International Journal of Research Studies in Education
2022 Volume 11 Number 12, 71-88

Odyssey to a peaceful repose: A review into the role of ICU nurses during COVID-19

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ISSN: 2243-7703
Online ISSN: 2243-7711

OPEN ACCESS

Received: 29 May 2022 **Revised**: 20 June 2022 **Accepted**: 24 June 2022
Available Online: 24 June 2022 **DOI**: 10.5861/ijrse.2022.330

Abstract

COVID-19 patients' odyssey to peaceful repose includes the role of ICU nurses in three aspects of care, which include self-care, care of dying patients, and care of significant others. The purpose of this review is to identify an encompassing holistic approach to achieving a peaceful end of life. Discussion begins with the prevalence of end-of-life care, which is followed by the objectives and role of nurses with critically ill patients, and the various insights into the essence of a good or quality end-of-life care. It is hoped that by understanding the various role of nurses during COVID-19, educational implications can be provided.

Keywords: COVID-19, end-of-life, intensive care units, nurses, literature review

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1. Introduction

End-of-life care (EOLC) is an essential part of any ICU or intensive care unit, with mortality in the intensive care unit ranging from less than a tenth to four-tenths of the patients. Healthcare professionals often lack training in the management of end-of-life issues like anxiety, dyspnea, and airway secretions. Usually, EOLC has different logistical challenges as compared to the provision of medical care with curative intent (Khan et al., 2016). Recently, decision-making in terminal illness has received increased attention. In Japan, patients and their families typically make the decisions without understanding either the severity of the condition or the efficacy of life-supporting therapy and treatments at the end of life (Shaku & Tsutsumi, 2016).

In a separate study, the patient's bereaved family evaluated the management of symptoms during EOLC of doctors and nurses as low, which prompts the assertion of the need to improve EOLC for dying patients (Kinoshita & Miyashita, 2012). Death and the dying experience are phenomena that are common in all clinical settings. Death and the dying present emotional and physical strain on the dying patient, his relations as well as professional caregivers (Faronbi et al., 2021). It is recognized that ethnoreligious specific education regarding EOLC is needed to address the attitude of nurses toward death and dying. In a separate qualitative study, Han and Eo (2020) described the phenomenon of the dying process as maintaining balance by becoming a ballast in the journey toward death. Another study revealed that approximately one in five Americans die in the ICU, but both planning for end-of-life (EOL) care and the actual interventions received are highly variable across demographic groups (Richter, 2017). Overall, the patients want to avoid being a burden to their families and maintain their dignity.

Due to limited data existing on EOLC practices in ICUs in Asia, a study was conducted to determine the healthcare practitioner's attitudes toward withholding and withdrawal of life-sustaining treatments in EOLC and to evaluate factors associated with observed attitudes. Whereas ICUs physicians in Asia reported that they often withheld but seldom withdrew life-sustaining treatments at the end of life, practice and attitudes varied widely across regions and countries. Multiple factors related to regions and countries, including cultural, economic, legal, and religious differences, as well as personal attitudes, were associated with these variations. Initiatives to improve EOLC in Asia must begin with a thorough understanding of these factors. In the study conducted among 1465 physicians, for patients with no real chance of recovering a meaningful life, 7 out of 10 reported almost always or often withholding, whereas a fifth reported almost always or often withdrawing life-sustaining treatments; less than three-quarters of the participants deemed withholding and withdrawal ethically different. Hemodialysis, vasopressor, or antibiotics were often withheld or withdrawn in EOLC, but not IV fluids, enteral feeding, and suctioning. Analysis of the data showed that physicians who refused to implement DNR were most likely physicians who did not value family requests, was uncomfortable discussing EOLC, perceived greater legal risk, and belong to low-and-middle-income economies (Phu et al., 2015). In low-income settings, or where there are limited resources, the ideal care needs to be incarnated in the real context. Issues of social justice also arise as finite resources need to be used prudently (McTavish, 2017).

The World Health Assembly urges its members to develop palliative care (PC) capacity as an ethical imperative. Nurses who deliver PC services in various settings, including the home, maybe the only health care professionals able to access some disparate populations. Identifying current nursing services, resources, satisfaction, and barriers to nursing practice is essential to building global PC capacity (Brant et al., 2018). Due to the prevalence of patients needing support due to their terminal illness, Juvet et al. (2021) assert that early exposure to caring for dying patients and appropriate attitude should be included in the curriculum for bachelor's degrees. This came after results revealed that healthcare students also expressed a positive attitude towards providing support to dying patients may give them professional fulfillment. Patients' thoughts toward EOLC

were also positive. Understanding the preferences for EOL care is imperative in providing quality care to patients with a life-threatening illness.

Likewise, a study conducted involving 254 ICU-based PC consult involved neurological disease, cardiovascular, and cancer as the most common conditions that prompt consult. The most common reason involved the management of symptoms, followed by the transition to EOL. Common symptoms include 6 out of 10 patients experiencing fatigue, almost half experiencing depression and dyspnea, and 4 out of 10 patients experiencing pain. Adherence to ICU quality metrics for PC was variable: clinicians documented capacity in only less than a tenth of patient encounters, assessed spiritual support in more than half of encounters, and reported an intervention for pain in all the patients reporting moderate-to-severe intensity pain (Hochman et al., 2016). In a different research conducted by Pollack et al. (2016), fatigue and dyspnea were still among the most prevalent symptoms reported by older ICU survivors rather than anxiety, pain, or depression. The infection brought by the COVID-19 virus is accompanied by an aggressive inflammatory response due to a large amount of pro-inflammatory cytokines being released, causing a hyperactive immune response of the host, which is also known as a "Cytokine storm" that leads to an excessive inflammatory reaction (Yadav et al., 2020). The participants' experience dwelled on the time when COVID-19 took the world by storm, causing unfavorable effects on the population with co-morbidities, elderly, and unvaccinated that led to an increased fatality and rising death count, severe acute respiratory syndrome, cardiovascular dysfunction, and emerging incidents of sudden cardiac death (Yadav et al., 2020).

2. Objective of ICU nurses during care of critically ill patients

ICU nurses perform constant intensive assessment and monitoring, timely critical care interventions, a continuous evaluation of management through multidisciplinary efforts are required to restore stability, prevent complications and achieve optimal health with PC being instituted to alleviate pain and sufferings of the patient and family in situations where death is imminent among COVID-19 patients (CCNAPI, 2014). When patients learn to recognize and support various emotions, their capability to tolerate emotional pain can elevate (Phillips, 2017).

2.1 Socio-demographic profile of ICU nurses

ICUs need a well-differentiated professional profile to give quality care and appropriate conditions at work, leading to a transformation of management practices and care. Among the 1427 ICU nursing professionals included in the study, more than a quarter of the professionals had a specialization degree in intensive care. In terms of sex, there were more females than males, while the marital status of the nurses revealed less than half of the total participants were single, while married nurses were around a quarter (Saldaña et al., 2021). While, a separate study conducted in Nepal also revealed that almost all of the staff nurses were female regardless of their assignment; however, younger generation nurses belong to the age range of 18-25 years old with at least 1-8 years of work experience (Pradhan et al., 2019). In terms of gender, only a third of the participants were female, which contrasts with the result of the study by Abduelazeez and Tahir (2016), where female registered nurses comprised the two-quarters of the sample, with a similar result revealed in the aforementioned National Nursing Workforce Survey whereby 9 out of 10 nurses were female (Smiley et al., 2021). This is due to the assumption influenced by the historical notion that the nursing role has been predominately a female profession (Pompilio, 2020).

Another research involving ICU nursing working in a recently established hospital revealed that the majority of ICU Nurses working were female, with a little less than half were around the age group 20–30 years, about 8 out of 10 finished GNM, half of the participants had around 5–10 years of working experience (Indrawati et al., 2020). A study by Kaur and Charan (2018), on the other hand, revealed all of the ICU nurse participants had an age range of 21-35 years. The National Nursing Workforce Survey, also revealed that only more than a quarter of the registered nurses belonged to ages 18-39 years old, and a fifth of the participants had age 65 years and older

(Smiley et al., 2021). In a separate literature, psychological profile of the ICU nurses involves the presence of a high level of resilience that results in a low level of depression or anxiety symptoms and burnout syndromes (Mealer et al., 2012). A separate study conducted among ICU nurses with parts involving profiles revealed that the majority of the participants were female, with more than a tenth of students aged 20-30, and the highest were ICU nurses belonging to the age range of 41-50 years old. In terms of educational attainment, more than half had bachelor's degrees, while only more than a tenth had master's degrees (Breau & Rheaume, 2014).

2.2 End-of-life care in nursing and its distinction to palliative care

A growing consensus is emerging across the nation about the importance of expert EOLC, especially as it relates to honoring individual wishes and preferences in the context of an advanced or terminal illness. EOL care generally denotes the provision of patient care preceding death, either while curative treatment is ongoing or after having a decision to focus on comfort rather than cure. Prognosis is uncertain with some serious illnesses, and it is unclear if the care provided is life-sustaining or EOL. On the other hand, PC is appropriate at any given time in the trajectory of serious injury or illness and does not substitute curative interventions. PC communication skills may be utilized to provide an explanation of prognosis or uncertainty about prognosis and to provoke patient and family perspectives even if a change in the plan of care does not occur (AACN, 2021).

The Victoria State Government, through its website better health channel, also clearly discussed the difference between EOLC and PC. While both EOLC and PC offer practical and emotional support to families, friends, and care givers as well as improve the quality of life for critically ill patients with life-limiting conditions, PC is not just for people nearing the end of their lives. They both focus on managing symptoms and providing comfort as well as mental health, emotional, social, and spiritual needs. Although, in some cases, PC can include EOLC, it is not limited to caring for patients at the end of their life. PC includes EOLC, the key difference is that it can be used at any point along the treatment process. While some patients or people might spend years receiving PC for a prolonged illness, others might only request this type of care in the months, weeks, or days before they pass away. On the other hand, EOLC is therapy or treatment, support, and care for people who are nearing the end of their lives. It is a crucial part of PC and aims to aid people to live as comfortably as possible in their last months, weeks, or days of life and to die with dignity. Every person has the right to express his/her wishes about where s/he wants to receive EOLC and where s/he wants to die. EOLC is also given to those whose death is thought to be imminent.

2.3 Role of ICU nurses in the provision of end-of-life care

AACN, or American Association of Critical-Care Nurses (2021), recommends that it is essential for nurses to develop and hone communication skills with transparency and honesty relative to decision making under crisis standards as well as relevant information, plan of care to patients and families. Further, nurses should utilize technology such as computers, tablets, letters, phones, and other methods to build rapport and aid members of the family in bidding their farewells and staying in touch with a loved one. Comfort, compassion, and dignity as deserved by patients should be provided while applying EOLC knowledge and skills. Factors that may impact increased ICU utilization at the end of life, include advanced directives and access to PC services (Weerasinghe et al., 2017).

The provision of EOLC to dying patients has both positive and negative aspects, as described by nurses' experience, according to the study by Kinondo and Nagata (2015). The positive aspects of the experience include deep involvement in facing dying and death and increased competence in facing dying and death. On the other hand, there are two factors related to the negative aspects of the experience, namely: uncertainty and difficulty dealing with dying and death and accustomed to dying and death. Since nurses are obliged to provide comprehensive and compassionate EOL care, they are expected to recognize patient's symptoms, take measures within their scope of practice to administer medications, provide measures of alleviating symptoms, and collaborate with other professionals to optimize the comfort of the patient as well as the family's understanding

and adaptation (HPNA, 2021). Nurses must explain that precise prediction of the duration of the individual patient's dying process is generally not possible but that the ICU nurse will assess and treat symptoms continuously and will be present throughout the process (Cook & Rocker, 2014).

High-quality EOLC is possible in an ICU setting. For all the domains, nurses play a vital role in the provision of high-quality EOLC for the family and individual ICU patients. In cases of ICUs that lack some of the recommended practices, such as sufficient staff resources and open visiting hours for EOLC, ICU nurses can utilize the evidence to promote best practices through discussion within the ICU and at political and organizational levels. It is encouraged that ICU nurses must be imaginative, pursue an individual approach to provide the best possible EOLC for the critically-ill patient and their family members, and share experiences with others (Jensen et al., 2020). In actuality, the participation of nurses in EOLC is crucial not only through their bedside care for the patient but also by communicating with both the family and the patient as well. ICU nurses usually possess a high level of knowledge about issues involving the patient that is nontechnical, may it be values or wishes. Lastly, nurses' involvement in EOL decisions is crucial for successful EOLC because EOL decision-making precedes the shift from lifesaving therapy to EOLC (Adams et al., 2011).

A study that aimed to explore the lived experiences of ICU nurses in caring for the dying revealed that the essence of their care was captured in the theme of promises to keep. These themes include promises related to being truthful, providing comfort, advocacy, promises that could not be kept, and remaining connected. ICU nurses accept the reality of death and express a strong commitment to making it as peaceful, comfortable, and dignified as possible, despite the environment in critical care that fosters a paradigm of curing rather than the paradigm of caring (King & Thomas, 2013). To plan the EOLC individually, open communication about the person's preferences and attitudes toward the EOLC can facilitate dignity and quality of life in patients and their relatives. EOLC discussions primarily depend on an atmosphere that is pleasant, professional attitudes of staff members, and trusting bonds between conversation partners. Starting early, including the family members, and promoting continuous discussions seemed beneficial for ELC conversations. Implementing conversations into existing care structures and using low-threshold impulses to start conversations were helpful. Individualized approaches should be preferred, and staff members can be a partner in detailed conversations about EOLC attitudes, even though some may feel unprepared to do so. Further, EOLC discussion skill training is also needed (Groebe et al., 2019). Nurses must play a pivotal role in the program's development to implement early discussion of goals of care. Further, they are instrumental in determining and identifying patients at risk and facilitating early engagement with surrogates in facilities where such programs exist.

Regardless of their infectious condition, nurses should ensure that all patients acquire high-quality personalized service (Fawaz et al., 2020). Due to the desire to help people, nurses chose this profession; however, COVID-19 has altered the capability to select options to help save lives. This inability to save lives significantly affects the front line emotionally and physically. Nurses have seen the loss of life, know death, and witnessed the suffering and pain of the dying and the grief of those left behind. Intensive care units that focus on preserving life may have the notion that death equates to failure; thus, the tsunami of death brought by the pandemic causes stress and distress (Jackson et al., 2020).

2.4 End-of-life decision making in ICU

Decisions regarding withdrawing and withholding therapy are often made in the ICU if life-sustaining therapy does not succeed (Lobo et al., 2017). These decisions should be made together with the patient if the patient is capable of making decisions (Jensen et al., 2020). Further, for patients who cannot participate, family members can give and contribute by providing knowledge about the patient's values and wishes. The patient's surrogate or preferred proxy must be identified because this person might not be a relative (Davidson et al., 2017). In addition, regardless of whether the members of the family can make decisions about withdrawing or withholding treatment, incessantly including and involving them in the assessment of the patient's condition is crucial to confirm their understanding of what is happening and that death may be the outcome (Linda et al.,

2011).

Accurate documentation should be done and secured in the hospital records that involve decisions relative to EOLC specifying what treatment is being withdrawn, withheld, or continuing (Curtis & Vincent, 2010). A DNR or do-not-resuscitate order does not automatically translate to the withdrawal of other therapies, and the order should be reconsidered if the condition of the patient changes (Loertscher et al., 2010). A quiet place for difficult talks and suitable for dying patients and finding the right time should be secured to allow upholding of respect for family member's feelings and reactions which is important since people reveal their feelings in different ways (Cook & Rocker, 2014). Openness among nurses and other members of the health care team is also essential for the provision of excellent EOLC (Kentis et al., 2015). In addition to EOLC for patients with family and surrogates, improving the care of unrepresented patients who lack decision-making capacity and have no surrogates or documents to guide their healthcare decisions also needs to be taken into consideration. Attention should be given to formally defining their place within the healthcare infrastructure and the key to ensuring optimal, ethical care for unrepresented patient populations (Flaherty & Meurer, 2021).

The roles of patient ethnicity, race, and low proficiency in English in impacting the quality of care at the EOL and developing treatment to ameliorate potential disparities are recognized as a research priority. Minority groups, including Hispanic, Black, and non-English speaking patients, were related to lower rates of advance directive completion and lower rates of change to a do-not-resuscitate (DNR) code status during admission to the ICU. Not having an advance directive on file was associated with lower rates of changing to DNR code status in the ICU. The role of healthcare providers, sociocultural differences, implicit institutional barriers, and bias needs to be explored to design effective strategies to lower these vital disparities (Barwise et al., 2016). Though timely EOL discussions have shown a positive impact on the care of patients and their families, in the ICU, there is little information relative to the perspective of the ICU nurses. Processing of dying in an ICU is complicated, and research on EOL care from the perspective of ICU staff may improve the quality of care. A study relative to this showed that the ICU nurses perceived integrating a PC team in the ICU favorably. Some areas of improvement in clinical care include the late EOL discussions (Sedhom & Barile, 2017). For many years, critical care nurses have cared for the dying.

3. Essence of a good end-of-life

Before the pandemic, critical viewpoints of the dying patients had established that pain management, spirituality or religiosity, preferences for a specific dying process, emotional well-being, treatment preferences, family, life completion, dignity, quality of life, relationship with HCP, and others were considered core themes of a good death (Meier et al., 2016). When death is due to a natural cause, associated with old age, and there is an ability to find meaning in death, even though the COVID-19 patient is dying and has a poor prognosis, one study revealed that holistic care may still potentially influence a patient's mental health and satisfaction in public and private hospitals (Kotwani et al., 2021). Neutral acceptance of life's end and mortality (Gegieckaite & Kazlauskas, 2020).

3.1 Interventions involved in the provision of end-of-life care

An evidenced-based approach related to terminal ventilator withdrawal has embedded special considerations during the COVID-19 pandemic. Commonly used methods include terminal extubation involving a process where the mechanical ventilation is turned off, and the tube is removed. Terminal weaning, on the other hand, involves reduction of ventilation and FIO2, including, in most cases, subsequent extubation. The Type of PPE dictates the type of weaning. The type of patient that may undergo withdrawal varies. Thus, the need for objective patient-respiratory measurement and a standardized approach surfaced. Family care is also vital, ensuring that the preference of the family is noted, may it be through FaceTime, Chaplain support, permitting last rituals or traditions. The process, expected behavior, and permitted family behavior should be described in lay terms.

Protocols in EOL may ensure sufficient comfort for patients. This may even involve non-pharmacological interventions to promote the alleviation of symptoms and promote comfort, such as touch therapy and music therapy (Epker et al., 2015). Due to their knowledge about the patient's manifestations of stress and agony, family members tend to be a good source of information, and these family members also promote comfort by allowing the patient to feel that they are cared for, loved, and safe just by hearing their voices. Awareness and sensitivity to the patient's comfort needs are factors that come into play in each situation (Jensen et al., 2020).

The knowledge from relational care facilitates evaluating the information and acting in different situations with "the heart eye or the perceptive eye," as described by a philosopher. Great effort must be exerted to determine and honor the wishes of the patients if they are awake (Cook & Rocker, 2014); for example, contacting people by telephone or use of technology like video chat if they are away if accessible allow specific people to visit. If the patient can eat, even if just a mouthful, their favorite food, can be procured. Efforts must be made to ensure that culturally appropriate food is available. As a rule, no wish should be rejected on the grounds of it being impossible. With imagination, innovation, and creativity, a lot can be done. The patient and accompanying family members may want to receive a visit from a chaplain or another spiritual leader. Health care chaplains are often key support agents for family, staff, and patients during the dying process (Timmins et al., 2018).

Chaplains often bring a hymnal, religious items like a Bible or a collection of poems. The ICU, if available, may also provide the materials for a ceremony if the patient or the family wants (Cullen, 2016). Furthermore, a visit from a beloved pet, especially if the patient has no relatives, can also be arranged (Gibson et al., 2012). The staff nurse is a vital substitute for relatives of unaccompanied patients. By providing the patients the assurance they have someone with them and are not alone, the nurse protects patients' privacy and integrity, ensuring a dignified death (Jensen et al., 2020). Initiatives must be made to engage ICU nurses in discussion and learn EOLC as well as PC concepts (Browning et al., 2012). The primary goal in caring for dying patients of most ICU staff nurse participants in a study conducted by Wu et al. (2014) was to ensure the patients were free of anxiety and pain. ICU nurses also believed that dying patients should have some control over how and with whom they spend their remaining moments. In providing comfort for dying patients, ensuring a dignified death, such as respecting a patient's wishes and ensuring their comfort, were crucial. "No pain and no fear" must be the primary goal in EOL patient care.

During the course of the disease, diverse kind of symptoms have been exhibited by dying COVID-19 patients, which include fever, cough, difficulty of breathing, or pneumonia-associated symptoms, as well as various types of pain like abdominal pain, chest pain, and headache (Weng et al., 2020). During COVID-19, a study showed that usage of warm blankets may reduce agitation and pain, as well as analgesic use request. Aside from this, the utilization of digital elements that are visually appealing such as family photographs and natural sceneries could relax older adults (Abdelsamad et al., 2022). One of the essential parts of caregiving is touch, which has been proven to reduce pain (Pedrazza et al., 2014).

3.2 Ethical and legal issues in end-of-life care

During times of insufficient supplies, the demand for care, lifesaving equipment, and an ethical triage system is implemented to make decisions about care. Triage's decision-making foundation is laid by utilitarianism aiming for outcomes that provide the greatest good for the greatest number of people (AACN, 2021). However, despite the presence of this environment wherein the healthcare team and nurses are working under a crisis standard of care, it is vital that patients still receive compassionate EOLC (Berlinger et al., 2020). Decision-making under crisis standards of care should be legal, ethical, fair, compassionate, and transparent. Healthcare institutions should also ensure that decision-making is shared in triage situations so that the burden is not carried alone. Further, guidelines, education, and communication should be upheld for nurses and other healthcare team members to fully understand the consequences and considerations. Nurses must strive, as always, to provide the best EOLC possible among patients, especially during these unprecedented times (AACN, 2021).

As technology in the medical field continues to advance, critical care nurses will remain at the vanguard of the health care team, working with patients and their families in delivering high-quality care. EOLC, as part of the continuum of care, should include basic knowledge of legal aspects and is an essential component of a critical care nurse's skill set (McGowan, 2011). In addition, factors involving legal implications should be understood by an ICU nurse when providing EOLC to critically ill patients. Courts have decided on several cases that helped establish legal principles in EOLC since the 1970s. According to courts, competent adults have the right to discontinue or refuse medical interventions, while decisions for incompetent adults and children will be made by surrogates. In the absence of advance documentation of goals of care or directive, the surrogate, together with medical team collaboration, determines the plan of care, which includes EOLC decisions. In cases of medical futility, the attempt to collaborate with patients and families should be pursued. However, if the dispute cannot be resolved, the transfer of care may only be an option. While EOL dilemmas are usually resolved among the patients, their families, and the medical team without requiring legal intervention, in cases of absence of consensus, some EOL questions have been brought to the courts for resolution. The courts have established that life-sustaining treatments include not only mechanical ventilation but also dialysis, chemotherapy, blood transfusions, hydration, and artificial nutrition.

A competent patient has the right to discontinue or refuse life-sustaining therapy and treatment, even if that desire conflicts with the desires of the family of the patient (Jensen et al., 2011). On the other hand, mentally incapacitated patients who have a living will or other advance directives with wishes detailed in the advance care document are enforceable and may be carried out on behalf of the now incompetent patient. A more difficult scenario involves patients with some cognitive impairment without previous directives for their care. In this situation, capacity in decision-making is a clinical determination made by those authorized under state law to make the determination, generally psychologists and physicians and often advanced practice nurses. Also, for a patient without the mental capacity to make medical decisions, a surrogate decision-maker should be identified. If the patient had previously identified a surrogate in an advance directive document or proxy form, that surrogate has authority (McGowan, 2011). This different research aims to determine the ethical issues perceived by ICU nurses in their everyday practice The qualitative content analysis identified EOLC decisions, interaction, teamwork, privacy, and healthcare access as emerging ethical issues. Personal, institutional aspects and team emerge as reasons behind the experience of these issues. Personal and team resources are utilized to solve these issues. Moral development and training are the most significant strategies (Fernandes & Moreira, 2012).

3.3 End-of-life in intensive care unit setting during COVID-19 pandemic

Many critical patients with terminal diseases are admitted to the Intensive Care Unit at the end of life. The concept of "Do Not Resuscitate" is acceptable in Muslim patients, though the decision is usually made after their admission. (Khalid et al., 2017). The COVID-19 pandemic highlighted the need for high-quality EOLC, unprecedented in scale and setting (Soosaipillai et al., 2021). Provision of EOLC in an ICU setting may have undergone alterations due to COVID-19 Pandemic. EOL leans toward performing interventions just before death, compared to PC that applies across injury and serious illness duration. Steps involved in EOL may include symptom management, which ranges from pain, anxiety, and breathing pattern problems while in strict isolation adherence and second, emotional support use of photos placed on their gowns, communication, and facilitation of family support either through phone or virtual calls. Chaplains and social workers may also aid in eliciting ideas from close relatives. Lastly, considerations are also noted during the final hours of the patients that range from terminal weaning, position change to provide comfort, and assisting the family in saying their goodbyes (Delgado, 2020).

Nurses are being called to provide EOL care differently than what they are used to, bringing about visitation restrictions that separate the families and patients during the dying process. Care of dying during the COVID-19 pandemic led to the nurses being at the bedside and being asked to "do it all," which includes providing psychosocial, physical, and spiritual care to patients who are dying alone. Nurses ensure that during the final hours, the patients are not abandoned, especially those that are expected not to survive. COVID-19 has

eliminated, if not limited, the access to interdisciplinary team members, leaving the nurses at the bedside to manage all aspects of care for the patients. Members of the family will always remember the last moments, days, hours, and minutes of the life of their loved ones. Amidst this pandemic, many may not be able to physically share this moment and time with their loved ones. Nurses at present have a sacred opportunity to be with the patients who are dying at the bedside and supporting their grieving families at one of the most challenging times in our healthcare system's history (Mazanec, 2020).

Intensive therapy aims to aid the survival of critically ill patients; however, one to three out of 10 patients die in ICUs globally, with differences mainly due to patient mix. Among those who die, a quarter and in cases almost all die after life-sustaining therapy has either been withdrawn or withheld. Wide variations within and between countries are largely due to cultural, religious, and personal factors. High-quality EOLC is, therefore, an important part of ICU work. Further, EOLC aims to assist persons who face distant or imminent death to experience the best quality of life possible until the end of their life regardless of their age, health conditions or medical diagnosis. Death may transpire after ICU discharge or in ICU per se, but in either circumstance, the patient needs high-quality EOLC in ICU. The focus of high-quality EOLC is the individual patient, but EOLC is also important for the family. Family members are likely to always remember events surrounding a loved one's death. The death of a loved one in ICU may also be associated with complicated anxiety, grief, depression, and posttraumatic stress disorder. Nurses need to use their moral and clinical judgment, imagination, and their own and other nurses' previous experiences to meet the needs of family and individual patients (Jensen et al., 2020). In ER setting, the life-saving mission of emergency nurses and the chaotic and fast-paced emergency setting induced some difficulties in providing EOLC which included family issues (Ho, 2015).

3.4 Preparing the family

Facing the reality of death has often been an expressed concern among family members since to be with a dying loved one or a person is a potentially frightening experience. The needs of the family members should be assessed by the nurses and prepared by communicating selected information considerately and clearly (Hinkle, et al., 2015). The expected symptoms and possible events that might happen or the patient might experience should be relayed to the family members. This may include coldness, death rattle, or discoloration of the skin. Families appreciate signs that nurses respect the patient. Examples of these signs include calling the patients by their name, praying and talking to their dying loved one, or simply holding the patient's hand. Although there are some cases wherein the family would prefer privacy and confidentiality when it is already time to bid their farewell. The nurse should be proactive in asking about the preference of the family. If the preference involves being alone with the patient, frequent visits to the room should continue for assessment of symptoms and condition as well as medication administration, ensuring comfort but still taking into consideration the coping of the family. Families with a preference for being alone with the patient still need assurance that assistance and help can still be swiftly received if required (Jensen et al., 2020). Various organizations promote the usage of tools to engage people in conversations related to EOL, though surprisingly few have used an approach that is data-driven to tool modification and development.

Families of geriatric patients are intricately involved in the EOL decision-making process for a family member with a critical, terminal, or serious illness in the ICU setting. However, families are not always as informed and involved as they would like to be. The creation of a culture that assesses the needs of the family and supports families is an essential component of family-centered care. There are numerous strategies that ICU nurses and other interdisciplinary team members can utilize to promote family-centered EOLC in the ICU. Nurses can get to know the family by assessing them, spending time talking with them, seeking to understand their perspectives on their family member's condition, and discussing previously verbalized patient wishes for care. Family members also need spiritual and emotional support. According to studies, the spiritual needs of family members should also be assessed by the nurse. The nurse may offer help in contacting spiritual advisors, especially if the process of dying is lengthy. Like caring for the patient, their relatives will also need rest, food, drink, fresh air, and sleep. A good chair or a bed found in the patient's room or even somewhere near within the

hospital vicinity will provide the needed sleep for the family member (Davidson et al., 2017). In terms of futile care, a study revealed that a futility assessment should be made for ICU patients ventilated or needing ventilation. If there is a consensus on futility, a family meeting is conducted virtually or face to face depending on the infection risk and infection control protocol. The family should be sensitively communicated about the futility of ICU measures and foregoing life-sustaining treatment (Salins et al., 2020).

Intensive care units utilize different practices after patients die. The music chosen according to the preferences of the dead person or family members could be played during the viewing to make that event memorable and special (Holm et al., 2012). In some ICUs, volunteers make patchwork blankets as a memory of the patient for the family to take home. Some ICUs provide other mementos, such as a lock of hair or handprints, and sometimes nurses even attend the wake of the funeral, and those who took care of the patient might sign letters of condolence. Institutions can provide leaflets containing information about practical issues such as funerals or grief after losing a loved one (Bloomer et al., 2013). If available, a patient diary kept during the patient's ICU stay can also give support during the post-ICU bereavement period. After a patient dies in the ICU, bereavement follow-up has reduced the risk of posttraumatic stress disorder and prolonged grief in family members (Johansson et al., 2018). Family members highly appreciate follow-up conversations after returning to the ICU when this is offered. Such a meeting provides the opportunity to explore and identify the events that led to the death of the loved one, which can help family members become reconciled to their loss (Kocket al., 2014).

Akgun et al. (2016) assert the importance of ICU family meetings that can be associated with outcomes favorable for the family members and providers and the patients themselves. It was noted that these family meetings might not routinely take place due to time constraints, competing clinical demands, and provider comfort. Family meetings may also facilitate communication, especially if patients cannot freely communicate like those attached to mechanical ventilators. Breakdowns in communication due to mechanical ventilation, according to studies, affect 800,000 mechanically ventilated patients in the US, contributing to adverse patient outcomes, such as misinterpretation of pain/symptoms, physical restraint, and medication treatment errors during acute care hospitalization. Further, the introduction of family care rituals aside from the facilitation of family meetings may significantly reduce the incidence of discordance-of-care.

4. End-of-life care in the Philippines

There are notably few studies that have examined systematically the cultural needs of Asian ethnic minorities in terms of EOLC. Filipino families may experience struggle with talking about advance directives and life support decisions or would even avoid the matter when a loved one is in critical condition or drying. This is due to culture and beliefs that may impact disclosure regarding prognoses or terminal health diagnoses. Caution should be applied when discussing advance directives due to beliefs and fear that unwanted outcomes may be invoked. A study revealed that overall attitudes towards advance directives were positive, especially among highly educated families, while in some cases, advance directives may become pointless due to fatalistic beliefs. Critical care nursing is widely recognized as a nursing specialty; however, in the Philippines, there is the absence of standardized national certification of the program for critical care nursing. Patients admitted to ICU need complex care and require technologically advanced monitoring and resources. Due to insufficient national and local health funding, this has become a challenge in the Philippines and the prevailing healthcare financing system. The need to elevate the competencies of critical care nurses on delirium and pain management and provision of EOLC and PC, and communication and inter-professional collaboration are recognized. Despite the critical care nurses' central role within the ICU, their active participation during inter-professional rounds or patient case analysis is still lacking (Martinez et al., 2021).

Experiencing the worst indignity of all, the Philippines fares badly compared to the rest of Southeast Asia, Asia, and the entire world in both qualities of life and death (Makabenta, 2016). The Philippines ranked 78 out of 80 countries in terms of Quality of Death Index Scores. The quality of death index commissioned by the Singapore-based nonprofit Lien Foundation was measured across five categories: palliative and healthcare

environment, human resources, affordable care, quality of care, and level of community engagement. Results revealed that there is no government-led strategy for the development and promotion of national PC (Economist Intelligence Group, 2015). Inadequacy in healthcare facilities and specialists that can provide palliative and EOLC made the results unsurprising. The Philippine government's unenthusiastic planning of programs in palliative and EOLC chooses to allocate resources for patients with a good chance of survival. Further, the shortage of EOL and PC specialists or subsidies for individuals availing end of life and PC services, as well as limited awareness and understanding of the public these services, attributes to the ranking of the Philippines (Pagulong, 2015). The supposed goal in the provision of EOLC is to allow the patient to experience a "good death," which means a beautiful death, a hope-filled death, a spiritual solace based on the Biblical promise of the second resurrection with the reuniting of righteous families, or a private and individual encounter that takes place with the patient's intimate circle of family and close friends. It is about time that people provide EOLC in this country with more resources and attention befitting critically ill or terminal patients, allowing them to acquire their inherent right to go in peace and with dignity (Castillo, 2022).

Reviewing the historical milestones of hospice and PC in the Philippines has been integrated into the family health program since 1989. With the current threat brought by the COVID-19 pandemic, the Society, in partnership with the Philippine Society of Public Health Physicians (PSPHP), Hospice Philippines, and the Ruth Foundation, released three Guidance Documents for PC. These documents include (1) Care for Palliative and Bedridden Patients in Communities on Enhanced Community Quarantine, (2) Guidance for Palliative Hospice and Bereavement Care for Covid-19 and other patients facing Life-Threatening Illness in Hospitals, and (3) Triage Decisions, Shared Decision Making and Advance Care Planning for Covid-19 Situation: A Guidance Document for Levels 2 and 3 Health Care Facilities. Further, Department Order 2020-1431 was released by the Department of Health (DOH) in light of the implementation of Republic Act 11215 and Republic Act. 11223, which aims for the development of the Procedures and Standards, Manual of Operations, and Training Modules with Phase One Implementation of the National Palliative and Hospice Care Program (Bausa-Claudio et al., 2020). The vivid scenario of stressful situations in the Philippines due to several natural disasters as well as the COVID-19 pandemic has exposed Filipino healthcare workers (HCW) such as nurses to newly surfaced challenges. These HCWs felt lost since these challenges may be directly or indirectly associated with the COVID-19 pandemic. It is notable that due to this recent crisis we are experiencing, the way people die has radically changed, which has caused confusion and influenced the Filipino bereavement and grief processes (Nambayan et al., 2021). Acceptable practice in the clinical setting on withdrawing or withholding treatment is grounded on the understanding of the ethical, cultural, medical, and religious issues. There is a need to individualize care option discussions to illness status and patient and family preferences, values, beliefs, and cultures (Manalo, 2013).

After the Philippines was noted to be one of the worst places to die, the Senate, in the person of Senator Sonny Angara, proposed a bill that will include palliative and end of life care services into PhilHealth. It was noted that the one aim of the proposed bill was to provide quality health care throughout the entire life cycle of Filipinos. The EOLC in the Philippines was given attention due to the poor scores acquired by the Philippines in the 2015 Quality of Death study index, as well as the inclusions of the World Health Organization of cardiovascular disease, cancer, diabetes, and chronic lung disease, which were also prevalent in the Philippines.

The Philippine Society of Hospice and Palliative Medicine and Hospice Philippines (2020) released some guidelines for the healthcare team to provide EOLC during community quarantine during the COVID-19 pandemic. For patients in the terminal phase of the disease that are considered non-COVID related, the standard infection control procedures were maintained while at the same time providing communication and support to the family, including active listening, social/emotional support, and counseling. Intra-family communication should be encouraged, and discontinuation of non-essential medications while monitoring and addressing symptoms with nursing care and medication is ongoing. COVID-19 positive patients, on the other hand, receive EOLC, while the safety of other patients, staff, and visitors is considered. The family is to be informed if the patient is in the irreversible phase of illness and if they wish to stay when death is imminent, full PPE should be

worn by family members. Aside from infection prevention and control measures, full PPE should be worn while performing essential bedside procedures. Tele-care or video calls are utilized to provide spiritual and psycho-social support. Clothes and blankets will be disposed of immediately after death, and items that can be wiped, such as pieces of jewelry, must be disinfected. Lastly, the body must be cremated within 24 hours of death or depending on the policies or protocol that the current local government unit is implementing.

4.1 What nurses go through psychologically and physically in EOLC

During an epidemic outbreak, negative and positive emotions of the front-line nurses coexisted and interweaved. In the early stage, negative emotions were dominant and positive emotions appeared gradually. Self-coping styles and psychological growth play an essential role in maintaining the mental health of nurses (Niuniu et al., 2020). The current global crisis prompted the need to mobilize system and individual level strategies and resources to support nurses in managing pandemic-related issues, including anxiety due to the risk of infection, supporting anxious children, mitigating moral injury; providing safe and quality nursing care for patients with COVID-19 and EOLC as needed to reduce anxiety; supporting relatives who cannot be present with a dying relative and care for grieving relatives and colleagues (Hofmeyer & Taylor, 2021). End-of-life decision-making in the Intensive Care Unit (ICU) can be emotionally challenging and multifaceted. Role ambiguity, communication issues, indecision on the futility of treatment, and the initiation of end-of-life discussions were some of the greatest challenges. The impact of these decisions included decreased job satisfaction, and emotional and psychological 'burnout' (Flannery et al., 2015). Nurses experiencing dramatic and abrupt challenges in the workplace in terms of reassignment, to other roles, workload, infection threat, COVID-related traumatic events, and frustration with the death of patients whom they care for which may have contributed to the elevation of burn-out levels among nurses by decreasing their emotional capacity to meet the demands posed by the pandemic emergency (Lasalvia et al., 2021).

Another psychological dynamic that ICU nurses experience in EOLC is moral distress. Many deaths in intensive care involve decisions about withholding and withdrawing therapy, potentially triggering moral distress. Moral distress occurs when individuals feel constrained from acting by a moral choice, or act against moral judgment, generating painful, unresolved emotions and problems that continue long after an event (St Ledger et al., 2013). Also, moral distress is a phenomenon that is complex and frequently experienced by critical care nurses. Ethical conflicts in this practice area are related to technological advancement, high-intensity work environments, and end-of-life decisions. Problems with the professional practice environment, difficulties with communication during end-of-life decisions, compromised nursing care as a consequence of moral distress, and few effective interventions were among the findings of the study conducted by McAndrew et al. (2016). The provision of compassionate care is a professional nursing value, and an inability to meet this goal due to moral distress may have devastating effects on care quality.

Recognizing death as part of life and thinking about death itself are social coping strategies. Although healthcare professionals occupy a privileged place in this process, the culture of concealment of death influences EOLC. The social process that leads to the loneliness of the dying in our days has been theorized. However, social acceptance of death also influences healthcare professionals' attitudes towards death. Thus, healthcare professionals' attitudes may affect the EOLC given to dying individuals and their families. The social patterns of death may contribute to the healthcare professionals' negative attitudes towards death. The concept of dignified death has been linked to the notion of the humanization of healthcare. Death should be approached from a more naturalistic perspective by healthcare professionals, healthcare, and academic institutions (Ruiz-Fernandez et al., 2021).

Working in services that provide interventions at the EOL has an impact on the personal and professional lives of healthcare staff. The complex practicalities of the role and additional factors such as moral distress, burnout, compassion fatigue, and death anxiety all impact the overall quality of services and patient care (Hussain, 2021). White and Meeker (2019) also assert that some of the most ethically challenging and

emotionally demanding aspects of nursing occur in caring for patients and their families at the end of life. Nurses experienced moral distress in situations of continuing treatment when a cure was unlikely. In managing symptoms for patients, they struggled to foster an often-tenuous balance of patient comfort and calm without over sedation. They struggled to manage the competing demands of a workload, including patients receiving curative care juxtaposed with those focused on comfort care. Nurses reflected on their fears as new nurses caring for end-of-life patients, the inadequacy of their preparation for this role, and their distress when the care provided felt inadequate. Nurses navigated challenges through support from nurse colleagues and effective leaders. They appealed to administrators to attend to care concerns arising from the time-intensive nature of care. Mentoring and education facilitated assimilation to comfort-care nursing for novice nurses. Futile care for EOL patients also has a negative impact on nurses' physical, psychological, and spiritual well-being (Prompahakul & Epstein, 2019).

Further, nurses tend to have higher moral distress related to end-of-life controversies and cost constraints that are associated to the tendency to leave ICU jobs. From the beginning, the COVID-19 pandemic increased ICU workloads and created exceptionally difficult ethical dilemmas. ICU staff around the world have been subject to high levels of moral stress, potentially leading to mental health problems. A study revealed that Moral distress during the pandemic is determined by situations related to the patient and family, the ICU, and resource management of the organizations themselves. ICU staff already reached moderate levels of moral distress, anxiety, and depression during the first wave of the pandemic. Temporary staff (redeployed from other units) obtained higher scores than permanent staff, as well as in greater intention to leave their current position. This intention was also stronger in health staff working in areas converted into ICUs less than half than in normal intensive care units (Garcia et al., 2022). Moral distress tends to be greater with more years of experience in nurses (Dodek et al., 2016).

Intensive care unit nurses experience a high level of burnout in general. A higher level of burnout was significantly associated with younger age, lower education level, single marital status, having no religion, less work experience, and previous EOLC experience. Higher levels of spiritual well-being were associated with lower levels of burnout (Kim & Yeom, 2018). Aside from Satisfaction in the provision of EOLC, job satisfaction, and personality traits may also influence the burnout in the ICU (Ntantana, et al., 2017). In a different study conducted by Elvira et al., (2021) during the COVID-19 pandemic, the results revealed that within the dimensions of emotional exhaustion, burnout had a significant relationship with depression and personality factors. Both sociodemographic factors (being younger, single marital status, and having less professional experience in ICU) and working conditions (workload and working longer hours) influence the risk of burnout syndrome. Similarly, Belayneh et al. (2020) conducted a study during the COVID-19 pandemic relative to anxiety symptoms among ICU and ER nurses which revealed that they have higher levels of anxiety symptoms as compared to other departments. This is due to frequent witnessing of life-threatening health conditions and the death of patients. One of the identified factors as a contributor to higher anxiety symptoms is marital status. Aside from anxiety, the professional quality of life of nurses was also affected by their marital status, religion, and education thus, the hospital policymakers and nurse leaders need to set a direction to improve the quality of life, and their unique spirituality is encouraged, accepted, and respected in clinical areas that could contribute to the improvement of compassion satisfaction and decreasing compassion fatigue among nurses.

5. Conclusion

The concept of EOLC has been tackled in numerous studies for decades. Such important care has been highlighted due to the ongoing COVID-19 pandemic. ICU staff nurses have always provided holistic care to critically ill patients that include care during the entirety of their journey from admission until the end of life. Despite the literature asserting the significance of EOLC in upholding comfort, managing symptoms, and maintaining the dignity of dying patients, only a few studies have utilized and established guidelines with a legal basis that includes the scope of practice, adaptable across different ethno cultural groups of terminally ill patients. Research involving the implementation of EOLC by ICU nurses has already established the importance of the

caring nature of this profession and how nurses implement EOLC whether or not the procedure has a local guideline or policy to back up the intervention. Globally, different high-income countries have already established the inclusion of EOLC in their healthcare system, providing legal support and financial resources for the healthcare team to carry out without drawbacks and negative implications.

The Philippines per se is already considered one of the worst places to die, supported by its poor score in the 2015 Quality of Death Study index in areas of palliative and healthcare environment, human resources, affordable care, quality of care, and level of community engagement. In the locality, however, where this study was conducted, literature has revealed gaps that may be filled in by this research. First, despite the numerous deaths amidst this pandemic, there are no new studies conducted in the local setting that will establish the utilization of end-of-life guidelines or describe the experience of nurses in the ICU during their care for a dying COVID-19 patient. Second, though numerous studies were conducted in the past, the radical change of landscape in healthcare and the way people die at present prompt the need to revisit the information gathering relative to the provision of EOLC in the ICU. Lastly, due to new nurses being deployed among COVID-19 patients, even if they are in the last moments of their lives away from family, it is still unknown how the EOLC phenomenon is defined and described by the ICU nurses. Conclusively, the phenomenon of EOLC provision during the COVID-19 pandemic is only one among the numerous gaps present in the pool of literature. However, the description of experience may prove helpful in establishing the different flows of concepts that may aid future studies to finally boost the adherence of ICU nurses in ensuring that Filipinos achieve not only quality of life but a high quality of dignified and peaceful rest.

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