of the pandemic contributed to healthcare staff developing stress, anxiety and depression (Adibi et al., 2021; Erquicia et al., 2020; Mota Romero et al., 2022; Poon et al., 2022; Sahebi et al., 2021; Ünver & Yeniğün, 2021). These changes made them feel helpless as they were unable to properly care for patients (Ashley et al., 2021; Poon et al., 2022; Torralba Melero et al., 2022).

As well as the changes described above, COVID-19 also presented a challenge to nurses for other reasons: a lack of resources, such as personal protective equipment (PPE) (Leng et al., 2021; Sahebi et al., 2021); long work-days due to staff shortages (Leng et al., 2021; Mosheva et al., 2021); as well as having to cope with the deaths of severely ill isolated patients without any family support (Leng et al., 2021; Mosheva et al., 2021). All these factors prompted high levels of post-traumatic stress in healthcare staff (Leng et al., 2021; Mosheva et al., 2021).

The impact of witnessing a large number of deaths by nursing professionals during the COVID-19 pandemic is a highly consequential phenomenon. Researchers have identified an association between this phenomenon and the development of burnout and post-traumatic stress among nursing professionals (Couper et al., 2022; Gualano et al., 2021; Kelly et al., 2021; Mosheva et al., 2021; Sharifi et al., 2020). For this study, we define burnout as chronic stress in the workplace that is not successfully managed and is characterized by fatigue, negative thoughts about work and reduced professional effectiveness (WHO, 2019). On the other hand, we understand post-traumatic stress as a persistent mental disorder that appears after exposure to a severe traumatic event (Leng et al., 2021).

The emotions most often felt by nurses when faced with a patient's death are compassion, sadness and helplessness (Kostka et al., 2021), despite the fact, as shown in Gerow et al. (2010), that some nurses consider a proper professional attitude as not showing any kind of grief for the deceased patient and continuing with their

care work without being affected personally. However, preparing the patient's body after their passing, comforting the family of the deceased and offering them support allows nurses to better handle their Feelings about death (de Swardt & Fouché, 2017). These strategies have been impacted by the COVID-19 pandemic situation and are consequently the subject of interest in this review.

A previous systematic review using a meta-ethnographic approach covered the topic of attitudes towards the deaths of nursing staff (Puente-Fernández et al., 2020). The present study continues this line of research but now focuses on the deaths of COVID-19 patients. As such, the importance of exploring and understanding this phenomenon lies in two factors: the ability to prevent healthcare professionals in future pandemics from suffering psychological repercussions and the need to mitigate these repercussions felt by these professionals during the current COVID-19 pandemic.

2 | THE REVIEW

2.1 | Aim

To identify and synthesize the experiences and attitudes of nursing staff regarding the deaths of COVID-19 patients.

2.2 | Design

A qualitative evidence synthesis was carried out using the meta-ethnographic approach developed by Noblit and Hare (1988). The meta-ethnographic systematic approach combines data from multiple qualitative studies to develop new insights into participants' experiences and perspectives of a phenomenon. Meta-ethnographies offer higher-order interpretation compared to a conventional narrative literature review and are considered a study in their own right. This approach was chosen as it is the one used in the previous review this work is based on (Puente-Fernández et al., 2020), allowing for a new conceptual framework using an interpretive synthesis method to be developed (France, Cunningham, et al., 2019). The review protocol was registered in PROSPERO (CRD42022330928).

2.3 | Search methods

Studies published from January 2020 to January 2022 were searched in PubMed, Web of Science, Scopus, CINAHL, CUIDEN and PsycInfo, using the software Mendeley (Elsevier; Amsterdam, The Netherlands) to reference and save the results. The following MeSH terms were used: "nursing", "nursing staff", "COVID-19", "SARS-COV-2", "death", "attitude", "experience" and "qualitative research", both in Spanish and English, and in free text form: "attitude towards death" and "experience", in both languages. The search strategy employed in each database is detailed in Table 1. The search was done by the main author under the supervision of another author (DPF).

2.4 | Eligibility criteria

The inclusion criteria were as follows: (a) primary qualitative studies (including mixed-methods studies with qualitative methodology) about nursing staff perceptions of adult COVID-19 patient deaths and (b) studies completed from 2020 onward in the context of the COVID-19 pandemic. The exclusion criteria were as follows: (a) studies carried out in languages other than Spanish or English and (b) non-peer-reviewed studies.

2.5 | Search outcomes

After conducting the search across each of the resources, any duplicates were removed. Next, a preliminary selection was made based

TABLE 1 Search strategy.

Date	Database	Equation
25 February 2022	PubMed	(nursing staff OR nursing) AND (COVID-19 OR SARS-CoV) AND Death AND (attitude towards death or attitude or experience) AND qualitative research
25 February 2022	WOS	Nursing staff OR nursing (Topic) and (covid-19 OR sars-cov-2) (Topic) and death (Topic) and (attitude towards death OR attitude OR experience) (Topic) and qualitative research (Topic)
25 February 2022	Scopus	(ALL ({nursing staff} AND nursing) AND ALL ((covid-19 OR sars-cov-2)) AND ALL ({attitude towards death} OR attitude OR experience) AND ALL ({qualitative research}))
25 February 2022	CINAHL	("Nursing staff" OR nursing) AND (covid-19 OR sars-cov-2) AND death AND (attitude towards death OR attitude OR experience)
4 March 2022	CINAHL	("Nursing staff" OR nursing) AND (covid-19 OR sars-cov-2) AND death AND ("attitude towards death" OR attitude OR experience) AND qualitative
25 February 2022	CUIDEN	("Personal de enfermería" OR enfermería) AND (COVID-19 OR SARS-CoV) AND Muerte AND (actitud frente a la muerte or actitud or experiencia)
26 March 2022	PsycInfo	("nursing staff" OR nursing) AND (covid-19 OR sars-cov-2) AND death AND ("attitude towards death" OR attitude OR experience) AND qualitative

Source: Prepared by the authors.

on the article's title and abstract, discarding those studies that did not meet the inclusion criteria. After reading each text in its entirety, studies that did not provide relevant findings were discarded, mainly because they did not sufficiently develop the topic at the centre of this review. The search was done by the main author under the supervision of another author (DPF).

2.6 | Quality appraisal

A critical appraisal was done in pairs using the CASP (Critical Appraisal Skills Programme) qualitative checklist (2018), which includes 10 questions related to methodological quality, relevance of results, and the applicability of the studies in its qualitative studies version. For the mixed-methods studies, the parts corresponding to qualitative methodology were assessed. Three reviewers participated in the critical appraisal. Two of these reviewers (MGBF, DPF) performed an independent review of the selected studies, later resolving potential points of discrepancy with the third reviewer (CHM) supervising the process. Finally, an agreement was reached in two rounds of review, in which the two reviewers covered the aspects that were not agreed upon in the first instance.

2.7 | Data abstraction

Data collection was done by two reviewers following a pre-existing protocol. The following data were extracted: country, sample size, age, professional profile, sex, study setting, design, data collection, data relating to each study objective and other related themes. After being recorded in an Excel database, data relating to each study objective were synthesized as described in the following section. While many studies included only nursing professionals, some also included other professionals. However, only data provided by the nursing professionals participating in these studies were synthesized.

2.8 | Synthesis

The selected studies were synthesized using the seven-stage meta-ethnographic method by Noblit and Hare (1988). In the first phase, which involves identifying the main theme of the synthesis, the theme of experiences and attitudes towards the death of COVID-19 patients among nurses was identified. In the second phase, which involves the identification and selection of appropriate studies, the qualitative studies were chosen based on their quality and the inclusion and exclusion criteria. In the third phase, when the studies are read, the results of each study were read in detail multiple times. This allowed for the identification of relevant themes/metaphors based on first- and second-order data (quotes from participants and author interpretations), to later produce the interpretive categories. Each study was considered a unit of analysis and the texts extracted from each unit were imported into the program Atlas.ti (Berlin, Germany).

In the fourth phase, the relationships between different studies were established based on lists of themes/metaphors. The theoretical similarity between each study was taken into consideration as well as the meaning of the themes/metaphors, grouping them as directly comparable, refutational or following a line of argument. In the fifth phase, studies were translated, comparing the themes/metaphors across various studies. In the sixth phase, translations were summarized, comparing the findings from the previous phase to develop new interpretations and produce third-order constructs (interpretive categories). From phase 3–6, the three principal investigators (MGBF, DPF, CHM) took part and results were later triangulated with the other collaborating researchers. The seventh and final phase involves reporting findings, including a summary of the main findings, comparing them with current literature and detailing the strengths and limitations of the study: aspects which are covered later in the Discussion section.

To create the report, the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines (Page et al., 2021) and the eMERGe Reporting Guidance (France, Cunningham, et al., 2019), were followed, the latter specifically focusing on meta-ethnography.

3 | RESULTS

During the initial search, a total of 343 articles were obtained. After removing duplicates, a total of 308 studies were selected. After applying the inclusion and exclusion criteria, a total of 12 studies were analysed through critical appraisal. The 12 studies were selected and included in the synthesis, as detailed in Figure 1.

The methodological quality of the selected studies is detailed in Table 2.

The selected studies were carried out in the United States (Arnetz et al., 2020; Foli et al., 2021; Naylor et al., 2021; White et al., 2021), Turkey (Durgun et al., 2022; Sezgin et al., 2021), Lebanon (Fawaz & Itani, 2021), Iran (Galehdar et al., 2020; Shamsalinia et al., 2022), Canada (Lapum et al., 2021), the United Kingdom (Montgomery et al., 2021) and China (Xu et al., 2021). Nine out of 12 of the articles analysed nurses' experiences in particular (Arnetz et al., 2020; Durgun et al., 2022; Fawaz & Itani, 2021; Foli et al., 2021; Galehdar et al., 2020; Lapum et al., 2021; Naylor et al., 2021; Sezgin et al., 2021; Xu et al., 2021), while three analysed the experiences of other healthcare professionals, such as physicians, physical therapists and dieticians (Montgomery et al., 2021; Shamsalinia et al., 2022; White et al., 2021). Ten of the studies were performed in hospitals (Durgun et al., 2022; Fawaz & Itani, 2021; Foli et al., 2021; Galehdar et al., 2020; Lapum et al., 2021; Montgomery et al., 2021; Naylor et al., 2021; Sezgin et al., 2021; Shamsalinia et al., 2022; Xu et al., 2021), one in nursing homes (White et al., 2021) and the other in inpatient/hospital

FIGURE 1 Flowchart (From: Page et al., 2021).

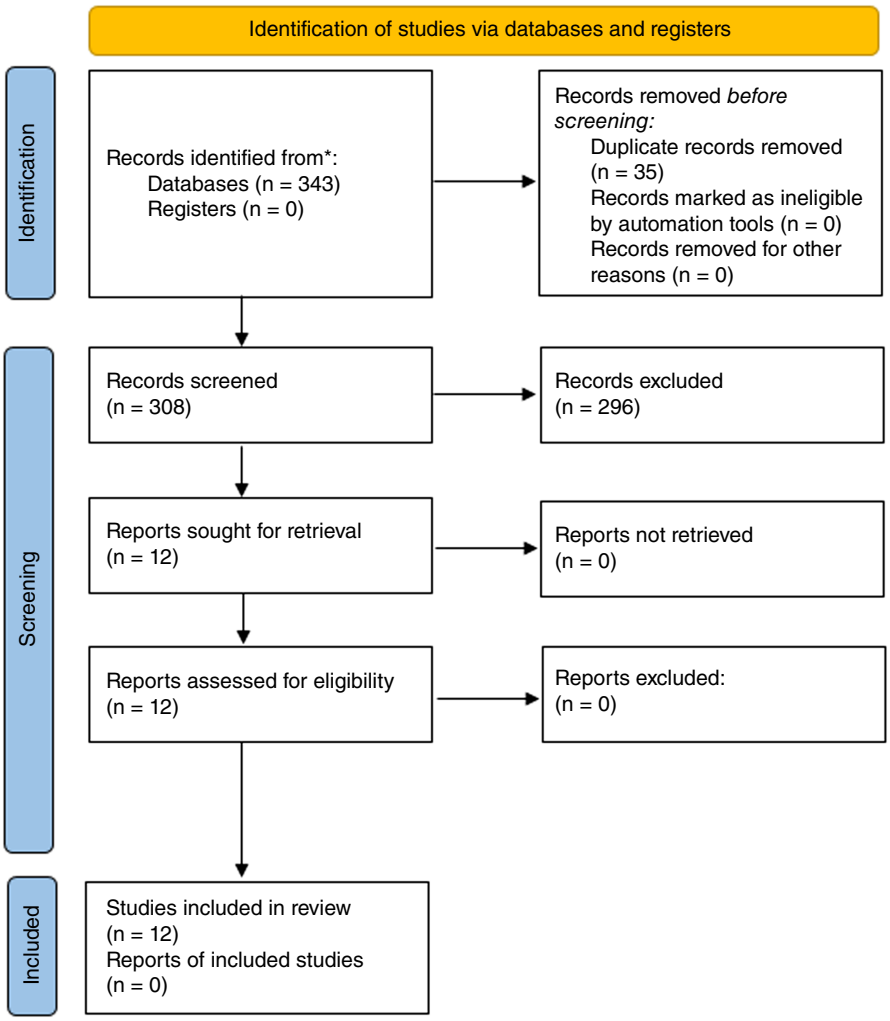

TABLE 2 Appraisal of methodological quality.

	Items									
Author and year	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Arnetz et al. (2020)	✓	✓	✓	×	✓	×	✓	✓	✓	✓
Durgun et al. (2022)	✓	✓	×	?	✓	×	✓	✓	✓	✓
Fawaz and Itani (2021)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓
Foli et al. (2021)	✓	✓	×	✓	✓	×	✓	✓	✓	✓
Galehdar et al. (2020)	✓	✓	×	✓	✓	✓	✓	✓	✓	✓
Lapum et al. (2021)	✓	✓	?	×	✓	×	✓	✓	✓	✓
Montgomery et al. (2021)	✓	✓	?	✓	×	×	✓	✓	✓	✓
Naylor et al. (2021)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓
Sezgin et al. (2021)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Shamsalinia et al. (2022)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
White et al. (2021)	✓	✓	?	✓	×	×	?	✓	✓	?
Xu et al. (2021)	✓	✓	?	✓	✓	×	✓	✓	✓	✓

Note: Items: 1. Were the objectives of the investigation clear? 2. Is the qualitative methodology consistent? 3. Is the investigation method appropriate to achieve research objectives? 4. Is the participant selection strategy consistent with the research question and the method used? 5. Are the data collection techniques consistent with the research question and the method used? 6. Has the relationship between the researcher and the object of study been considered (reflexivity)? 7. Have ethics been taken into consideration? 8. Was data analysis sufficiently rigorous? 9. Are the results described clearly? 10. Are the results of the research applicable? Appraisal: ✓=Yes; ×=No;?=Cannot Tell.

Source: Prepared by the authors.

and outpatient settings (Arnetz et al., 2020). The characteristics of each study are shown in Table 3. As well as the experiences and attitudes towards the deaths of COVID-19 patients, the studies also discussed other themes (Table 3).

Upon analysing the results and following the Noblit and Hare model (Noblit & Hare, 1988), in phase 3 there were a total of 109 themes/metaphors identified after the complete reading of each article. These themes/metaphors corresponded to sentences, concepts or ideas extracted from first- and second-order data (Supporting Information).

In phases 4 and 5 of the analysis, it should be noted that a considerable proportion of the themes/metaphors are directly comparable to those from the analysed studies, although refutational aspects were also identified among them (main outcomes of relating studies in Table 4). These themes were grouped into 33 interpretive categories (third-order constructs). Table 5 shows the distribution of interpretive categories in each study.

Finally, in phase 6, the final synthesis was performed, initially finding five constructs based on the interpretive categories. After triangulation between the main authors and the collaborators, they were grouped into three final constructs upon which the findings of the review are based. In the final synthesis stage, the framework used in the previous review (Puente-Fernández et al., 2020) helped to illustrate the changes observed in nurses' experiences and attitudes towards death, in this case, focusing on COVID-19 patients.

3.1 | Determining factors of care

First, it is highlighted that nurses are faced with a high number of deaths (Arnetz et al., 2020; Fawaz & Itani, 2021; Foli et al., 2021; Galehdar et al., 2020; Naylor et al., 2021; Sezgin et al., 2021; Shamsalinia et al., 2022). Nurses viewed COVID-19 as the cause of death of the majority of their patients (Naylor et al., 2021), making reference also to the deaths of nurses (Sezgin et al., 2021; Shamsalinia et al., 2022) or other loved ones (Fawaz & Itani, 2021; Foli et al., 2021). As discussed in the study by Naylor et al. (2021), there comes a time when the number of deaths is so high that it is impossible keep count:

> The amount of loss that I've seen since March, at first it was always in front of my mind. I would say, I've lost four patients so far, I've lost six patients so far and now the sad truth is, I can't even keep track anymore (Naylor et al., 2021).

Other nurses commented on the fact that, in the last year, they feel like the only thing they have done is take patients to the morgue (Fawaz & Itani, 2021).

> For the past year… with COVID-19, the blast and now the immense outbreak, all that we have been doing is discharging people to the morgue…putting people in bags (Fawaz & Itani, 2021).

This led nurses to refer to COVID-19 with metaphorical expressions such as 'poison' or 'the grim reaper' (Durgun et al., 2022).

Another important factor discussed has to do with the spread of COVID-19. Nurses often referred to patients as being blameless for catching the virus, shifting any responsibility away from them (Galehdar et al., 2020).

One of the most highlighted factors in patient care was the absence of family members (Arnetz et al., 2020; Foli et al., 2021; Montgomery et al., 2021; Shamsalinia et al., 2022). This situation caused loneliness among patients (Foli et al., 2021;Lapum et al., 2021; Naylor et al., 2021), and some studies underlined the importance of ethics committee responses in this respect (Lapum et al., 2021; Naylor et al., 2021). Nurses highlighted the unique circumstances of COVID-19 regarding family members not being allowed to visit admitted patients, emphasizing that they did not think it was the right decision, as discussed in the study by Montgomery et al. (2021):

> And that was a Covid specific thing, just because it had been so…challenging to be able to do it all remotely…to not be able to support the relatives, and just not have them there, it just didn't seem right at all (Montgomery et al., 2021).

Furthermore, it was mentioned that this absence of family members had repercussions on patients as they did not have the psychological support they needed in that moment (Shamsalinia et al., 2022) and they suffered greatly by not having their family there (Arnetz et al., 2020). The humanization of care was highlighted when family members were allowed to see patients before they died (Montgomery et al., 2021).

Communication with family members posed a new challenge for nurses, because they had to provide updates via video call in a rapidly changing clinical context with uncertain prospects (Lapum et al., 2021). Some patients had to say goodbye to their family by video call (Foli et al., 2021).

At times, staff shortages were a further obstacle in providing optimal care to patients (White et al., 2021). Nurses highlighted their feelings of helplessness by making reference to the little help their training was in situations where patients got progressively worse (Lapum et al., 2021). Lack of training was also highlighted as an influencing factor on patient care and on communication with family members, as many nurses did not feel they were prepared to care for terminally ill patients and provide updates to their families (Galehdar et al., 2020). Regarding patient care, at the start of the pandemic some protocols did not specify what to do with COVID-19 patients when they died (Montgomery et al., 2021).

TABLE 3 Characteristics of the studies included in the review.

Study	Country	*N*	Age	Profile	Setting	Design	Data collection	Other themes
Arnetz et al. (2020)	The United States	455	<35 18.1% (82) 35–44 21.8% (99) 45–54 24.8% (113) 55–64 26.6% (121) >65 8.7% (38)	Nurses (455) M(26) F(429)	Hospitals (240) Outpatient facilities (104) Unknown (111)	Qualitative descriptive content analysis	• Sociodemographic data • Questionnaire of 84 closed questions • One open question	• Fear of infection • Problems in the workplace • Problems with PPE • Lack of knowledge of COVID-19 • Opinion of COVID-19 in social spheres
Durgun et al. (2022)	Turkey	227	30.27 ± 7.36	Nurses (227) M (35) F (192)	Hospitals (227) • Covid Unit	Mixed Methods, qualitative, phenomenological	• Sociodemographic data (10 items) • One open question in the form of a metaphor	• COVID-19 as a living organism • Feelings • Danger
Fawaz and Itani (2021)	Lebanon	18	24.6	Nurses (18) M (8) F (10)	Hospitals (18) • Covid Unit • ICU • ED	Phenomenological Thematic analysis	• Interviews	• Feelings of helplessness • High rates of mortality and depression • People's carelessness and governmental responsibility • Panic and incompetence
Foli et al. (2021)	The United States	105	34 ± 11	Nurses (105) M (3) F (102)	Hospitals (105) • ICU	Qualitative, descriptive content analysis	• Sociodemographic data questionnaire • Two open questions	• Psychological stress • Family and work environment • Work dissatisfaction • Resilience
Galehdar et al. (2020)	Iran	20	31.95 ± 6.64	Nurses (20) M (5) F (15)	Hospitals (20) • 1/20 Covid Unit • 6/20: ED • 11/20: ICU • 2/20: General.	Qualitative, descriptive content analysis	• Sociodemographic data • Semistructured telephone interviews	• Anxiety about the type of health condition • Anxiety about patient funerals • Fear of infecting family members • Stress about wasted time • Giving bad news • Fear of infection • Obsessive thoughts • Uncomfortable PPE • Conflict between fear and awareness of disease • Ignorance to sanitary measures in the general population

(Continues)

TABLE 3 (Continued)

Study	Country	N	Age	Profile	Setting	Design	Data collection	Other themes
Lapum et al. (2021)	Canada	20	Unknown	Nurses	Hospitals (20)	Narrative	• Sociodemographic data • Semistructured video interviews	• Emotional experience: fear of infection, uncertainty, frustration and anger • Intense traumatic feelings, isolation from family • Changes in patient care due to fear of infection • Problems accessing PPE. • Poor management
Montgomery et al. (2021)	United Kingdom	40	Unknown	Nurses (22) M (2) F (20); Physicians (9) M (6) F (3); Die titian (1) F (1); Surgeons (3) M (1) F (2); Physical therapists (3) F (3); Secretaries (2) F (2)	Hospitals (40) • ICU	Semistructured telephone interviews and rapid analysis. I	• Semistructured telephone interviews	• Fear of COVID-19 • Moral duty to help others • Difficult experiences in providing patient care • Isolation because of COVID-19 • Creativity in managing resources • Team work
Naylor et al. (2021)	The United States	13	29 (range: 24–41)	Nurses (13) M (3) F (10)	Hospitals (13)	Phenomenological	• Semistructured video interviews	• Concerns about use of PPE • Caring for patients with little training • Difficulties arising from staff shortages • Overall sense of unease • Support from colleagues • Preparation for a pandemic during university studies • Choosing to be a nurse again
Sezgin et al. (2021)	Turkey	10	Mean = 25	Nurses (10) M (2) F (8)	Hospitals (10) • ICU	Naturalism Descriptive qualitative approach	• Semistructured video interviews	• Social exclusion upon saying they work with COVID-19 patients • Lack of standards of care for COVID-19 patients • Empowerment and lack of job satisfaction as a nurse • Experiences with PPE

TABLE 3 (Continued)

Study	Country	N	Age	Profile	Setting	Design	Data collection	Other themes
Shamsalinia et al. (2022)	Iran	22	Unknown	Nurses (14) M (3) F (11); Physicians (5) M (5); Other (3) M (3)	Hospitals (19) Other (3) • Haemodialysis ward, • Nursing Office, -ED, • ICU, • Internal ward, • Covid Unit	Qualitative, descriptive content analysis	• Face to face interviews	• Late understanding of what COVID-19 is • Sudden changes in job role • Difficulties with management • Lack of patient care due to absence of family members • Ethical dilemmas • Obsessive thoughts • Opportunity to grow thanks to what has been experienced • Problems accessing PPE
White et al. (2021)	The United States	152	Unknown	Nurses (38); Physicians (15); Administrative assistants (10); Other	Nursing homes or long-term care facilities (152)	Inductive thematic analysis	• Electronic survey with closed questions and four open questions	• Problems accessing PPE • Lack of consistent regulations • Concern for themselves and their families • Concern for residents • Lack of public recognition • Poor management
Xu et al. (2021)	China	9	34.3 ± 2.5	Nurses (9)	Hospitals (9)	Qualitative, descriptive content analysis	• Semistructured video interviews	• Stress and concern • Experiences working in a team • Experiences of logistic support and overall care • Importance and significance of the experience • Problems accessing PPE • Poor management

Source: Prepared by the authors.

Abbreviations: ED, Emergency department; F, female; ICU, Intensive Care Units; M, male.

TABLE 4 Main outcomes of relating studies.

Relate reciprocally	
Study	**Outcome**
Arnetz et al. (2020); Fawaz and Itani (2021); Galehdar et al. (2020); Shamsalinia et al. (2022); Xu et al. (2021)	Anxiety and stress that nursing professionals were under
Arnetz et al. (2020); Fawaz and Itani (2021); Foli et al. (2021); Galehdar et al. (2020); Naylor et al. (2021); Sezgin et al. (2021); Shamsalinia et al. (2022)	High number of deaths, especially in the beginning stages of the pandemic
Arnetz et al. (2020); Foli et al. (2021); Galehdar et al. (2020); Lapum et al. (2021); Montgomery et al. (2021)	Sadness felt by nurses
Arnetz et al. (2020); Foli et al. (2021); Montgomery et al. (2021); Shamsalinia et al. (2022)	Absence of patient family members
Arnetz et al. (2020); Fawaz and Itani (2021); Galehdar et al. (2020); Lapum et al. (2021); Montgomery et al. (2021); Naylor et al. (2021); Sezgin et al. (2021); Shamsalinia et al. (2022); White et al. (2021); Xu et al. (2021)	Psychological repercussions for nurses both during and after the pandemic
Fawaz and Itani (2021); Foli et al. (2021); Montgomery et al. (2021); Sezgin et al. (2021); Shamsalinia et al. (2022); Xu et al. (2021)	Doubts of the nursing staff regarding the quality of care
Arnetz et al. (2020); Galehdar et al. (2020); Lapum et al. (2021); Naylor et al. (2021); White et al. (2021); Xu et al. (2021)	Feeling of helplessness among nurses
Arnetz et al. (2020); Fawaz and Itani (2021); Naylor et al. (2021); Sezgin et al. (2021); Shamsalinia et al. (2022); Xu et al. (2021)	Healthcare staff concerns for their well-being and that of their patients
Foli et al. (2021); Lapum et al. (2021); Naylor et al. (2021)	Patients dying alone
Arnetz et al. (2020); Foli et al. (2021); Galehdar et al. (2020); Lapum et al. (2021); Sezgin et al. (2021); Shamsalinia et al. (2022)	Patient suffering
Relate refutationally	
Study	**Outcome**
Montgomery et al. (2021); Xu et al. (2021); Arnetz et al. (2020)	Positive outlook nurses had of their profession, which was reinforced during the pandemic versus the desire to leave the profession was highlighted
Foli et al. (2021); Lapum et al. (2021); Sezgin et al. (2021)	Nursing profession as being worthwhile versus the possibility of leaving it

Source: Prepared by the authors.

TABLE 5 Interpretative categories distribution.

	Determining factors of care												
	High number of deaths	Death of nurses	Loss of loved ones	Metaphors for death	Context of infection	Absence of family members	Dying alone	Ethics	Role of family members	Humanisation	Communication with family members	Saying goodbye to family	Lack of staff and training	Confusion about protocols
Arnetz et al. (2020)	✓					✓								
Durgun et al. (2022)				✓										
Fawaz and Itani (2021)	✓		✓											
Foli et al. (2021)	✓		✓			✓	✓					✓		
Galehdar et al. (2020)	✓				✓								✓	
Lapum et al. (2021)							✓	✓			✓		✓	
Montgomery et al. (2021)						✓			✓	✓				✓
Naylor et al. (2021)	✓						✓	✓						
Sezgin et al. (2021)	✓	✓												
Shamsalinia et al. (2022)	✓	✓				✓								
White et al. (2021)													✓	
Xu et al. (2021)														

Source: Prepared by the authors.

3.2 | Feelings about death, feelings of helplessness regarding caregiving

Stress and anxiety were very present among nurses, who often expected the worst outcome in every situation (Arnetz et al., 2020; Fawaz & Itani, 2021; Galehdar et al., 2020; Shamsalinia et al., 2022; Xu et al., 2021). Phrases such as 'crying' were identified (Lapum et al., 2021; Sezgin et al., 2021; Xu et al., 2021) and occasionally some studies discussed depression and burnout (Fawaz & Itani, 2021; Foli et al., 2021; Lapum et al., 2021; White et al., 2021). Stress was especially high at the beginning of the pandemic, when the number of deaths was at its highest (Galehdar et al., 2020). In one study, it was mentioned that some nurses were considering leaving the profession altogether (Arnetz et al., 2020).

Nurses expressed doubts regarding the quality of care they were providing, despite their efforts (Fawaz & Itani, 2021; Foli et al., 2021; Montgomery et al., 2021; Sezgin et al., 2021; Shamsalinia et al., 2022; Xu et al., 2021), even asking themselves whether they would be capable of saving the life of their patients (Xu et al., 2021). In addition, care after death (Arnetz et al., 2020; Montgomery et al., 2021; Sezgin et al., 2021) also varied because other staff, such as porters, were restricted from entering rooms with deceased COVID-19 patients (Montgomery et al., 2021). Nurses even began to doubt their own ability to correctly perform their duties and that this would affect patients, as shown in the following quotation from Montgomery et al. (2021):

> I have dealt with death a lot over the years, but there was one day that I just…I thought, I can't…if I have to do that again, look after somebody who was dying, I don't know if I could do it, and I've never had that experience before, with 20 odd years of ITU, I've never thought, "I just don't know if I can do that (Montgomery et al., 2021)

Nurses reported feeling helpless in response to patient suffering (Arnetz et al., 2020; Foli et al., 2021; Galehdar et al., 2020; Lapum et al., 2021; Naylor et al., 2021; Sezgin et al., 2021; Shamsalinia et al., 2022; White et al., 2021; Xu et al., 2021), seeing as they could not do anything to help them while their clinical condition worsened, as shown in the following quotations:

> Watching patient's [sic] suffocate while intubated and having nothing else that I can do for them. We have exhausted all efforts and there is literally nothing left to do (Arnetz et al., 2020).

> One patient who could not speak our language grabbed my hand when I was giving care and started kissing my hands while crying (Sezgin et al., 2021).

Another one of the most highlighted factors is the psychological repercussions (Arnetz et al., 2020; Fawaz & Itani, 2021; Galehdar et al. (2020); Lapum et al., 2021; Montgomery et al., 2021; Naylor et al., 2021; Shamsalinia et al., 2022; White et al., 2021; Xu et al., 2021) felt by nurses during and after the pandemic. In the study by Galehdar et al. (2020), a nurse commented on how upset she felt at times when she saw she could not do anything else for her patients, and that she will remember those scenes for the rest of her life:

> The fact that you can't do anything in those last moments bothers you a lot, the scenes that I may not forget for the rest of my life. (Galehdar et al., 2020).

Feelings about death												Dealing with death						
Anxiety and stress	Crying	Depression and burnout	Doubts about care	Care after death	Helplessness in patient care	Patient suffering	Psychological repercussions	Fear felt by nurses	Fear felt by patients	Patient panic	Sadness	Obsessive thoughts	Guilt	Respon-sibility	Lack of meaning	Meaning	Motivation	Resilience
✓					✓				✓	✓	✓							
✓		✓	✓				✓	✓				✓	✓		✓	✓	✓	
		✓	✓			✓					✓						✓	
✓					✓	✓	✓				✓		✓					
	✓	✓			✓	✓	✓				✓				✓			✓
			✓	✓			✓				✓							
					✓		✓	✓										
	✓		✓	✓		✓	✓	✓										
✓			✓			✓	✓	✓	✓	✓		✓		✓				
		✓			✓		✓						✓					
✓	✓		✓		✓		✓	✓				✓	✓					

Some nurses felt scared knowing that they were the last people to see their patients alive (Fawaz & Itani, 2021; Naylor et al., 2021; Sezgin et al., 2021; Shamsalinia et al., 2022; Xu et al., 2021). This feeling of fear and panic was also present among patients (Arnetz et al., 2020; Shamsalinia et al., 2022), as mentioned in the study by Arnetz et al. (2020):

> Seeing the fear in the eyes of Covid patients that cannot breathe and are begging me not to let them die (Arnetz et al., 2020).

Others, however, highlighted the sadness they felt knowing that some patients might catch COVID-19 because of the carelessness of other people. (Arnetz et al., 2020; Foli et al., 2021; Galehdar et al., 2020; Lapum et al., 2021; Montgomery et al., 2021). In addition, the fact that patients died alone also intensified these feelings of sadness (Montgomery et al., 2021). Nurses reported feeling sad after meeting a patient when they were admitted to hospital and then later being the ones to take care of the body after their death, as in the following study:

> The most upsetting thing is to meet patients when they come into the hospital walking and talking and to get to know them personally. Then to be the same nurse just a short time later to take care of the same patient after their passing, by putting them in a body bag and wheeling them to the morgue (Arnetz et al., 2020).

3.3 | Strategies for coping with death

One of the strategies for coping with the deaths of COVID-19 patients is related to the inability to remember them after their passing due to its huge emotional impact and the fear that is felt when providing care in these circumstances. To avoid this, nurses tried not to think too much about the time they spent with patients (Xu et al., 2021).

> In order to adjust the psychological pressure, we need to forget such things in a short time (Xu et al., 2021).

Due to the complexity of the situation, some nurses began to feel responsible at times for the lack of care given and the high number of deaths (Fawaz & Itani, 2021; Galehdar et al., 2020; White et al., 2021; Xu et al., 2021). This caused obsessive thoughts to manifest among nurses about their job (Fawaz & Itani, 2021; Shamsalinia et al., 2022), as they felt more responsible for their patient's care due to the absence of the patient's family members (Shamsalinia et al., 2022).

> I am afraid all the time that my patient would die…I triple check everything I do (Fawaz & Itani, 2021).

They tried to find meaning (Fawaz & Itani, 2021; Lapum et al., 2021) in the situation they were experiencing to stay motivated and keep going (Fawaz & Itani, 2021; Foli et al., 2021), which occasionally formed more resilient behaviour (Lapum et al., 2021).

Figure 2 summarizes the main findings of this review.

4 | DISCUSSION

This interpretive qualitative synthesis of the experiences and attitudes of nursing staff regarding the deaths of patients due to COVID-19 identified three main themes: Determining factors of care, Feelings about death and Strategies for coping with death. Problematic experiences and attitudes were related to the high number of deceased patients who were isolated from family members, strained communication with those family members and doubts surrounding the quality of care given during the pandemic. These issues contributed to feelings of fear, stress, sadness and anxiety among nurses. Further complicating the high emotional impact were conflicting feelings of responsibility and powerlessness to mitigate these circumstances. Together, these experiences have changed nursing staffs' perception of death due to COVID-19. To the best of our knowledge, the attitudes and experiences related to the deaths of COVID-19 patients among nursing staff have not been the subject of any other systematic review with interpretive synthesis.

Regarding Determining factors of care, the high emotional impact on nursing staff when caring for dying COVID-19 patients stands out. The high number of deaths and the fact that these patients died alone resulted in perceptions of a poor-quality death. This factor was also observed in previous research (Puente-Fernández et al., 2020), but the many deaths stemming from the pandemic situation conditioned how nurses were able to support patients and families and made the emotional strain more intense. The absence of family members at the bedside was a particularly notable factor of care. Nurses reported communication difficulties when attempting to circumvent this absence through video and telephone calls. In some cases, family members did not have the opportunity to say goodbye to the patient or had to say goodbye over the phone. This situation intensified the relationship between nurses and patients, as they did not have anyone else with them, resulted in the perception of patients dying alone, and professional healthcare workers consequently suffering burnout (Mota Romero et al., 2022). Both Montgomery et al. (2021) and Wendlandt et al. (2022) emphasize communication difficulties between healthcare staff and family members in the context of the COVID-19 pandemic and the lack of understanding of family members about what was happening (Wendlandt et al., 2022). These findings differ from studies completed prior to the COVID-19 pandemic (Puente-Fernández et al., 2020).

The lack of staff training and experience was another Determining factor of care, potentially worsened by the lack of protocols and the overall lack of knowledge at the time regarding COVID-19 (Mota Romero et al., 2022; Puente-Fernández et al., 2020). Inadequate numbers of trained staff to attend to the high number of patients requiring

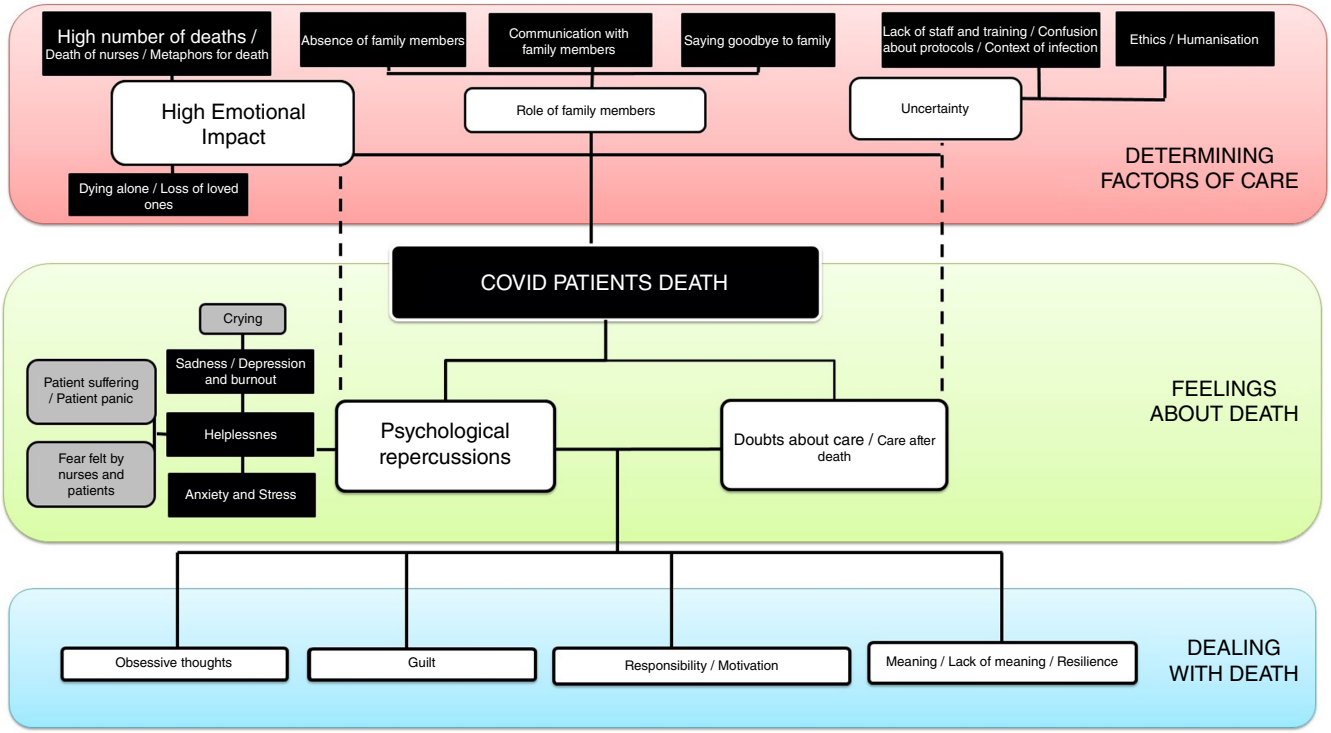

FIGURE 2 Nursing professionals' attitudes and experiences related to the deaths of COVID-19 patients. Interpretative categories are expressed within the figure. In addition, the prevalence of the interpretative categories is shown by the size of the font.

care in the first waves of the pandemic made it impossible to provide high-quality care. The importance of adequate nurse staffing during the pandemic has been repeatedly emphasized in the literature. For example, White et al. (2021), in their qualitative study carried out in nursing homes in the first wave of the pandemic (May–June 2020), found that the lack of staff in these facilities resulted in a perceived decrease in the quality of care. The study by Gorges and Konetzka (2020) found that the total number of nursing hours provided to nursing home residents was related to a lower number of COVID cases and deaths. This emphasis on adequate staffing is another novel finding when compared to pre-pandemic qualitative studies on the death experiences of nurses (Puente-Fernández et al., 2020).

In terms of Feelings about death, negative emotional states prevail: sadness, suffering, fear, anxiety and stress stand out. It should be noted that a potential cause of these strong emotions may be doubts surrounding the quality of patient care provided during the pandemic. Our results coincide with what was found in the available literature, both before and during the pandemic (Adibi et al., 2021; Labrague et al., 2022; Mota Romero et al., 2022; Nymark et al., 2022; Puente-Fernández et al., 2020; Sahebi et al., 2021), where authors highlight the reduced quality of care of COVID-19 patients, compared to patients without COVID (Nymark et al., 2022), a decrease in patient safety (Nymark et al., 2022), inadequate patient observation, as well as insufficient communication with patients (Labrague et al., 2022). The lack of knowledge about COVID-19 as well as the fear of contagion may have worsened emotional states.

These difficult Feelings about death during the COVID-19 pandemic could explain increasing reports of burnout among nursing professionals. Post-traumatic stress, anxiety and burnout have increased in different care contexts as a result of COVID-19 (Couper et al., 2022; Kelly et al., 2021; Saragih et al., 2021). In a study carried out in the United States, it was observed that 54% of nursing professionals experienced moderate burnout due to the COVID-19 pandemic (Kelly et al., 2021). Pre-pandemic research has linked nurses' burnout with work settings characterized by higher patient death rates (e.g. ICU, ED). Proactive strategies to mitigate nurses' negative Feelings about death could prevent burnout, have a protective effect on their retention, and in sequence, sustain the proper functioning of hospitals and health systems (Shah et al., 2021). With a growing global shortage of nurses, it will be important to implement policies and programmes that promote the emotional health of nursing professionals.

Strategies for fostering a good death, according to Meier et al. (2016), are as follows: controlled symptoms, no suffering, passing in sleep; one in which patients have a degree of control over death and their family's involvement with and preparation for it; one where patient dignity is respected, emotional support is available and patients can say goodbye to their loved ones. Several studies in this qualitative evidence synthesis suggest the pandemic has prevented detailed analysis of aspects of this concept, such as presence of a family member both during hospitalization and death, being able to say goodbye to loved ones, or not suffering during the process. However, this concept depends on social, cultural and political factors (Cottrell & Duggleby, 2016), that is, it depends on individual circumstances. As such, the circumstances of the COVID-19 pandemic should be taken into consideration, revising the concept

of a good death in the context of the COVID-19 pandemic. With regard to strategies for fostering a good death, it must be highlighted that many of the reported strategies before the pandemic (Puente-Fernández et al., 2020) could not be employed during the pandemic.

During the COVID-19 pandemic, many nurses have reported conflicted feelings about whether to continue working as a nurse or to leave the field altogether. The ability to deliberate about nursing employment may restore a sense of control over an uncertain situation and a perceived lack of political and institutional support. These results coincide with those of other studies, where nurses discuss their desire to leave the field due to organizational and personal factors, such as from fear of infecting their family or the lack of PPE (Chen et al., 2021; Mosheva et al., 2021; Mota Romero et al., 2022; Poon et al., 2022; Varasteh et al., 2022). Other studies show that the nurses who have been most impacted by the pandemic tend to want to leave the profession more than those who have been less affected and at higher rates than pre-pandemic (Alnaeem et al., 2022; Chen et al., 2021; Raso et al., 2021; Varasteh et al., 2022). Furthermore, the avoidance of COVID-19 patients and other negative coping behaviours such as forgetting patients, have been identified among nursing staff after caring for COVID-19 patients (Nie et al., 2020; Puente-Fernández et al., 2020).

4.1 | Limitations and strengths

This review is not exempt from limitations. The proposal described by Noblit and Hare (1988) for meta-ethnography currently occupies a relevant space in the use of meta-synthesis techniques; however, a certain variability exists in the application of its phases in many of the works in which it has been utilized, making an exhaustive application of the author's suggested steps more difficult (France, Uny, et al., 2019). Literature about the topic of death during the COVID-19 pandemic has continued to expand; future reviews may offer additional insights. The studies included in this review were carried out primarily in Europe, the United States and Asia. Other cultural contexts, such as South America, Africa and Oceania are not represented in our study. This gap in representation may have prevented a deeper analysis of relevant differences between countries. Furthermore, in future editions of this review, we believe that using additional search terms may broaden search results. Strengths of the study include a rigorous search strategy, team-based analysis, inclusion of studies of an appropriate quality and transparent reporting (France, Cunningham, et al., 2019).

4.2 | Practical implications

Syntheses of qualitative studies, such as meta-ethnographies, can provide evidence about people's experiences and inform decision making in healthcare services, policies and programmes (France, Cunningham, et al., 2019). Our research highlights that nurses desire greater assistance in providing a good death for their patients during the pandemic, but that it was not always possible. This gap in clinical resources may contribute to increased risk of emotional strain, burnout, post-traumatic stress and a growing shortage of nurses. In this line of thinking, it will be necessary to continuously assess levels of anxiety, burnout and post-traumatic stress among nurses, as was prospectively carried out in a number of facilities during the first waves of the pandemic (Aparicio Betancourt et al., 2022; Couper et al., 2022; Gualano et al., 2021).

The results of our study have future implications for supporting nurses and other healthcare professionals through policies and programmes to help them cope with the emotional toll of patient death in such unprecedented circumstances. In this sense, the results of our study have identified the elements that need to be addressed. The literature's main recommendations are to pay attention to staffing, flexible scheduling, workload, family presence, mental health problems, educational opportunities, leadership support and the creation of healthy work environments which may prevent or reduce burnout (Aparicio Betancourt et al., 2022; Couper et al., 2022; Sharifi et al., 2020).

5 | CONCLUSIONS

The COVID-19 pandemic has posed a great challenge for nursing staff around the world. The difficulties in providing nursing care and the high number of deaths have increased anxiety, stress and depression in these professionals. All these factors, along with their experiences of patient suffering and the deaths of many of these patients without their family members, have resulted in psychological repercussions for nursing staff. It should be noted that there was already a lack of Strategies for coping with patient death observed before the pandemic.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE[#]):

1. substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
2. drafting the article or revising it critically for important intellectual content.

[#]http://www.icmje.org/recommendations/.

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No conflicts of interest have been declared by the authors.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Additional supporting information can be found online in the Supporting Information section at the end of this article.

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