

The Lived Experience of Nurses Applying with Postmortem Care: A Qualitative Evidence Synthesis

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Abstract

COVID-19 is an ongoing pandemic and alarming public health issue throughout the globe. Nursing staff encounter patient deaths many times throughout their careers. The death of a patient is one of the most common stressors associated with their clinical duties. Failing to address these issues mystifies the experience and leads to nurses suppressing their emotions out of fear and discomfort. These barriers hold nurses back from reflecting and prevent them from effectively coping with patient deaths, which negatively impacts their physical and mental health. A qualitative evidence synthesis was conducted to assess the experience of nursing staff with patient deaths and during postmortem care. The databases were searched for qualitative studies published after 2009. The search resulted in a total of 802 articles that were screened for eligibility. Duplicate studies were excluded. After eligibility screening, four qualitative studies on nurses' experience of patient deaths and postmortem care were identified and included in the analysis. An integrated analysis was conducted on the four qualitative studies. The studies were based in the United States, South Africa, Taiwan, and the United Kingdom. A total of 30 nursing staff reported their experiences of postmortem care. Three themes were identified: concerns associated with postmortem care, anxiety associated with death, and emotional alienation.

Keywords: Nursing staff experience, Postmortem care, Qualitative research

Introduction

Globally, until now Coronavirus disease-2019 (COVID-19) causes 6.85% of mortality rate. Nearly 50% of deaths in Taiwan take place in hospitals [1]. When a patient dies in the hospital, nursing staff provides the first line of care to the body, ensuring it is clean, tidy, and dignified [2]. However, experiencing the death of a patient is one of the most common stressors in nurses' clinical work [3].

An individual's cultural background can influence or determine his or her beliefs and attitudes toward life and death [4]. Chinese culture is influenced by ancestral worship, Taoism, Confucianism, Buddhism, and other beliefs. In contrast, Western culture typically views death not as the termination of life but as a change in life. In addition, western cultures tend to spend more time talking openly about and preparing for death [5]. These cultural influences have a profound impact on an individual's views on death [6,7].

Several factors impact nurses' experiences in managing patient deaths, including their personal experiences, cultural background, education, and clinical experiences. Often nurses neglect their personal feelings and psychological well-being during emotionally draining clinical duties [8]. The outbreak of coronavirus disease-2019

(COVID-19) forced nurses to face the life and death. When individuals are unable to clarify and discuss their emotions, they are more likely to hide their fears and uneasiness by suppressing their grievances. This can have a negative impact on their psychological well-being and on their work. The imbalance between body and mind can create additional pressure in the work environment. This study evaluates the literature on the experiences and psychological state of nursing staff during patient deaths and postmortem care. The findings from this qualitative analysis may help identify supportive interventions to facilitate physical and psychological adjustment during patient deaths. In addition, the findings may help inform policy on psychological counseling for clinical staff.

Methods

The value of qualitative systematic analysis

Qualitative research explores the nature of clinical care and deepens researchers' understanding of the experiences and behaviors of individuals. It serves several functions, including (1) explaining the health-related situations of individuals, communities, and groups (related to disease, how to deal with health conditions, how

to make decisions, etc.); (2) providing the views and perspectives of the caregiver, health professional, or health care interactions; (3) determining the mechanism of experiences through various perspectives; (4) developing care and care measures; (5) helping understand the process of change; and (6) resolving dilemmas from local culture [9].

It is inevitable that clinical staff will encounter patient deaths. Therefore, experiences with postmortem care require investigation and evaluation. Given the way medical education is delivered and deep-rooted cultural traditions, few clinicians adequately attend to the emotional ups and downs associated with clinical care. Many providers believe they must maintain an objective, reasonable, and unsympathetic state of mind. In addition, they strive to be sensible during postmortem care and avoid any emotional influence. This study describes the typical experience of nursing staff during patient deaths and while providing postmortem through an analysis of the literature.

Search strategy

Five databases-PubMed, CINAHL, Medline, Cochrane, and Airiti Online Library (CEPS)-were searched for eligible studies. The PICO (population, intervention, context, and outcome) tool was used to identify relevant keywords. Keywords related to the population (nurses, nursing nurse, nursing staff), intervention (post-mortem care, corpse care, after-death care, patient's death care, body care), and context (post-mortem care experience in hospital, hospital body care experience) were used to identify published qualitative studies on experiences of patient deaths and postmortem care among nurses. Boolean operators were used in the search strategy to input synonymous keywords with OR and connect multiple concepts with AND.

We searched databases using chinese and english keywords. Titles or abstracts of each identified article were screened for relevance. Inclusion criteria included a qualitative research design, a focus on the experiences of nursing staff during patient deaths or while performing postmortem care, and Chinese or English language. The initial search resulted in a total of 802 articles. The reference lists of identified articles

were reviewed for relevant studies. Duplicate articles were removed, and titles and abstracts were screened. Articles were excluded if they included the wrong study population, had internal nonconformity, or had no full text. Following title and abstract screening, four articles met the study inclusion criteria. Articles from the United States, South Africa, Taiwan, and the United Kingdom were included and reviewed (Figure 1).

Assessment of methodological quality

The Critical Appraisal Skills Programme (CASP) was used to assess the methodological rigor of the included studies [10]. This user-friendly tool provides a structured approach to critically appraising qualitative empirical research. Studies are appraised based on several criteria. The first two questions are as follows: (1) Is there a clear research objective? (2) Is the research methodology sound? If the answer to the first two questions is "yes," the reviewer completes questions 3 to 10: (3) Is the research design suitable for the research purposes? (4) Is the recruitment strategy appropriate to the research objective? (5) Does the method of data collection address the research question? (6) Is the relationship between the researcher and participants considered? (7) Have the ethical issues been considered? (8) Is the data analysis sufficiently rigorous? (9) Are results clear? (10) Does the research add value to the literature?

The review tool includes 10 questions that have sub-question prompts to consider as part of the assessment. The reviewer moves through each item and responds "yes," "no detailed explanation," or "no." If the reviewer responds "yes" to the majority of the sub-questions, the article receives a "yes" for that question. More "yes" responses indicate higher quality research.

The included articles were reviewed by two graduate students. The critical appraisal found that all studies received >7 "yes" responses. These findings were validated by qualitative research experts who indicated >7 "yes" responses for each study. When there was a disagreement between the two reviewers, the qualitative experts were consulted. For instance, the experts were consulted to determine whether the method of data collection was appropriate (5) and

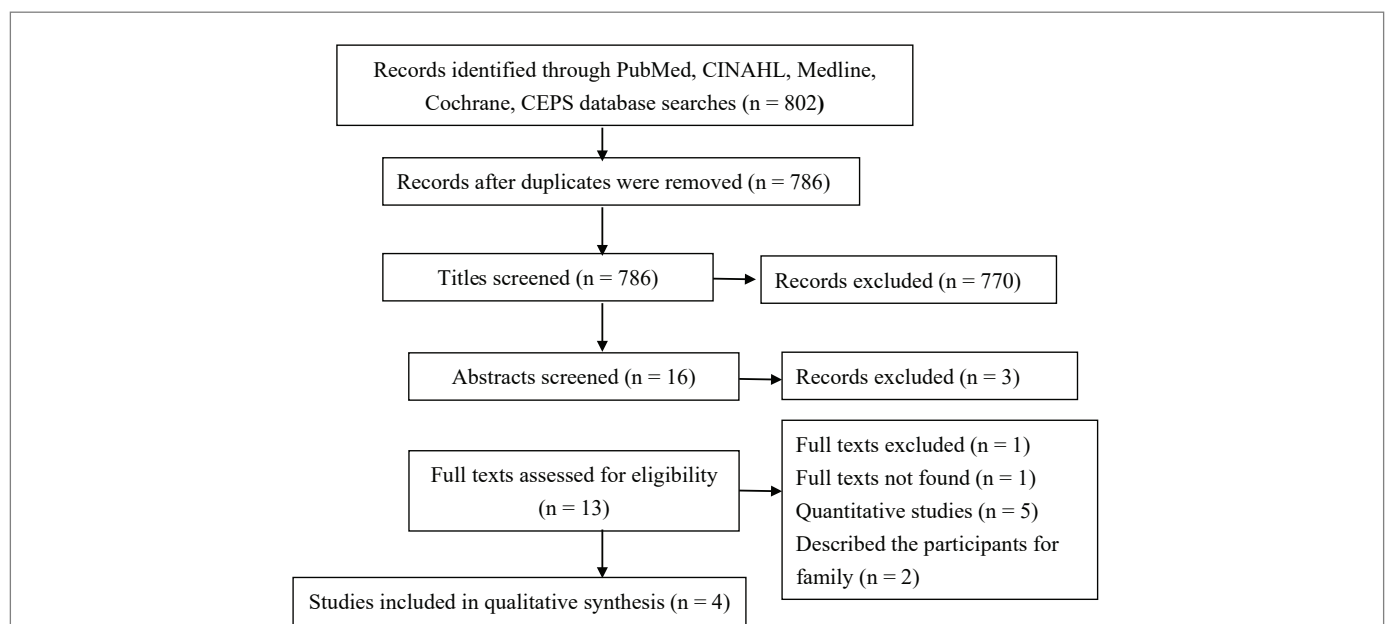


Figure 1: Flow diagram of the search results and review process.

whether the analysis was sufficiently rigorous (8). The results of the critical appraisal are summarized in table 1. Based on the results of the critical appraisal, the studies were graded. There are three grades of literature quality (or credibility): unequivocal (i.e., no doubt about the evidence presented), credible (i.e., some explanations for the data are equivocal and reasoning is logical), and not supported (i.e., most data do not support the conclusions) [9]. After analysis by all four researchers, the evidence presented in the four included studies was deemed of the highest quality with unequivocal clarity.

Data extraction and synthesis

The included articles were independently reviewed by two graduate students with experience in qualitative research. Information relating to the authors, research purpose, research method, data collection, analysis, results, and conclusions was extracted and summarized (Table 2). Each reviewer identified meaningful topics, and inconsistent findings or subthemes were discussed by the two reviewers and qualitative research experts to determine their relevance. Ultimately, three topics and five subthemes were extracted.

Prior to translating the English articles into Chinese, the reviewers read the full texts to assess the authors' tone and conclusions. Interviews were translated, and the translated scripts were repeatedly compared to the original versions to ensure that the final translated articles matched the intended meaning of the original works.

Results

This literature search identified very few research studies on the experiences of nursing staff during patient deaths and postmortem care. Only four articles met the study inclusion criteria: one Chinese-language work and three English-language studies. The studies were based in Taiwan, South Africa, America, and England (Study Nos. 1, 2, 3 and 4, respectively). In total, the studies included 30 licensed nurses. The participants ranged in age from 28 to 60 and had between 1 and 40 years of nursing experience. Nursing services included general inpatient care (27%, n=8; No. 1), intensive care (40%, n=12; Nos. 2, 3), and hospice care (33%, n=10; No. 4).

The experiences of nursing staff during patient deaths and postmortem care were extracted and summarized (Table 2). Thematic analysis of the four papers identified several recurring themes, including concerns associated with postmortem care for the remains, anxiety associated with death, and grief avoidance through emotional alienation.

Concerns associated with postmortem care

Feelings, such as discomfort and fear, are the accumulation of personal understanding, cognition, and experience. Nurses reported feelings associated with the removal of tubing from the dead body as well as emotional responses to the appearance and feel (i.e., temperature and softness) of the body.

Reality shock: An expectation gap can occur when the expectations of a new care provider are greater than his or her actual feelings. Such gaps can result in significant psychological pressure among nursing staff. They may worsen during stressful clinical situations, such as experiencing a patient death. These experiences can lead to negative emotions, such as self-denial and frustration, which hinders nursing staff's ability to adapt to the new environment. Several participants highlighted such an expectation gap when beginning their nursing careers.

"The post-mortem care techniques taught in school are practiced on a fake body. This is very different than a real dead body, which might have corpse spots and a swollen face; not at all something good to look at. Also, there were often people around to supervise during internships. When I began working, I had to handle everything by myself, and the gap was really big" (Table 2).

"Witnessing the death of the patient can be a stressful experience for new nurses on the ward, especially when they need to provide last offices. Some nurses are not prepared to experience the patient death. The impression of death is never great, and this experience can consume their thoughts, which impacts their ability to perform their clinical duties" (Table 2).

"I want to ensure I handle the body the proper way. I am not a machine [hand wave], I am still a human being" (Table 2).

Table 1: Critical appraisal of the included studies.

Critical appraisal skills program: Qualitative checklist	1. MCT& YHL (2006), Taiwan	2. CdeS & NF (2017), South Africa	3. KAH (2012), United States	4. SM & KB (2015), England
1. Was there a clear statement of the research objective?	Yes	Yes	Yes	Yes
2. Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes
3. Was the research design appropriate to address the research objective?	Yes	Yes	Yes	No
4. Was the recruitment strategy appropriate to the research objective?	Yes	Yes	U	Yes
5. Were the data collected in a way that addressed the research objective?	U	U	U	Yes
6. Has the relationship between researcher and participants been adequately considered?	U	U	Yes	Yes
7. Have ethical issues been taken into consideration?	No	Yes	Yes	No
8. Was the data analysis sufficiently rigorous?	Yes	U	U	U
9. Is there a clear statement of findings?	Yes	Yes	Yes	Yes
10. Does the research add value?	Yes	Yes	Yes	Yes

*U=Unclear

Last offices: Last offices are the final care provided by the caregiver, which is an inherently ceremonial process. Because postmortem care can have spiritual dimensions, the process of removing life-supporting tubing can invoke uncomfortable feelings.

“I remember the patient who stayed in bed 141. He mentioned he was a veteran without any relatives, which was not a good situation to begin with. His health condition deteriorated rapidly within a day or two and received tracheal intubation. My colleague collected his corpse for body care. I did not help with the body care; however, my colleague later told me that night the patient stayed with her. She did not know if the tracheal tube was inserted too deep and did not remember much of what happened, but the patient stayed with her” (Table 2).

“I don’t want to say it is scary, but it is not a nice feeling. It is something that is not nice. I will say that it is not easy” (Table 2).

“Then they were dressed in these ghastly white shrouds; they were horrid, they were really horrid.” Nurse with more than 26 years of experience (Table 2).

Anxiety associated with death

Death is often mystified, but it is also an inevitable reality for human beings. Nursing staff bring different social and cultural beliefs and lived experiences to their experiences of patient deaths. As a result, they may have different psychological responses to death. Although death is inevitable, discussing death is often taboo. Nursing staff should consider the range of social, cultural, and lived experiences when encounter patient deaths, as these experiences can result in different feelings and behaviors.

Differences in religion and culture: Nursing staff come from different social and cultural backgrounds. Their backgrounds can impact their thoughts and behaviors as they provide patient care.

“When I was doing care, I prohibited others from calling my name. I wouldn’t stand by end of the bed because I thought the dead patient might get up and I would be in their way” (Table 2).

“When I have to perform the care by myself, I am really scared some patients open their eyes after death. That scares me and I have to close their eyes with my hand. I always tell the body to rest in peace! I carefully clean the body for the coming journey and hope the dead will never bother me” (Table 2).

“I am not particularly scared of the cadaver itself. Through my nursing training I have learned how to take care of cadavers. However, I am aware of many taboos related to death, and I don’t completely understand them. Therefore, I worry when performing cadaver care because I don’t want to break any taboo, so I really panic” (Table 2).

“It depends on the religion of the patient that passed away. For instance, in the Jewish faith there are certain things that you are allowed and not allowed to do” (Table 2).

“The soul is going to God and we have to pray and let them go” (Table 2).

Thoughts about life and death: Attitudes are relatively long-term ways of thinking or feelings about a particular individual or situation. Attitudes toward life and death may manifest as different cognitions, emotions, and behaviors.

“We often develop some feelings for a patient who stays on the ward for a long time. We sometimes feel relieved when the patient expires because we have seen the patient’s extended hospitalization, without the chance of disconnecting their respirator or moving from their bed. Day after day the patient struggles. When the patient expires, we feel

that they are free at last” (Table 2).

“You plan everything, but you do not think about your own death. It is so unknown. I am scared when it comes to that” (Table 2).

“The sad thing is patient deaths don’t bother me as much as they used to. I usually see it as a relief” (Table 2).

Emotional alienation

Experiencing a patient death can lead to conflicting feelings among nursing staff. Because nurses feel that they have a responsibility to provide the best care for patients and their families while adhering to professional nursing standards, they often hide their sadness and only express their emotions in private.

Distancing oneself from death: Nurses are taught to set boundaries and put aside their feelings to effectively perform their roles as nursing professionals.

“If you experience a sudden death of a patient, whose face is covered in blood, the only thing on your mind is how to quickly wipe away the blood and to find a way to save the patient’s life. Once the care is complete, I am able to reflect. I view the encounter as routine and keep thinking about how to make things better for patients” (Table 2).

“Usually we don’t want to ‘take patients’ in our unit. We know well that patients admitted here are not in a good condition and may die any time, but we try our best to keep them alive. No one wants to experience the death of a patient” (Table 2).

“It makes me feel sad, and I even cry sometimes, but I cry in silence. At times, I go to the washroom, shed some tears and then return to work” (Table 2).

“I think I put up a wall. I mean, I am sad for the family [of the dying patient], but I have to be happy with the other families” (Table 2).

“I don’t like anybody to die on me, even if the patient is ready. It is difficult dealing with the grieving families. I would rather it happened on the other shift” (Table 2).

“You do kind of have to have some form of closure so if you can’t have that closure you become so bogged down with emotions, you can’t actually carry on and be a good nurse.” Participants with more than 6 years of nursing experience (Table 2).

Discussion

Concerns associated with postmortem care

Encountering patient deaths can have a major psychological impact on nursing staff [11]. The literature suggests that there is a significant identity gap as nursing student’s transition to becoming nursing staff [12]. When nursing staff experience postmortem care early in their career it can serve as a turning point in the transition into their professional role. If nurses have not completely adjusted to their new role, they may find themselves conflicted by the educational values taught in the nursing curriculum and the values of clinical work. The clinical duties of a new nurse can highlight the gap between idealism and reality.

Culture differs in Eastern and Western countries. The Chinese traditionally avoid talking about death, as discussing the time, place, and process of death is taboo. These cultural taboos contribute to mystifying the experience of death [13]. One similarity between Eastern and Western countries is the uncomfortable feeling or fearful response associated with death or cadavers. This study identified some common reactions associated with experiencing patient deaths, including active

Table 2: Characteristics of four qualitative studies describing nurse's experiences with patient deaths.

No	Author (S), Year, Nation	Objective	Methods	Data Collection/Analysis	Participants	Concepts
1	MCT & YHL (2006), Taiwan	To explore the psychological process of nurses during postmortem care	Hermeneutic approach to qualitative research	In-depth unstructured interviews were used for data collection. Glaser's (1995) constant comparative method was used	Nurses (n = 8) who had worked in the general ward of a hospital in central Taiwan	<ol style="list-style-type: none"> 1. Postmortem care and reality shock of new nursing staff 2. Death taboo and belief in ghosts 3. Adjusting to postmortem care
2	CdeS & NF (2017), South Africa	To examine ICU nurses' experiences with patient deaths	Qualitative research design using a descriptive method	Semi structured interviews were audiotaped and transcribed verbatim. Colaizzi's (1978) seven-step inductive method was used to identify naive themes.	Six nurses (two males and four females) working in an intensive care unit in a private hospital in Cape Town. They ranged in age from 31 to 63 and had from 2 to 44 years of experience working in an ICU	<ol style="list-style-type: none"> 1. Care of the dead body 2. Detachment 3. Thanatophobia
3	KAH (2012), USA	To explore the lived experiences of critical care nurses who encounter patient deaths	Qualitative pilot study using a descriptive phenomenological approach	Semi structured interviews were used. The researcher used bracketing to set aside personal feelings and opinions about the research topic. Data analysis was guided by Colaizzi's method.	Six critical care nurses. Their mean age was 41 (SD, 6.8) years, and their average years of experience in critical care nursing was 15.7 (SD, 4.4).	<ol style="list-style-type: none"> 1. Coping 2. Personal distress 3. Emotional disconnect 4. Inevitable death
4	SM & KB (2015), England	To explore nurses' experiences of carrying out last offices in hospice inpatient and community settings and their views on involving the individual's significant others in the process	Interpretive, thematic analysis of interviews	Semi structured interviews were conducted and audio recorded.	Ten nurses in a small hospice in England. They ranged in age from 41 to 60 and had 1 to 40 years of experience working in critical care nursing.	<ol style="list-style-type: none"> 1. Range of care activities 2. Learning and coping challenges 3. Time of transition 4. Demonstration of respect and support

avoidance of the cadaver, negative emotions associated with a patient dressed in a white shroud, and a desire to preserve the ceremonial process while removing various tubes from the body. Participants reported discomfort associated with touching a cold body after death and wiping away blood and dirt on the body. Some individuals in Eastern cultures believe that removing the tracheal tube after death releases the patient's ghost. Those involved with postmortem care may feel additional pressure to ensure that the ghost is disposed of properly [14]. In addition, there may be a fear that the ghost will haunt them. In the West, especially among people of the Jewish faith, death is a time to reflect on life [15,16]. The remains are treated as an individual, not as an object, and death is considered from the perspective of the deceased.

Anxiety associated with death

Given the limited education and cross-cultural taboos associated with death, religion and spirituality can help patients and families cope with disease and foster a positive mental state and emotions [17,18]. In Western cultures, nursing staff may express respect for the deceased through religion, such as offering prayers or praying for the soul to return to God's embrace. In contrast, in many Eastern cultures, it is difficult to comprehend the meaning of life and death. Birth is often associated with joy and happiness, but death brings fear and sorrow.

Moreover, these experiences are influenced by the Chinese confucian way of thinking. In Eastern cultures, individuals often believe that "ghosts and gods are far away" and "without first understanding life, one cannot understand death" [19]. Individuals cannot grasp their powerlessness within the real world, except through fear and respect [20]. Given the nature of the nursing profession, nurses often suppress any emotions associated with a patient's death, which can lead to occupational stress as well as physical and mental exhaustion [21]. Furthermore, according to confucianism, the purpose of the mourning ceremony is to let the souls of the deceased drift away. As these souls drift away, they may attach to nearby living bodies, which can invoke anxiety, fear, and other feelings among those involved with postmortem care. Ensuring that nurses are trained in the proper etiquette of postmortem care may reduce their fears [22].

Several Western cultures recognize that life and death are two separate states of existence. Although the thought of death can create fear and anxiety in Western cultures, this fear and anxiety is less often associated with ghosts or spirits than in Eastern cultures. One similarity between Eastern and Western cultures involves the convergence of religion and social factors during death. In some instances, death is viewed as a relief for the patient when it ends his or her suffering. The various similarities and differences between Eastern and Western cultures affect their attitudes and beliefs associated with death.

Emotional alienation

Death was traditionally considered taboo in China. As times have changed, the concept of death has also changed. Many Chinese residents have grown up in a system of conservative education. Although Chinese culture has become more cosmopolitan, the taboo remains. However, death is inevitable, and for some, it can come unexpectedly. Failing to recognize and accept this fact can create various challenges. For instance, the pressure nursing staff experience when encountering a patient death can lead to fear and anxiety.

As in other Eastern cultures, death is a taboo subject in Taiwan. It is often considered an unlucky event, and people avoid discussing it. As a result, nursing staff often experience ineffective communication and insufficient training related to death. When faced with a patient death, nurses often adopt an attitude of avoidance [23]. This study highlights the fact that both Eastern and Western nurses tend to avoid discussing death, which is consistent with the findings of Lu CW, et al. reported [24]. In addition, senior nursing staff tends to regard death as an escape from suffering [25]. These findings suggest that care workers in both Eastern and Western countries experience discomfort or negative emotional responses when faced with a patient death.

The traditional nursing education teaches nurses to maintain a good therapeutic relationship with patients and their families. Given their professional role, nurses believe it would be inappropriate to cry or express their inner feelings to patients or their families. This helps them maintain their professional image, as emphasized in clinical and traditional nursing education. Moreover, nursing staff are socialized within their professional role to suppress their emotions. One study highlighted the social expectation of nurses to hide their emotions to qualify as professional nursing staff [26]. This study underscores the common escape mentality and self-isolation among nurses when faced with patient deaths. In addition, nursing staff are often emotionally involved in the care of their patients and fail to promptly isolate their feelings, which can lead to a negative emotional response following patients' death.

Conclusion and Relevance for Clinical Practice

Given their clinical role, nursing staff often encounter patient deaths. Nurses' experiences with death and postmortem care differ according to their religious beliefs, education, nursing experience, culture, and organizational policies. This review of four articles found that nursing staff experience various emotional responses while performing postmortem care. Several nurses expressed feeling significant pressure during patient deaths and while providing postmortem care. These feelings were heightened in new nurses due to academic and clinical gaps associated with transitioning to their new role. Cross-country studies have consistently reported negative emotional responses when faced with patient deaths; however, several factors can affect these experiences. One main difference across cultures is that in many Eastern cultures people believe that one becomes a ghost after death. This belief has implications for nursing staff that are involved with postmortem care and are required to remove an endotracheal tube, which is thought to release the ghost. This leads to nurses avoiding standing at the end of the patient's bed and closing the patient's eyes to not disrupt the ghost. In addition, nurses avoid saying their names or the names of other caregivers, avoid touching the dead body, and perform various rituals to reduce their anxiety about death.

Despite the cultural differences between the East and West, one common reaction among nursing staff to patient deaths is to suppress their feelings and distance themselves from the death. This provides an emotional escape and allows the nurses to focus on their clinical

duties of providing postmortem care. Moreover, nurses attempt to create space by treating the death as something far away or unrelated. These findings raise the question of whether their feelings would still be ignored if they became more intense and unbearable.

Coronavirus disease-2019 (COVID-19) is a new and ongoing pandemic, and an alarming public health issue throughout the global. Blocking the spread of COVID-19, the government restricts family members to prohibit entry into hospitals, and the remains are cremated as soon as possible. Nursing staff becomes the most important bridge and emotional support between patients and their families. The experiences and feelings of nursing staff when faced with patient deaths are complex and influenced by many factors. Empirical evidence suggests that the nursing curriculum should include three main components. First, educational programs should incorporate issues of life and death. In regard to death, the curriculum should teach about techniques of postmortem care, sociocultural factors that impact the death experience, and cultural taboos. Integrating additional topics related to death would provide students with new perspectives and a greater understanding of the death experience, which may help them adjust to their clinical duties. Second, nursing education should incorporate additional opportunities for clinical care practice. Both students and experienced nurses should have opportunities to develop and maintain clinical skills associated with postmortem care. These skills could be practiced and assessed using objective structural clinical skills (OSCE). Third, the nursing curriculum should incorporate research. It is our hope that, given the paucity of literature related to postmortem care, more research will be conducted on this subject.

In Taiwan, religion plays a central role in shaping an individual's values and beliefs. When nursing staff are faced with patient deaths, they may experience various emotions, such as fear, anxiety, loss, and helplessness. Nurses should not have to experience a patient death and provide postmortem care alone. Clinical nursing leaders should support their staff during these emotionally challenging clinical duties. For instance, nursing leaders may perform or supervise postmortem care and welcome nurses to openly share their feelings and beliefs to reduce their fears. If nursing staff display an escape mentality, it may be beneficial to provide a private space for them and encourage them to discuss and express their feelings. Nursing leaders may use situational simulation and group discussions to help nursing staff understand and address their feelings.

Although this study described several experiences and feelings among nurses encountering patient deaths and performing postmortem care, the paucity of evidence limits these findings. Further research is needed to evaluate interventions to support nurses during patient deaths.

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