Full title:
Qualitative Systematic Review of Resilience in the Inpatient Palliative Care Nursing Workforce: A Thematic Synthesis

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Word Count: 5742

Keywords
hospice; nursing; palliative; resilience; stress.

Abstract

Background:
Nurses in inpatient palliative care are frequently exposed to death and dying in addition to common stressors found in other nursing practice. Resilience may mitigate against stress but remains ill-defined and under researched in the specialist palliative care setting.

Objective:
The aim of this systematic review was to understand resilience from the perspectives of inpatient palliative care nurses.

Design:
A thematic synthesis of qualitative studies was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.

Data Sources:
Academic Search Ultimate, Cumulative Index to Nursing and Allied Health, Medline Complete, Psych INFO and Scopus.

Review Methods:
The review stages were: searching for relevant literature, selecting relevant papers, data extraction, critical appraisal, and thematic synthesis.

Results:
Eight studies revealed 10 sub-themes, three descriptive themes and one analytic theme: Resilience occurs when nurses incorporate stressful aspects of their personal or professional lives into a coherent narrative that enhances their ability to cope with the demands of their role.

Conclusion:
Palliative care nursing is more stressful if patients or situations remind nurses of personal experiences. Nurses cope better with adequate support; however, coping does not necessarily imply increased resilience. Resilience occurs when nurses cognitively process their experiences, articulate their thoughts and feelings into a coherent narrative and construct a sense of meaning or purpose.

Future research could explore how nurses understand resilience and how it could be enhanced in the palliative care inpatient setting. With resilience, nurses may remain in the profession longer and improve the quality of care when they do.

Contribution of the paper:

What is already known about this topic:

- Nursing is considered a stressful profession and those working in palliative care are exposed to death and dying more frequently than their counterparts in other specialities.
- The demand for palliative care is predicted to increase yet the supply of registered nurses is diminishing. The retention of skilled, experienced nurses is of paramount importance.
- Resilience may mitigate against the stressors within the role yet is poorly defined and under researched in the specialist palliative care nursing workforce.

What this paper adds:

- This paper identifies the importance of meaning construction as a component of resilience in this workforce.
- Nurses in palliative care experience similar stressors as in other specialties but find it more challenging when patients or situations remind them of their own experiences of mortality.
- Palliative care nurses cope in different ways, such as choosing to adopt either a technical or relational approach to care; expressing or suppressing emotions; giving and receiving support; maintaining a work-life balance; and finding ways to 'make a difference'.
- Resilience is distinct from coping and derives from the ability to make sense of, and construct meaning from experience.

1 Introduction

Nursing is considered inherently stressful and some claim that palliative care is especially so due to exposure to terminally ill patients and their families [1-4]. Resilience may help to mitigate the deleterious effects of stress yet there is a lack of empirical evidence on how it is defined, developed and enhanced in the palliative care nursing workforce.

1.1 Aims

The aim of this review was to:

- identify, appraise and synthesise data from qualitative research studies that describe resilience from the perspective of inpatient palliative care nurses.

The aim was guided by the following question:

- How do palliative care inpatient unit nurses describe or infer resilience?

2 Background

2.1 Resilience theory

Resilience is a process, not a personality trait, and an ability to bounce back or recover easily when confronted by adversity, trauma, misfortune or change [5]. Resilience enables effective coping, successful adaptation and growth [6]. The study of resilience has evolved over the past four decades, from initial assertions that resilience was akin to invulnerability or demonstrated by an absence of psychopathology [5], to an understanding that the ability to thrive under adverse circumstances is complex and multifactorial [7].

2.2 Stress in the nursing workforce

The prevalence of work-related stress, anxiety and depression in the United Kingdom is significant and accounted for 37% of work-related health issues in 2015-16. Factors that cause workplace stress have remained constant over time and include issues with workload, lack of support from managers and organisational change [8]. Furthermore, these issues are prevalent in many other countries and care settings [9] with nurses reporting similar issues in their workplaces regardless of how their country's healthcare system is organized [10].

There is growing concern about a disproportional prevalence of stress in the health care workforce. Nursing has much higher rates (3010 cases per 100,000) for example, than do skilled tradesmen (550 cases per 100,000), [8]. Consequences of excessive or prolonged stress include burnout, compassion fatigue and attrition at a time when the nursing workforce is depleted and struggling to meet the demands of the healthcare system [11]. The number of vacancies in the UK National Health Service has doubled in the past three years, with the number of people entering the profession significantly lower than those leaving [12]. There is a predicted global shortage of nurses within the next 10 to 20 years [13].

The quality of care experienced by patients is negatively affected when staff are stressed [14]. Johnson, et al. [15] found that where the ability to cope is compromised, the distress associated with perceived failure undermines healthcare professionals' resilience. This leads to negative outcomes such as shame, depression and anxiety, which in turn increases the likelihood of further distress and so the cycle continues.

Whilst many recognise the stressors inherent in generic nursing, some claim that palliative care is especially stressful due to working with terminally ill patients and their families [1-4]. These authors suggest that resilience may enable nurses to better tolerate workplace stress yet resilience is considered difficult to define, especially in the nursing literature [16] as it is a complex concept and comprises different elements, including risk and protective factors that interact with the environment. Little is known about nurses' experiences of resilience in specialist palliative care inpatient settings.

3 Methods

3.1 Design

This review was conducted systematically and comprised the following steps: searching for relevant literature, selecting relevant papers, extracting data from identified papers, and critically appraising identified papers. This process culminated in a thematic synthesis of literature according to the three steps outlined by Thomas and Harden [17]:

1) Line by line text coding
2) Developing descriptive themes
3) Generating analytic themes

At each phase of the processes involved in screening, assessing for eligibility, quality appraisal and analysis, the lead author (MP) undertook the task and the results were scrutinized and verified by the second (KF) and third (SG) authors. Any disagreements were highlighted, and consensus reached through discussion.

3.2 Search Methods

The search strategy was devised in conjunction with a specialist librarian, resulting in the identification of three sets of terms, as listed in table 1. Search terms were restricted to English language. The terms in each set were combined with the logical operator 'OR', and each set was combined with the logical operator 'AND' in the following databases: Academic Search Ultimate, Cumulative Index to Nursing and Allied Health (CINAHL), Medline Complete, Psych INFO and Scopus.

Table 1 Search terms

Set 1	Set 2	Set 3
hospice	Coping	Nurs*
Palliat*	Cope	
End of life care	Resilien*	
Terminal care	Hardiness	
	Adaptation	
	Adjustment	

Medical subject headings (MeSH) were modified according to each database and the exact search terms used for each can be found in Tables 2-6. The search was conducted in December 2018 with each database unrestricted by date range to retrieve the maximum possible number of relevant papers.

Table 2. CINAHL search strategy

CINAHL Search Strategy			
Sequence	**Search items**	**Limiters**	**Results**
S13	S4 AND S9 AND S12	Find all my search terms	View Results (721)
S12	S10 OR S11	Find all my search terms	View Results (50,208)
S11	TI (hospice OR palliat* OR end of life care OR terminal care) OR AB (hospice OR palliat* OR end of life care OR terminal care)	Find all my search terms	View Results (35,778)
S10	(MH "Hospice Care") OR (MH "Hospices") OR (MH "Terminal Care") OR (MH "Palliative Care")	Find all my search terms	View Results (37,879)
S9	S5 OR S6 OR S7 OR S8	Find all my search terms	View Results (91,240)
S8	TI (coping OR cope OR resilien* OR hardiness OR adaptation OR adjustment) OR AB (coping OR cope OR resilien* OR hardiness OR adaptation OR adjustment)	Find all my search terms	View Results (72,978)
S7	(MH "Coping")	Find all my search terms	View Results (20,845)
S6	(MH "Adaptation, Occupational") OR (MH "Adaptation, Psychological")	Find all my search terms	View Results (16,189)
S5	(MH "Hardiness")	Find all my search terms	View Results (4,505)
S4	S1 OR S2 OR S3	Find all my search terms	View Results (405,301)
S3	TI nurs* OR AB nurs*	Find all my search terms	View Results (384,087)
S2	(MH "Nurses")	Find all my search terms	View Results (45,822)
S1	(MH "Hospice and Palliative Nursing")	Find all my search terms	View Results (3,845)

Table 3. Academic Search Ultimate Search Strategy

Academic Search Ultimate Search Strategy			
Sequence	Search Items	Limiters	Results
S12	S3 AND S7 AND S10	Limiters - Language: English	View Results (299)
S11	S3 AND S7 AND S10	Find all my search terms	View Results (310)
S10	S8 OR S9	Find all my search terms	View Results (43,463)
S9	TI (hospice OR palliat* OR end of life care OR terminal care) OR AB (hospice OR palliat* OR end of life care OR terminal care)	Find all my search terms	View Results (43,285)
	((DE "HOSPICE care" OR DE "HOSPICES (Terminal care facilities)") OR (DE "PALLIATIVE treatment")) AND (DE "TERMINAL care" OR DE "TERMINAL care -- Psychological aspects")	Find all my search terms	View Results (2,436)
S7	S4 OR S5 OR S6	Find all my search terms	View Results (345,682)
S6	TI (coping OR cope OR resilien* OR hardiness OR adaptation OR adjustment) OR AB (coping OR cope OR resilien* OR hardiness OR adaptation OR adjustment)	Find all my search terms	View Results (341,470)
S5	DE "ADJUSTMENT (Psychology)"	Find all my search terms	View Results (16,882)
S4	(DE "RESILIENCE (Personality trait)") OR (DE "ORGANIZATIONAL resilience")	Find all my search terms	View Results (6,068)

S3	S1 OR S2	Find all my search terms	View Results (238,536)
S2	TI nurs* OR AB nurs*	Find all my search terms	View Results (235,485)
S1	DE "NURSES" OR DE "NURSES -- Job stress"	Find all my search terms	View Results (45,660)

Table 4. PsychINFO Search Strategy

PsycINFO Search Strategy			
Sequence	Search Terms	Search Options	Actions
S12	S3 AND S7 AND S10	Limiters - Language: English	View Results (276)
		Find all my search terms	View Details
S11	S3 AND S7 AND S10	Find all my search terms	View Results (291)
S10	S8 OR S9	Find all my search terms	View Results (20,896)
S9	TI (hospice OR palliat* OR end of life care OR terminal care) OR AB (hospice OR palliat* OR end of life care OR terminal care)	Find all my search terms	View Results (17,289)
S8	(DE "Hospice" OR DE "Palliative Care") OR (DE "Terminally Ill Patients")	Find all my search terms	View Results (15,480)
S7	S4 OR S5 OR S6	Find all my search terms	View Results (233,794)
S6	TI (coping OR cope OR resilien* OR hardiness OR adaptation OR adjustment) OR AB (coping OR cope OR resilien* OR hardiness OR adaptation OR adjustment)	Find all my search terms	View Results (223,366)
S5	((DE "Adjustment") OR (DE "Adaptation")) OR (DE "Coping Behavior")	Find all my search terms	View Results (65,070)
S4	DE "Resilience (Psychological)"	Find all my search terms	View Results (10,389)
S3	S1 OR S2	Find all my search terms	View Results (88,231)
S2	TI nurs* OR AB nurs*	Find all my search terms	View Results (86,275)
S1	DE "Nurses" OR DE "Nursing"	Find all my search terms	View Results (37,057)

Table 5. Medline Complete Search Strategy

Medline Complete Search Strategy			
Sequence	Search Options	Actions	Results
S16	S3 AND S8 AND S14	Limiters - English Language	View Results (811)
S15	S3 AND S8 AND S14	Find all my search terms	View Results (885)
S14	S9 OR S10 OR S11 OR S12 OR S13	Find all my search terms	View Results (115,188)
S13	AB (hospice OR palliat* OR end of life care OR terminal care) OR TI (hospice OR palliat* OR end of life care OR terminal care)	Find all my search terms	View Results (82,689)
S12	(MH "Terminally Ill")	Find all my search terms	View Results (5,978)
S11	(MH "Terminal Care")	Find all my search terms	View Results (24,357)
S10	(MH "Palliative Care") OR (MH "Palliative Medicine")	Find all my search terms	View Results (46,726)
S9	(MH "Hospice Care")	Find all my search terms	View Results (5,480)
S8	S4 OR S5 OR S6 OR S7	Find all my search terms	View Results (386,713)
S7	AB (coping OR cope OR resilien* OR hardiness OR adaptation OR adjustment) OR TI (coping OR cope OR resilien* OR hardiness OR adaptation OR adjustment)	Find all my search terms	View Results (337,946)
S6	(MH "Adaptation, Psychological")	Find all my search terms	View Results (83,890)
S5	(MH "Emotional Adjustment")	Find all my search terms	View Results (254)
S4	(MH "Resilience, Psychological")	Find all my search terms	View Results (3,123)
S3	S1 OR S2	Find all my search terms	View Results (430,378)
S2	AB nurs* OR TI nurs*	Find all my search terms	View Results (393,245)
S1	(MH "Hospice and Palliative Care Nursing") OR (MH "Nurses") OR (MH "Nursing")	Find all my search terms	View Results (82,517)

Table 6. Scopus Search Strategy

Sequence	Search terms	Results
S1	(ABS (nurs*) AND ABS (hospice OR palliat* OR terminal *) AND ABS (coping OR cope OR resilien* OR hardiness OR adaptation OR adjustment)) AND (LIMIT-TO (DOCTYPE , "ar")) AND (LIMIT-TO (LANGUAGE , "English"))	340

The SPIDER acronym [18] informed the review question, search terms and inclusion/exclusion criteria. Papers that inferred resilience by describing how nurses managed or coped in the face of adversity were accepted, subject to the criteria outlined below.

3.3 Inclusion/Exclusion Criteria

Criteria were developed by all authors with a decision to focus this review on published peer-reviewed articles only. Financial and language resources were not available to consider texts published in any language other than English. Initial scoping of case reports, conference reports and poster abstracts revealed consistent, insufficient richness of material to meaningfully contribute to a greater understanding of the phenomena of resilience in hospice/palliative care nursing.

Inclusion Criteria:

1. Qualitative research, or mixed methods studies where qualitative data is extractable
2. Participants were exclusively Registered Nurses, or where data for Registered Nurses could be extracted
3. Study was designed to elicit information about resilience or coping when working with patients in a dedicated palliative care inpatient facility

Exclusion criteria:

1. Focus on burnout (a distinct concept, not an inevitable consequence of resilience)
2. Studies not published in peer reviewed journals
3. Studies not published in English
4. Case reports, conference proceedings, poster abstracts and theses,
5. Studies that collected qualitative data but analysed with quantitative methods
6. Studies that focus on the experiences of patients, informal caregivers or family members.

3.4 Search outcome

This systematic literature review and thematic synthesis was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance [19], demonstrated in Figure 1. A total of 2438 citations were retrieved and organised with Endnote v.7 (Clarivate Analytics, Philadelphia) and 1329 duplicates were removed. The titles and abstracts of the remaining 1109 papers were screened by the lead author (MP) and the results scrutinised by KF and SG. The full paper was obtained if the paper met the inclusion criteria or if there was any doubt about suitability for inclusion.

154 full-text articles were assessed for eligibility by MP, and the resultant lists were again scrutinized by KF and SG. Eight studies were included in the review and the characteristics of each, including methods of data collection and analysis can be seen in Supplementary Table 1. In addition, the studies were reviewed according to the Consolidated criteria for reporting

qualitative research (COREQ) [20], with results reported in Supplementary Table 2. The studies were conducted in the following countries: United Kingdom (n=2), Australia (n=2), Japan (n=1), Taiwan (n=2) and the Netherlands (n=1). A total of 154 nurses participated in these eight studies.

All included studies were either qualitative (n=6) or mixed methods with extractable qualitative results (n=2) and used interviews to collect data. One study was published in 1990 and the remaining seven were published after 2002.

3.5 Quality Appraisal

All papers in this review were assessed for quality using the Hawker, et al. [21] checklist. Each question is designed to appraise the quality of the following aspects of the paper: abstract and title, introduction and aims, method and data, sampling, data analysis, ethics and bias, results, transferability or generalizability, and implications and usefulness. To assist with quality assessment the following categories were assigned a corresponding numeric score (shown in parenthesis): Good (4), Fair (3), Poor (2) or Very Poor (1). The total score for each paper is shown in Table 9.

Table 9 Quality assessment of included papers

	ABLETT, J. R. & JONES, R. S.	ALEXANDER, D. A. & RITCHIE, E.	BARNARD, A. et al.	GEORGES, J.-J. et al.	HUANG, C. C. et al.	PETERS, L. et al.	SHIMOINABA, K. et al.	WU, H.-L. & VOLKER, D. L.
Abstract and Title	3	3	3	3	3	4	4	4
Introduction and aims	3	4	3	2	3	4	4	4
Method and data	3	3	4	3	4	4	4	4
Sampling	3	4	3	3	3	4	3	4
Data analysis	3	4	3	3	4	4	3	4
Ethics and bias	3	3	4	2	2	2	3	4
Results	4	4	4	4	3	4	4	4
Transferability	3	4	4	3	3	4	4	4
Implications and usefulness	4	4	4	3	4	4	3	3
Total score (Max 36, Min 9)	29	33	32	26	29	34	32	35

Two studies reported on any previous relationship between the researcher(s) and participants [22 23] and no studies explicitly reported what participants knew of the researchers. Participants were recruited purposively in four studies [22 24-26], by convenience in three studies [23 27 28] and by snowball techniques in one study [29]. One study described the number of participants who refused to participate or dropped out [24]. No studies described

returning transcripts to participants for comment or correction and it is unclear whether participants fed back on findings. All studies lacked specific descriptions of diverse or minor cases and two gave examples of coding frames [22 26].

Overall the studies were judged to be fair or good, however the decision to include all studies regardless of outcome of quality assessment was taken in advance of the review due to the unresolved debate on the utility of quality assessment in reviews of qualitative studies [30].

3.6 Data abstraction

The three steps of the thematic synthesis method [17] are to code line by line, develop descriptive themes (attending to similarities and differences between studies [31]) and develop analytical themes that 'go beyond' primary studies to generate new interpretations. This synthesis creates higher order themes that stay true to the original work of the original authors yet enable enhanced comprehension of the concept of resilience than disaggregated studies permit.

Each identified paper was read multiple times to increase familiarity and obtain a thorough understanding of the study aims, methods and outcomes. All text under the headings 'findings' or results' was imported in to NVIVO [32] and coded iteratively, until all content was reviewed. The process was repeated multiple times for each paper and then again after all papers were coded to ensure that all papers were considered against all iteratively generated codes. These codes were aggregated in to descriptive themes, which were subsequently developed in to one analytical theme, the "going beyond" individual papers required in synthesis [17].

4 Results

The thematic synthesis yielded 10 sub-themes, three overarching themes and one analytic theme, as demonstrated in Table 10.

Table 10. Thematic Synthesis findings

Descriptive themes:	Sub-themes:	4.4 Analytic theme
4.1. Stressors	4.1.1. This stress is common to all nursing work	**Resilience occurs when nurses incorporate stressful aspects of their personal or professional lives into a coherent narrative that enhances their ability to cope with the demands of their role**
	4.1.2. Too close to home	
	4.1.3. Some patients are more challenging than others	
4.2. Coping	4.2.1. Technical or relational care?	
	4.2.2. Emotional expression or suppression?	
	4.2.3. Giving and receiving support	
	4.2.4. Maintaining a work-life balance	
	4.2.5. Making a difference mind-set	
4.3. Exposure to death	4.3.1. Exposure to death is stressful	
	4.3.2. Exposure to death is an opportunity for growth	

4.1 Theme 1: Stressors in palliative care nursing:

4.1.1 This stress is common to all nursing work

There are many stressors inherent in nursing and these studies reveal that the palliative care inpatient unit is no exception. Participants identified stressors such as unmanageable workloads, shift work, staff shortages, the turnover of patients in beds [22] and lack of training on specific issues such as psychiatry and communicating effectively in conflictual situations [24].

4.1.2 Too close to home

The most widely reported stressor is how nurses identify with patients or their relatives. Identification with the suffering or because of proximity in age were cited in particular *"you tend to identify with relatives particularly if they're about the same age as you"* [24, p.31] and: '*When I experience a situation at work which overlaps with my personal experience, it recalls my feelings ... I feel emotional pain when my experience overlaps*" [26, p.506]. One participant succinctly captures the essence of this stress with the words "*too close to home*" [22, p.737].

4.1.3 Some patients and relatives are more challenging than others

Certain patients are more challenging for nursing staff, such as those considered manipulative, demanding or reluctant to be discharged [23]. Furthermore,

"*Patients with motor neurone disease fostered ambivalence in some nurses because they found it hard to reconcile the degree of physical dependency with the integrity of the patient's mental powers. Demanding and manipulative were epithets sometimes used to describe such patients*" [24, p.31].

Patients with psychiatric symptoms were challenging for staff to deal with, along with those suffering from uncontrolled pain, nausea or vomiting and dyspnoea [24]. The key factor underlying the stress associated with uncontrolled or unmanageable symptoms is how nurses feel helpless in the face of such suffering, which prevents meaningful communication between the patient and the nurse [23 24].

Communicating with patients' relatives is considered by some to be more stressful than dealing with the death of patients. Unsurprisingly this includes specific tasks, such as informing them of the patient's death [22] but less expectedly includes communication in general [24 28].

4.2 Theme 2: Coping

4.2.1 Technical or relational care?

Palliative care involves caring for the whole person, including their physical, spiritual and psychological well-being, not treating disease in isolation [33]. This ethos underpins the ways nurses care for patients in specialist palliative care settings and likely leads to a level of intimacy and rapport that both patients and nurses value [27]. However, this approach may come at a cost to the nurses who give of themselves when striving to ensure patients receive the best holistic care possible, leading to compassion fatigue and burnout if unmediated [22].

Nurses reported coping with this level of intimacy, with patients with limited life, by retreating behind a uniform [22 23] or shifting from 'being with' patients to a stance of 'doing to' them instead. This concept of 'doing' rather than 'being' served in some ways to protect the nurses from vulnerability [27], but also enabled them to adapt and fit with the environment they worked in. This phenomenon is encapsulated by the nurses working in an academic ward of a hospital, who reported needing to be considered professional and taken seriously by their medical colleagues [23].

Nurses who adopt a technical approach to their care [23] believed their professional lifespan in palliative care was limited compared with those nurses who espouse a relational approach to care, embracing connection and contact beyond the technical with patients [25-27]. This suggests the technical/task approach may be less rewarding or fulfilling, particularly for nurses who believe:

"*hospice care stresses that we can't divide human life into parts, especially that we can't focus on physical aspects but ignore the others. I like this idea. Hospice care is close to the kind of nursing job I wanted originally*" [29, p.580].

Enhanced self-awareness not only contributed to greater appreciation of life, but also enhanced the care that is provided to patients:

"*By monitoring feelings, attitudes, beliefs and ideas about a patient's holistic being, the meaning of their care-giving role develops*" [26, p.506]

… and their care is transformed from performing routine gestures to something more intuitively caring [25].

4.2.2 Emotional expression or suppression?

Closely aligned to coping by 'doing to', rather than 'being with', is whether to express or suppress emotion when caring for patients. Nurses choose to avoid feeling overwhelmed by feelings [23 25] or combining a '*stoical avoidance'* with '*acceptable crying with patients'* [26, p.507]. Overall, the studies suggest that nurses need to express their emotional responses to others, whether patients or families themselves, or colleagues, friends and family.

4.2.3 Giving and receiving support

The most reported coping strategy is how nurses 'offload' and gain support from others, primarily with colleagues but also with family and close friends [22-24 26-29]. The willingness to both give and receive support is a key component of resilience and further distinguishes resilience from coping [34].

4.2.4 Maintaining a work-life balance

The nurses emphasized the importance of reducing workplace stress by maintaining a work-life balance [22 26 27]. However there are challenges particular to palliative care, such as how nurses wished to retain the memories of patients who died and not forget them as soon as they left duty [27]. Alexander and Ritchie [24] highlight how this could be a conflict of interest for nurses who wish to maintain a division between home and the workplace yet struggle to do so because of their humanity and relational connection to their patients.

4.2.5 'Making a difference' mind-set

Nurses were inclined to care for patients in the best way they could, determined to "*make a difference"* and "*make this day the best day that we can for you [patient], so if there is something we can do for you we will*" [27, p.8].

Making a difference to patients and their families was often cited as the reason for entering the nursing profession [22 23 26 27]. Whilst nurses report satisfaction associated with making a difference, adopting this attitude supports them to cope with the challenges they face; e.g. when they struggle to support patients considered manipulative or demanding [24]. Under these circumstances, a deliberate intention to avoid labelling the patient as difficult and searching for a way to improve their life supported them to cope with demands that might otherwise seem unreasonable [25].

4.3 Theme 3: Exposure to death:

4.3.1 Exposure to death is stressful

Loss is a universal phenomenon [35] and will be experienced by all at some point in life and nurses in palliative care are no exception. This exposure may enhance the ability to cope with death and dying, however nurses report how earlier experiences contributed to

current stressors, such as being reminded of the experience each time the nurse identifies with a patient in some way:

"*I remember that when my grandmother was dying, she did not close her eyes until she saw me, her favourite granddaughter. When I was caring for that elderly patient, I couldn't help but relive that scene in my mind's eye. I would never say goodbye to that patient before going off duty*" [25, p.113].

Another participant was reminded of her perceived failings surrounding her brother's death and tried to redeem herself by caring for others facing the end of their lives [25]. Vulnerability was often associated with previous personal loss experiences, such as the traumatic death of a close relative yet this also appears to motivate nurses to enter the speciality of palliative care; either to replicate the great care they witnessed or to correct the failings of those before them. However, only examples of negative care were reported in the articles, e.g.:

"'I had a bad experience when I lost my mother. I found that the nurses did not do all that they could have done", and *"The death of her mother was a great loss to Kelly, and she felt that painful wound was reopened when taking care of a dying woman around the same age as her mother"* [25, p.113].

When earlier experiences of death and dying are unprocessed in some way, it becomes more problematic to witness the death of others, as articulated by one participant:

"*However, I probably did not manage my feelings comprehensively. I had special affections for an aged female patient and spent a lot of time accompanying her through the sad process of dying. After she passed away, Afterwards, I no longer experienced the same strong feelings when caring for other elderly women*" [25, p.113].

This suggests it may not be necessary to have emotionally processed all earlier experiences prior to starting to work in palliative care if caring for patients can be a therapeutic opportunity for the nurse to process unfinished business or unresolved grief, acknowledging that the care may not be considered "genuine":

"*The song was my mum's favourite and was sung by a choir at her funeral. When I heard the song, I felt really sad and needed to leave the room. I was working as usual after mum's death, and I had thought I cried with patients and families. However, I realised that I was crying for my grief. I thought I am not offering genuine care while I cry for my sadness and grief. I realised that I can care for someone [only] after I overcome my own grief ... it's difficult. But I can put it [my grief] aside now*" [26, p.507].

4.3.2 Exposure to death is an opportunity for growth

Seven of the studies describe how nurses make sense of life and death in relation to palliative care work [22-27 29] by reflecting on aspects of previous loss, spirituality, mortality and self-awareness. One nurse believed that an experience of loss is an opportunity to process fundamental life questions and prepare for a role in palliative care:

"I think I had to be ready to come into this before I actually started it. I think with palliative care you've got to have been through a bereavement yourself and sorted out your questions yourself, you know" [22].

Another reported how her work:

"*helped me understand that I also had to engage in my own spiritual growth and needed to stabilize myself before helping patients face death. After nurses identify their own emotions and problems, they will adjust to cope with these problems*" [25, p.114].

Two papers report how engaging in spiritual growth, identifying emotions and problems [25] and becoming comfortable with spirituality enables nurses to better support patients to deal with their own fears and anxieties, e.g:

"… I think that until a person is comfortable with their own spirituality, whatever they regard that to be, I don't see how they can be comfortable with the patients, dealing with patients' needs to the full extent" [22, p.736].

Awareness of mortality led nurses to appreciate the limited nature of their own lives [27], encouraging them to appreciate their health and families more [24] or think that '*life is for living'* and ' *I just think, today is today and I'm going to enjoy it!*' [22, p.736]. Working within palliative care enhanced the lives of the nurses, helping them to appreciate life in a way they previously could not:

'...it teaches me to be grateful for what I have and what I've done with my life. It sobers me because I realize that none of us know what tomorrow may bring, so make the most of what we have today as long as we have it.' [27, p.10].

Nurses described accepting what is within their sphere of influence and found ways to tolerate aspects of their work that were outside their control. This included the inherent downward trajectory of the patients' condition, leading to ultimate death [22] and accepting that patients may still suffer regardless of the quality of care provided [23]. Accepting that '*life is a variable I can't control'* enabled one nurse to continue to care for patients facing the end of their lives [25, p.114], and the recognition that working in palliative care is often counter to the approaches taught during basic training, where curative intent prevails [26].

4.3.3 Analytic theme:

Resilience occurs when nurses incorporate stressful aspects of their personal or professional lives into a coherent narrative that enhances their ability to cope with the demands of their role.

This synthesis identified a myriad of challenges to nursing work in relation to caring for those with a palliative diagnosis. These challenges are stressful and relate to the organisation, to patients and their families, and to issues that the nurse brings to the role, such as personality and previous experience. The ability to make sense of the experiences and incorporate them in to a coherent narrative, referred to as meaning reconstruction [36] in

the loss literature, appears instrumental in developing or maintaining resilience in the palliative care nursing workforce, as shown in Figure 2.

These studies suggest the importance of growth and meaning making in developing and maintaining resilience in the palliative care context. In all studies, where nurses appear to go beyond coping, they demonstrate psychological assimilation of experience [37] through linguistic expression and description of how the exposure to adversity has informed their values and beliefs. It appears this is the defining feature that distinguishes resilience from coping in the nurses in the palliative care inpatient setting. Some nurses reflect on their experiences and make sense of them by constructing a narrative to explain how life's challenges and adversities affect them. This informs how they live their lives and appears to extend beyond coping, suggesting the potential to thrive instead:

"Why are we here? Why does this happen?'...well, it made me question life really and what's it all about.... I think I had to be ready, and I suppose it does affect your life because you realise life's short really and it changes your values" [22, p.736].

5 Discussion

This review aimed to explore resilience, or inferred resilience, from the perspective of registered nurses working in dedicated palliative care inpatient settings. Whilst resilience can be challenging to define, it has relatively stable characteristics across contextual boundaries[38], with consistent reports that it is preceded by stress, trauma or adversity and demonstrated by subsequent positive adaptation [5 6 39-46]. This discussion will focus on how the review findings relate to resilience, where resilience is the ability to adapt, grow and construct meaning from stressful experiences.

5.1 Stressful experiences

The studies in this review reveal that palliative care nurses experience similar stressors to nurses in other settings, however they are additionally exposed to regular death, dying and suffering as a core component of their work. The nurses reported stress associated with two broad categories of patients; those they identify closely with and those who were particularly challenging to care for due to psychiatric or physical symptoms that were not easily controlled.

Patients who remind nurses of deceased family members trigger powerful emotional reactions in the nurses and led some to describe their rationale or motivation to enter the speciality of palliative care; either to provide the kind of care they wished for their relative or hope to receive themselves should they find themselves in a similar situation. It is unclear from this small number of studies whether nurses who bore witness to this kind of suffering in their own lives are more, or less resilient, when caring for patients in similar circumstances. This identification with others who are suffering is reported in the literature [47 48] but there is no available evidence to demonstrate how this affects resilience.

Clearly, palliative care nursing involves managing emotions on a daily basis, either one's own or supporting others to do so. Emotional labour is a term used to describe how nurses manage their emotions in an organisational context, where there may be expectations

about how they balance their own needs with that of patients, families and the organisation they work for [47]. Whilst it is recognised that nurses are likely to experience similar, normal emotional reactions to loss as anyone else, there may be discord between how they grieve personally, and professionally. A degree of emotional labour in palliative care is to be expected and this review found that nurses used 'emotional labour' as a coping mechanism in the workplace rather than citing it as a specific cause of stress.

5.2 Coping

Nurses in the studies commented on the need to be prepared for working with patients who have life-limiting disease and to develop coping strategies to deal with this. The main strategies identified in this review were to approach care from either a technical or relational perspective; to consciously decide how much emotion to either express or suppress; to give and receive support; maintain a work-life balance; and to adopt a mindset that reinforces how they 'make a difference'.

O'Mahony et al. (2018) [49] describe how the effects of repeated exposure to loss and suffering in palliative care clinicians may be cumulative, leading to clinically significant levels of distress. Furthermore, they found that nurses who are overly empathic have higher prevalence of secondary traumatic stress and compassion fatigue. It is understandable therefore that nurses may detach from their patients and adopt a more 'technical' approach to care, in order to protect themselves from emotional attachments that will be disrupted when the patient becomes less well and consequently dies. However, whilst this may be effective as a coping strategy, nurses who empathise less with patients are less likely to develop a sense of meaning or purpose in their work[49], which, according to our findings, is key to maintaining and enhancing resilience.

Another critical component of resilience is the ability to both give and receive support, which is widely recognised as necessary for nurses to cope with the demands of their role [50]. The nurses in this review were no exception and highlighted that support could take many forms and come from a variety of sources. In addition to external support, nurses reported how they supported themselves by maintaining a work-life balance and adopting a mind-set that enabled them to continue working with palliative care patients. This self-awareness appears to increase not just job satisfaction but enhanced life satisfaction, through an appreciation of the finiteness of life and acknowledging the indiscriminate pervasiveness of disease.

Supporting colleagues with the use of humour as a coping mechanism is reported in the wider literature [47 51] but was not apparent in this review. Humour, however, is not sufficient to prepare nurses for future experiences [52], which is a key feature of resilience. It is possible that humour involves paying attention to the stressful situation and perhaps this focus means the nurse will learn from the experience and be better equipped to deal with similar events in future.

Gaining insight through the processing of experience is the basis of reflection and the accompanying increased self-awareness is often referred to as 'growth' [53-57]. Unfortunately studies show that nurses have little time for reflection, especially in organised groups, due to heavy workloads and inadequate staffing [58]. Without the space and time to reflect on

experiences of working with palliative care patients, there is increased likelihood that nurses will cope with death by avoiding emotional attachment, relying on previous life/death experience and adopting a resigned attitude towards death as simply a natural part of life. Whilst the latter is true, it does not encourage greater thought, reflection, growth and learning that will lead to greater preparedness for the complexities of death in a specialist palliative care setting where patients are likely to be highly symptomatic and accompanied by distressed relatives who may not be as accepting of death.

5.3 Growth, adaptation and meaning construction

When hospice nurses have a sense of purpose or meaning in their lives, this enhances self-esteem and buffers against potential negative outcomes following exposure to stress [59]. However, this review identified the importance of making sense of stressful experiences at work (rather than in life) and developing a sense of meaning or purpose in their role. Existential coping and the ability to find meaning in life and suffering is referred to as self-competence by Cheung et al. (2018) [60], who suggest that a failure to develop such self-competence will lead to compassion fatigue and burnout when working in end of life care. Funk et al (2018)[47] agree and argue that a greater sense of purpose in palliative care work helps to compensate for any emotional exhaustion associated with the demands of the role.

Self-competence may be enhanced through previous exposure to loss and could contribute to enhanced resilience in nurses, especially if they have psychologically processed and created meaning from their experience. The concept of meaning making is increasingly common in contemporary loss and bereavement literature [61] and is strikingly similar to the concept of posttraumatic growth [62], where an encounter with loss becomes a precursor to positive change.

This review suggests there is potential for growth from experiences of loss, either personally or professionally for nurses working in palliative care. Where growth occurs, it is likely that this will enhance resilience at the level of the individual nurse and enable him or her to cope better with future adversities. Meaning reconstruction is one way that individuals make sense or create meaning from their experiences, characterised by the ability to linguistically describe and explain to others. This linguistic expression helps to accommodate and assimilate the experience in ways that influence how individuals develop a sense of identity, relate to others and behave in future [54].

6 Limitations

This review focused on resilience, a poorly or rarely defined concept and therefore a necessary reliance on search terms that infer resilience where it is not explicitly stated was created. Whilst every care was taken to identify appropriate search terms, including the support of a specialist librarian, it is possible that relevant studies may have been omitted. Researchers sometimes use ostensibly oblique titles for their studies [63], using participant's quotes which may not accurately describe the context or content of the paper.

Due to the language limitations of the authors, only articles written in English were considered. Two articles were rejected due to language limitations, however they both would have been excluded under other criteria (one was not a study about Registered Nurses and the other was conducted in an intensive care setting).

This review focussed exclusively on articles published in peer-reviewed journals only and therefore may be subject to publication bias.

Finally, there were eight included studies which may be considered a small number in a thematic synthesis; however a typical number of studies in syntheses of qualitative studies is between six and fourteen [64].

7 Conclusion

Working as a nurse in palliative care may be stressful at times, especially if patients or situations remind nurses of their own personal experiences. Nurses appear to cope well with the challenges of the role when there is adequate support available, with 'offloading to colleagues' being the preferred strategy. Coping well with the demands of the role does not necessarily imply increased resilience. Resilience is more likely when nurses cognitively process their experiences by linguistically articulating their thoughts and feelings. This articulation leads to the construction of meaning, helping nurses to make sense of their experience and prepare them for future challenges in a way that merely coping (cognitively or behaviourally managing each adversity as it happens) does not.

Further research should be undertaken to explore how nurses themselves might define resilience and suggest ways that resilience could be enhanced in the palliative care inpatient setting. This in no way suggests that responsibility is solely located within the individual and organisations would do well to look at multifaceted strategies to improve resilience. Enhanced resilience may mean that nurses stay in the profession longer and improve the quality of care that patients receive when they do. Furthermore, resilience research to date has focused on strategies designed and implemented by researchers on multidisciplinary groups [65 66]. Curiously, little research has been conducted by nurses on the topic of resilience in palliative care. There is a gap in the literature regarding how nurses, the professional group who spend most time with patients during inpatient stays, believe resilience could be enhanced. The authors recommend Participatory Action Research to encourage nurses themselves, as experts in their field to co-research resilience further in the palliative care setting.

ACKNOWLEDGEMENTS:

Competing Interest: None declared.

Funding Statement:

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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