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ORIGINAL RESEARCH

Nurses' Lived Experiences Following End-of-Life Care: A Hermeneutic Study from a North Central State, Nigeria

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Abstract

Background: Death is a common occurrence in nursing practice, and nurses are expected to provide professional and sensitive care to families, which can be psychologically demanding. However, there is a paucity of studies describing the experiences of nurses dealing with pediatric end-of-life (EOL) care and death.
Purpose: This study explored nurses' lived experiences following EOL care among pediatric nurses working in two selected hospitals in Nigeria.
Methods: A hermeneutic qualitative design was adopted to describe and interpret participants' experiences. Twenty-one nurses were purposively selected from pediatric wards. Data were collected through semi-structured, in-depth interviews and analyzed using ATLAS.ti with thematic analysis.
Results: Five themes emerged: (1) EOL care training during nursing education, (2) experiences of EOL care as a practicing nurse, (3) perceived contributing factors to child death, (4) nurses' roles in supporting families after child loss, and (5) coping strategies for managing grief after pediatric patient death. The findings revealed that nurses are affected by the death of a child regardless of years of experience. Limited knowledge of EOL care negatively influenced their coping abilities. Nurses considered open grieving unprofessional, with the primary coping strategy being increased commitment to work.
Conclusion: The study concluded that years of work experience do not significantly influence nurses' lived experiences of pediatric patient death. Limited knowledge of EOL care strongly shapes their perspectives on death, dying, and grieving. Grieving is perceived as unprofessional, while dedication to work serves as the preferred coping mechanism. Mandatory training on EOL nursing care and the provision of institutional guidelines are recommended.

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1. Introduction

Grief and loss are inevitable occurrences in human lives. While loss is the absence of a valuable person or substance, and can either be a recognised loss by others (actual) or one that only the individual involved can verify (perceived), grief is the emotional impact of loss (Oates & Maani-Fogelman, 2022). Grieving is a lifelong experience of grief which undergoes changes depending on the dynamic circumstances of life. Though grief is a one-time experience, grieving is a familiar presence, and the individual involved would have developed coping mechanisms to handle the sense of loss (Schoo et al., 2025). Nurses experience grief at some point in their career due to either a loss of a close relative or friend, or as a major support system for the family and significant others of a patient who has just died (Oates & Maani-Fogelman, 2022). However, nurses may not be able to resolve their grief from the loss of a patient before another loss occurs, which can lead to compassion fatigue (Ernstmeyer & Christman, 2021) and may cause psycho-somatic illnesses, insomnia, panic, emotional suffering, anger, and withdrawal.

Death and dying are both stressful situations for health workers, especially for nurses, who are the closest to patients and their significant others. Due to this, they are at risk of burnout

(Faremi et al., 2019; Guo & Zheng, 2019). Other challenges nurses face while caring for the dying are not limited to insufficient resources, staffing problems, no support from experienced nurses, and poor communication. Very often, their physical and mental health is ignored for the "bigger picture" of providing care, but all these portend exhaustion or compassion fatigue (Ajayi & Hämäläinen, 2022). Emotional detachment may be impossible, particularly if the dying patient is a child who has suffered a great deal of discomfort. In such instances, the nurse feels as if the death is a personal loss, but this loss cannot be expressed to be able to continue with the care of other patients (Karn & Yadav, 2018). As such, nurses are unable to go through the grieving process described by Kubler-Ross's theory of grieving, and this has myriad consequences for the health and well-being of both nurses and their patients (Brosche, 2003, as cited in Karn & Yadav, 2018).

Understanding the grief nurses as professionals undergo is important to be able to avoid or reduce the damaging impact of recurring grief, particularly in paediatric units. It has been suggested that this will help in developing institutional guidelines on the management of nurses who have been overly exposed to the loss of patients. The guidelines are necessary to prevent the detrimental effects of poorly managed grief on nurses and other patients by extension (Gilart et al., 2021). The study on death anxiety by Pehlivan et al. (2019) supports this assertion, as it was noted that the lack of education or training on death is one of the major factors responsible for the inappropriate grieving of a patient's loss by nurses. This has further been found to be responsible for the avoidance of dying patients by nurses, particularly among those who have lost close relatives or who have worked in units with a high number of dying patients. Similarly, Pratama and Wardaningsih (2020) also discussed the benefits of knowledge and institutional guidelines for nurses caring for dying patients, including improved professionalism, increased empathy, and enhanced nurse-patient-relative therapeutic relationships and interprofessional collaboration. Therefore, given the physical, psychological, and social characteristics and impacts of death, it is vital to provide nurses with education and training to enhance their skill set and improve their knowledge and attitudes towards death (Cybulska et al., 2022; Ghaemizade Shushtari et al., 2022).

End-of-life (EOL) care, death, and grieving are quite unpleasant circumstances for nurses. However, Fristedt et al. (2021) in their study found that nurses who have worked in the palliative unit for a longer period of time, with extensive clinical experience and have undergone some form of training and education on EOL care, have a better attitude towards EOL care. They also noted that nurses communicated better with the patients and their relatives compared to newly employed or posted registered nurses. These findings are similar to those of Faronbi et al. (2021), who found in the Nigerian hospital where their study was conducted that years of nursing experience were responsible for nurses' positive attitude towards death and dying of patients. On the other hand, Kostka et al. (2021) disagreed with these findings. They noted that even though the capability to handle death increases with years of experience, stress and intense emotions due to EOL care and frequent contact with death are still experienced by nurses despite the long years of experience. In nurses with approximately 20 to 40 years of clinical experience, anxiety is still present. Years of experience influenced the different coping mechanisms nurses use in palliative units (Kostka et al., 2021).

Though ensuring a peaceful death is part of the core roles of the nurse, the actual experience of death and dying can be traumatic and can impair the well-being of nurses, and predispose them to developing negative attitudes towards their patients. According to Yoong et al. (2020), this can be due to insufficient or no training and experience among nurses. Training is necessary for the development of appropriate coping mechanisms, which will assist in protecting their mental health and improving the quality of care provided (Alodhialah et al., 2024). Studies have also explored the effect of dying and death on undergraduate/student nurses. It has been affirmed that sadness, anxiety, and fear are among the myriad emotions that assail the students. Recommendations have therefore been made to include EOL care in the curriculum and ensure they rotate through palliative care settings to gather adequate clinical experience before they are registered as nurses (Gorchs-Font et al., 2021; Nabirye et al., 2025). Also, Frisedt et al. (2021) observed that there is no noteworthy difference in attitudes between registered nurses and student nurses regarding EOL and death, despite nurses' experience. This may be due to a lack of knowledge in EOL care and the placement of the nurses, as nurses working in palliative care settings had better attitudes compared to those who were not.

Nurses working with children requiring EOL care are at risk of moral distress because of the ethical challenges they may encounter (Kadivar et al., 2021). Although it was found that older nurses cope better with providing EOL care to children, especially neonates, it is recommended that training courses on palliative care, EOL care, and ethical decision-making be provided to all nurses to improve their attitude towards care of terminally ill neonates and their parents. The curriculum for paediatric nursing should also include Palliative care and EOL care to be able to increase cognitive, psychomotor and affective domains of paediatric nurses (Kadivar et al., 2021).

To be able to still keep up with expectations of optimal care, nurses temporarily put on their "Nurse face", achieved by being clinically practical and focused on the task at hand as a form of coping strategy to avoid delving deep within their emotions by giving a professional mien to the nurse. Another form of coping strategy adopted by nurses is emotionally or physically distancing themselves from dying patients and their families, either overtly or covertly, to prevent forming a solid nurse-patient interpersonal relationship (Meller, 2018). Other common strategies used to deal with the effects of death and dying include requesting professional support from work colleagues and superiors, and social support from the nurse's family and friends (Kostka et al., 2021).

Most studies on patients' death are interested in the response of the significant others, or how the nurse is expected to give emotional support and assist the relatives in the grieving process (Athanasiou et al., 2024; Gijzen et al., 2016). Studies that have been conducted regarding the nurses' emotional needs are mostly on burnout, compassion fatigue, and secondary stress syndromes, three phenomena that address a wide range of situations that affect the nurse, but rarely address how nurses manage their grief following the death of a child. It can be assumed that this is because death is a difficult topic to discuss, or because nurses are expected not to be too emotionally invested in their patients during the orientation and working phases of the nurse-patient interpersonal relationship, and should be able to completely detach themselves following the termination of said relationship at the death of the patient (Felber et al., 2023).

Although there have been studies that have attempted to identify and describe the effects of patients' deaths on nurses, very few have described the experiences of nurses dealing with paediatric end-of-life care and death (Chew et al., 2021). Moreover, studies on the emotions of nurses when working with terminally ill patients and strategies for coping with these emotions are limited (Kostka et al., 2021). Most of the quantitative studies conducted in Nigeria do not focus on grieving or on the consequences of a patient's death for nurses (Okwaraji & Aguwa, 2014; Olude et al., 2022). However, qualitative studies can provide a deeper understanding of nurses' experiences with loss and their emotional responses. Hence, this study was conducted to explore nurses' lived experiences following end-of-life care.

2. Methods

2.1. Research design

The study design was a hermeneutic qualitative study. This design was used because it helped to describe, interpret, and give meaning to the experiences of the nurses while recognising the individualistic nature of their experiences (Alsaigh & Coyne, 2021). It also attempts to construct an animating, evocative description of human actions, behaviours, and intentions. This study is based on Gadamer's ontological viewpoint, whereby the researchers are influenced by their experiences caring for dying children and their parents (Alsaigh & Coyne, 2021).

2.2. Setting and participants

The study was conducted at two selected hospitals; Hospital A (a federal government owned tertiary hospital), and Hospital B (a state government owned paediatric hospital). Hospital A has five Paediatric units namely: Emergency Paediatrics Unit, Paediatric Medical Ward, Paediatric Surgical Ward, Out-born Neonatal Intensive Care Unit, and In-born Neonatal Intensive Care Unit and Paediatric Clinic. The paediatric units of the hospital have to manage children with chronic, long-term, and terminal illnesses, particularly as the last referral point. The palliative unit in the hospital only runs a clinic and community visits, and co-manages patients on admission, and does not have a paediatric nurse. Hospital B was established in 1935 as one of the first healthcare facilities in Northern Nigeria. The hospital is currently the only functional government-owned paediatric hospital in Ilorin. It is the first point of call for most indigenous parents of children, and not all children present to the hospital when they first display symptoms of illness,

contributing to the mortality rate of the hospital. The hospital presently does not have a palliative unit.

Participants were nurses recruited purposively from the paediatric units (Emergency, Medical and Surgical wards, Special Care Baby Unit) of the selected hospitals. Using maximum variation sampling, a form of purposive sampling, nurses of different cadres, years of experience, and qualifications were selected from the ward rosters. Participants were drawn from the 86 nurses working in the paediatric units of Hospital A, and the 34 nurses working in Hospital B, to ensure variety in line with the study's objectives. Studies have shown that for qualitative studies, a rigid sample size cannot be used, several examples of previous qualitative studies revealed that researchers enrolled between 10 to 18 participants and achieved theoretical saturation (Lawrence, 2021). Data saturation is used to determine sample size, which signifies that ample data are collected to explain a phenomenon in qualitative research (Chew et al., 2021; Lawrence, 2021). For this study, data saturation was achieved at the 19th participant after it was observed that the data collected were repeating similar information. Two additional participants were interviewed to ensure no new information was received from the participant. The inclusion criteria were nurses who had provided end-of-life care, had witnessed the death of patients they cared for, had at least one year of working experience in the clinical area, and were working in paediatric medical and surgical wards, or paediatric emergency units. The exclusion criterion was being away from the clinical area for at least three months.

2.3. Data collection

Data were collected using a semi-structured interview guide to conduct face-to-face interviews and in-depth conversations with the participants due to the sensitive nature of their lived experiences. Permission to collect data from the nurses was obtained from the gate-keepers of the hospitals i.e., the chief medical director, the director/head of nursing services, and the head of each ward. Participants were met and the aim of the study was discussed with them. They were also asked for times when it would be convenient for them to participate in the interviews. The interview guide was developed based on an extensive literature review, and had two sections, i.e., the introductory section and the main section. The guide was pilot tested before being used for the main study, and questions were adjusted for clarity. The introductory section elicited responses on sociodemographic characteristics (years of working experience, age, marital status), while the questions in the main section focused on participants' experiences of a child's death and their feelings during and after the event. These included: "Describe your first experience of a child's death as a nurse in training," "Did you have any training on end-of-life care as a student? If yes, how has this influenced your care with children with terminal illnesses?" "Have you ever been able to forget the memory of patients who have died? and "Describe the ways you adopted in trying to forget patients who have died, and the effectiveness of these methods. The interviews were audio-recorded with the permission of the participants. The interviews lasted for 30 to 45 minutes and were conducted by one of the authors, who is a paediatric nurse educator (KEI) in the wards. Data collection was conducted between November and December 2022.

2.4. Data analysis

Thematic analysis was used to analysed the interview data based on grounded theory as proposed by Braun and Clarke (2006). This primarily involved evaluating the study transcripts for themes and patterns of meanings based on the research questions. This was done in six basic phases. First, the interview transcripts were read and reread in order to familiarise with the interview contents. Afterward, the transcripts were coded based on emerging ideas from the interviews. The codes were later recoded in order to remove redundant ideas. Themes and sub-themes were generated from the themes and sub-themes. Subsequently, a report was written on the emergent themes. Three independent coders (O.O.O., K.E.I., E.O.A.) generated the initial set of themes and a fourth independent coder (I.M.O.) reviewed the themes and reorganised the thematic ideas. Discrepancies were resolved by reviewing the transcribed interviews again, discussing, and conducting additional rounds of coding. In the development and validation of codes, an iterative process was used to ensure that the codes accurately represent the data collected. The codes were developed by familiarization, initial coding, creating a codebook, axial coding, selective coding, and refinement. The generated codes were validated through agreement

among coders, peer review and debriefing, member checking, audit trail, and triangulation. The analysis was done using ATLAS.ti version 23.0.

2.5. Trustworthiness/rigor

Rigour was ensured using the framework as described by Lincoln and Guba in 1985 and 1994: credibility, dependability, confirmability, transferability, and authenticity (Lincoln & Guba, 1985). Their framework has formed the basis of rigor in qualitative studies. To ensure credibility, in-depth interviews were carried out to allow respondents to discuss fully their experiences taking into consideration the different cadres and years of experience in paediatric units and different cultural backgrounds to ensure variation that captured the human reality as lived experiences are not the same. Also, transcribed interviews were viewed by some of the participants to ensure that their expressions and meanings were fully captured. Dependability was achieved by thick descriptions and the use of an audit trail, while confirmability was ensured by a joint review by the authors of the transcribed interviews compared to the audio recording to reduce bias. Purposive sampling technique was used to select respondents whose characteristics are germane to this study, using their rosters to ensure maximum variation, and details of that were provided for transferability. Finally, for the purpose of authenticity, the researchers ensured that some of the exact statements of respondents were used to convey their sentiments without any alteration.

2.6. Ethical considerations

The participants were required to give informed consent before they participated in the study. All interaction with the participants was with the strictest confidentiality, and interview sessions were individual and not grouped. The only means of identification required from the participants were the sociodemographic data, but their names were not necessary to ensure anonymity. Participants' autonomy was ensured through requesting their consent before commencing the interviews. Participants were also informed that they were free to disengage at any point they felt uncomfortable. Sincerity was maintained in reporting findings. Confidentiality was achieved by saving and securing all recordings and transcribed interviews using passwords which only the authors have access to. Participants did not have to respond to questions that were uncomfortable or emotionally distressing. Ethical approval was granted by the Ministry of Health Ethical Research Committee for Hospital B (Approval ID. ERC/MOH/2022/09/073), and the Ethical Research Committee of Hospital A (Approval Number ERC PAN/2022/11/0332).

3. Results

3.1. Characteristics of participants

The study was carried out among 21 nurses whose age range was between 22 – 50 years of age. All of the nurses are Registered Nurses (RN), all, except two, are Registered Paediatric Nurses (RPdN) or Registered Midwives (RM). Only a few of them had Bachelor of Nursing Science degree, and at least one of them had a Diploma in Public Health and Basic Life Support training. Majority of the nurses were Principal Nursing Officers, few were Deputy Directors of Nursing or Chief Nursing Officers, while only one was Senior Nursing Officer or Assistant Director of Nursing. In relation to their years of practice, the nurses had between two and five years of experience, while their total years of experience ranged from 10 – 12 years.

3.2. Themes

Five themes emerged from the interviews: (1) End-of-life care training during nursing education, (2) Experience of end-of-life care as a practicing nurse, (3) Perceived contributing factors to child death, (4) Nurses' roles in supporting families after child loss, and (5) Coping strategies for managing grief after paediatric patient death. The themes provide valuable insight into how their experiences have defined what end-of-life care is, and how to cope with grief following the child's eventual death.

3.2.1 Theme 1: End-of-life care training during nursing education

The discussions commenced with the nurses sharing their experience with end-of-life care. Some of them stated that they received end-of-life care training during their academic training; one of them said, *"Yes now, we were taught. You know end of the life care; you know our work"*

(P14 HOSP A). Another described the kind of training that they received in these words: *"That when a patient is about giving the ghost? Yes. When we were in the school of nursing, they just taught us stages of dying like denial stage, acceptance, bargaining"* (P21 HOSP A). Another participant also considered the training that was received during the schooling period to be very effective because *"…nursing a patient, you at least understand the support the parents need, you know all those conditions come with a lot of anxiety of the patient, of the parents, of the relatives"* (P17 HOSP A).

Table 1. Sociodemographic data of the participants

Variables	Frequency	Percentage
Age (at last birthday)		
20-30	3	14.3
31-40	4	19.0
41-50	6	28.6
51-60	8	38.1
Marital Status		
Single	3	14.3
Married	18	85.7
Religion		
Christianity	12	57.1
Islam	9	42.9
Ethnicity		
Yoruba	19	90.5
Igbo	2	9.5
Years of Experience		
1-10	3	14.3
11-20	8	38.1
Above 20	10	47.6
Qualification		
RN Only	2	9.5
RN/RM Only	6	28.6
RN/RM/RPdN Only	2	9.5
RN/Other	1	4.8
Diploma and BNSc	10	47.6
Cadres		
Nursing Officer I	2	9.5
Nursing Officer	3	14.3
Senior Nursing Officer	1	4.8
Principal Nursing Officer	5	23.8
Assistant Chief Nursing Officer	1	4.8
Chief Nursing Officer	4	19.0
Assistant Director of Nursing	1	4.8
Deputy Director of Nursing	4	19.0

Notes. RN – Registered Nurse; RM – Registered Midwife; RPdN – Registered Paediatric Nurse; BNSc – Bachelor of Nursing Science

However, another interviewee commented that the training was not as detailed as they would have loved it to be. In their own words, the interviewee said, *"I think I have a note on end-of-life care, but not in detail" (P15 HOSP A)*. Several interviewees spoke of their first experience of child death during training as a nurse. The nurses found it to be quite traumatizing, especially when they considered the pain that the mother had to go through. They felt emotionally down, and a number of them said they actually cried when the event happened. Two participants stated:

> *It was traumatising to be candid. Can you remember the child's diagnosis? I can't remember, but I know it was traumatising. When you get back to the hostel then, you will be kind of emotional. You keep flashing your memory back to that scenario. I cannot remember the diagnosis and the name, but I know it was actually traumatising. That day did you cry? Of course, of course.* (P15 HOSP A)

First time, I cried like kilode. All our seniors, the staff I mean, those that are in charge of the ward, they are asking me, why now? Why are you crying like a baby? I said, ah this baby is painful. I don't have experience of pregnancy then but I felt for the woman. So, I cried o. What was the case? That time, I think it is tetanus, neonatal tetanus. (P4 HOSP B)

Some nurses, however, mentioned that they had no experience of child death during their training period, even though they were posted to paediatric units as students. One of them said:

No. All through school of nursing? Honestly. Even when I want erm. In fact, 2 weeks to my hospital final, I've never packed a corpse, I have to call, I have to go to each ward and inform them that if there is any corpse, I want to do the procedure. Then we were using intercom, so, they have to call me from the hostel that we have a corpse, come and pack the corpse. Even at post basic? Yes. It's either I leave and it happens or it happen before I resume. So, my first experience was in the labour market. (P5 HOSP B).

3.2.2 Theme 2: Experience of end-of-life care as a practicing nurse

Compared to their experiences as nurses-in-training, the nurses stated that they had several experiences of child death while practicing as a nurse. The child deaths were adduced to several factors including cerebral malaria, severe malaria, ghastly accidents, and snake bites, which are common in the area, especially as the children are not taken to the hospital on time for appropriate management. One participant stated: *"I think it's severe malaria with anaemia. As in that area, you know, the level of education of our people there is, people do come from the rural area more"* (P15 HOSP A). Other nurses stated:

Hmmm. The one I witnessed was an accident victim who was involved in a ghastly accident with 2 parents and 2 other relatives. They were all gone, the child is the only surviving child in the accident with extensive burns and serious pain. It was difficult managing her because we see none of the relatives. We had to raise funds to support her, provide emotional support, and even parental care. It was a bad experience which I don't pray to witness again. (P 17 HOSP B)

The snake bite happened on Wednesday; they brought the child on Friday. Inflammation had already set in place. In fact, we didn't take the child out of triage. They brought the child around 6:15, the child died around 7:15. So we cannot say too; it is complicated cases that they bring. (P13 HOSP A)

Based on their experiences, the nurses were also asked to describe what constitutes end-of-life care. It was generally described as the nursing activities given to a dying patient. The goal is to ensure that the patient enjoys a peaceful and painless death while also reassuring the relatives. It is often given to patients who are in terminal sickness conditions. These could be seen in the words of some of the nurses who spoke:

The terminally ill patient, the child that is dying, we make sure we nurse them to have, erm, a peaceful death in such a manner, you know, as a nurse, we make the child comfortable, we reassure the mother, okay? Then we try all our possible best to make sure that this child has a peaceful death, not in pain, not in distress, you know. We make sure, if such a child is on oxygen, we make sure the oxygen is much available to help in peaceful death, okay? So, prevent pain in as much as possible, then reassure the mother. (P12 HOSP A)

I think the, to my own understanding, maybe they are the care they give to terminal cases. You know this patient, they are going, you know that they are going, but what you can do, maybe to sustain, maybe in the next 3 hours, what you can do to extend it, maybe a day, anything you can, just to make him have a peaceful death. (P13 HOSP A)

To my understanding, it's nursing a patient to a peaceful death. Like a patient, you already know this is the prognosis of your ailment. Regardless, you know, at least death is the end

of every, but regardless, we can't just abandon a patient like that because of their own, because of that particular ailment. You still have to nurse them to a peaceful death. Like, by giving, if he's in pain, you nurse them based on the symptoms they actually bring at a particular. If it is pain, give them relief. (P15 HOSP A)

3.2.3 Theme 3: Perceived contributing factors to child death

Participants identified several factors contributing to child deaths beyond the severity of illness, including inadequate critical care, complications, and unintentional errors or negligence in care after presentation in the hospital. Some participants stated:

That was when I did postings. I won't say negligence on the nurses' part because they were very busy. The cord, I won't say it was not properly tied, they used a cord clamp. I think the thing loosened and the child bled to death. (P2 HOSP B)

I experienced the death of a child when I was posted to a children's ward. The child was an HBSS patient. The baby had a crisis, and in the process of looking for blood for the child, the child gave up. (P3 HOSP B)

It was not a funny experience. It occurred at the paediatric unit, UITH. The baby was severely anaemic, was transfused with 2 pints of blood. The condition just changed. It was a case of severe anaemia with cerebral malaria. That day I was not myself. You know as a nurse, it is only when they come out alive that you will be happy, that's the essence of nursing them. But nursing to death is a very terrible experience. That day I was not myself. I got home and could not eat. Just recalling my experience, this was about 7 years ago. (P1 HOSP B)

3.2.4 Theme 4: Nurses' roles in supporting families after child loss

The nurses said whenever a parent loses their child, they endeavour to provide emotional support for the parents in order to help them bear the pain, through counselling and allowing them to express their grief. A nurse said,

As a paediatric nurse we give our best. At least nobody wants a child to die, but eventually if a child leaves us, then that is the will of God. It's not easy to lose a child, it's not easy. Is it the 9 months you want to think of, or are we putting all our efforts, and eventually the child gives up? It's somehow pathetic to me. (P20 HOSP A)

Participants described providing various forms of support to parents during a child's final moments. They emphasized doing their best within their professional limits, such as offering comfort, oxygen, or suctioning. One participant stated: *"Seeing a child dying, it's just to support them at that dying period. You just need to support them. Just supporting. That's all I know"* (P17 HOSP A). Meanwhile, other participants reported:

My own is just to try my best. When a child is dying, I will try my best, but I cannot hold life. I'm not the one that created the life. Ehen. But anything I can, maybe he's in pain, I can do what I can do, maybe he's gasping, to give oxygen, to suction, and anyone that maybe, God will give him a peaceful rest. There's nothing I can do about it. (P13 HOSP A)

You give emotional support, do whatever you know you're supposed to do so that your conscience will be clear even when the patient dies, you know that you've done what you can do for that patient. No negligence. (P19 HOSP A)

Also, the nurses stated that they usually educate mothers on coping strategies following a child's death, including ways to prevent future occurrences and to manage their mental health. Some of the nurses explained:

They need to know specifically what's going on if you need to let them know, educate them about it, and the method of preventing such a condition that are preventable. Let them know so that it won't reoccur with another sibling, or even with neighbours. They'll at least carry the knowledge back home. (P17 HOSP A)

So, I think, what comes up in my mind is providing health education at early stage and carrying them along, so that some preventable cases are prevented, while some are inevitable. (P17 HOSP A)

3.2.5 Theme 5: Coping strategies for managing grief after paediatric patient death

The death of a child is often as painful to the nurses as it is to the parents of the child. Nurses reported different kinds of feelings that they have whenever a child dies. One of the nurses said she usually feels emotionally disturbed, *"Ha, I will feel disturbed. Sometimes I do have headache, that ha, all the effort is wasted on this patient. Because when I care for patient, I'm doing it from my own mind"* (P16 HOSP B). Another said she usually feels like crying, *"I used to cry inside. You know, as a nurse you are in uniform, you cannot cry. But some patients, when they suffer, I used to cry inside me"* (P18 HOSP A).

4. Discussion

The study aimed to explore the lived experiences of nurses following end-of-life care in Kwara state, Nigeria. Five themes emerged, including end-of-life care training during nursing education, experience of end-of-life care as a practicing nurse, perceived contributing factors to child death, support to parents who lose their child, and coping strategies for managing grief after paediatric patient death. Each of the themes is discussed in the following section.

4.1 End-of-life care training during nursing education

Nurses who experienced a child dying while in training still feel emotionally down whenever a child dies (Henao-Castaño & Quiñonez-Mora, 2019) It was also noted that they do not have sufficient knowledge of EOL care and what it entails. Studies have shown that nurses who received end-of-life nursing education are able to meet challenges of providing care to dying children and deal with grief appropriately (Anguis Carreño et al., 2023; Ghaemizade Shushtari et al., 2022; Shimoinaba et al., 2021). According to Zheng et al. (2021), most new nurses find it difficult to manage dying patients due to their lack of education and experience, and most rely on their senior colleagues to guide them on what to do. The emotional torture of the nurses can also be attributed to a lack of knowledge about EOL care. This is similar to the observations of Frisedt et al. (2021), Yoong et al. (2023), and Cheong et al. (2019), that training nurses in EOL care improves their attitudes toward death and helps them develop appropriate coping mechanisms to protect their mental health. Education of nurses on end-of-life care should be prioritised (Yoong et al., 2023). Presently, it is included in the general nursing curriculum of the Nursing and Midwifery Council of Nigeria, but is not in the paediatric nursing curriculum, which will not prepare paediatric nurses for caring for a dying child. Since it is a national curriculum, the paediatric nursing curriculum should be reviewed, with end-of-life care for children included to ensure that dying children are well taken care of, and there is less risk of emotional torture for the nurses.

4.2 Experience of end-of-life care as a practicing nurse

The experience of caring for a dying child is very uncomfortable and can be a heavy burden complicated by communication challenges between the parents and the health care team, particularly nurses (Mani, 2024). This is because nurses usually recognise quickly the likelihood of a child dying (Nacak & Erden, 2022), but do not have a standard of providing care in such situations as found in this study, that no matter the amount of experience gathered over the years, nurses are still affected by the death of a child, not minding if it is the first experience or the last. The good nursing for end-of-life care as experienced by nurses should involve actions that address the psychological and spiritual needs of patients and their relatives. This might include holding a patient's hand as they are dying or simply being present in silence, but it is also important for nurses to maintain a suitable emotional distance (Lee et al., 2024). Also, some nurses reported that they have a responsibility to maintain the feeling of hope for patients receiving palliative and

end-of-life care until the end, as well as providing moral support to the patients (Sarıkahya et al., 2023)

4.3 Perceived contributing factors to child death

A major contributory factor to a child's death in this study is late presentation to the hospital. This finding is not surprising, as most parents would rather use home remedies (Oluseye et al., 2023). Usually, it is when the illness is unresponsive to these remedies that the child is brought to the hospital, and many times, the situation cannot be salvaged (Eze et al., 2023). Also, perceived negligence may be due to an inadequate number of nurses on each shift. With the mass migration of Nigerian nurses to Western countries, the healthcare system is under a lot of strain (Samuel & Haruna, 2025). The Nigerian healthcare system is also underfunded, and the available healthcare workers are overworked and lack the necessary equipment to work with (Josiah et al., 2024). Addressing these systemic challenges through improved healthcare funding, workforce retention strategies, and community health education is therefore essential to reduce preventable child deaths in Nigeria.

4.4 Nurses' roles in supporting parents who lose their child

Providing support to parents is rather difficult due to a lack of perception of what parents really need. Even in situations where pre-loss care is given to parents, nurses are not sure whether it is effective enough to alleviate feelings of grief. This is further complicated by their own conflicting emotions while caring for the child (Kochen et al., 2022). It was noticed that the nurses expressed fear and anxiety in breaking the news to the parents because they perceived that the family could react violently. To prevent violent reactions and accusations, they insist that at least one family member be present during resuscitation so that nurses cannot be accused of negligence and malpractice, which has led to the child's death. They were also of the opinion that breaking such news is not easy, as they are humans who will also die someday. This may be attributed to fear of consequences and a need to satisfy their consciences that they are not responsible for the child's death (Bian et al., 2023). This aligns with the observation that fear of errors and consequences is part of what makes EOL care stressful for nurses (Rosser & Walsh, 2014).

In another study, some nurses reported that the death of a child always affected their work, reducing their ability to provide care for other patients, increasing their stress levels, and making them worry about the psychological distress and well-being of the parents. They reported remembering parents they have supported previously and have always wondered whether they have been supported enough to move on with life (Mohammed et al., 2024). These findings highlight the lasting emotional burden that pediatric death places on nurses, emphasizing the need for institutional psychological support and debriefing interventions to help them cope effectively.

4.5. Coping strategies for managing grief after paediatric patient death

Death is an event viewed with trepidation, as it signals an irreversible end to life. Nurses, as part of their roles, are expected to make the transition from life to death as peaceful as possible. But the impact of them carrying out that role is often ignored, especially grief, which is an emotional response to death (Ernstmeyer & Christman, 2021). It is possible that the nurses have also suffered moral distress and compassion fatigue, which are two of the consequences of nursing the dying, especially children (De Brasi et al., 2021; Panagou et al., 2023). This can be exacerbated due to their lack of effective coping strategies during and after paediatric end-of-life care. Studies have noted that peer support is key in areas where dying children are nursed (Anguis Carreño et al., 2023; Groves et al., 2022; Shimoinaba et al., 2021; Zheng et al., 2021), however, peer support is low as nurses in this study were taught during clinical postings not to grieve or cry but face the work at hand to reduce the feelings of regret, a common phenomenon in nursing practice (Ma et al., 2021; Meller, 2018). Some of those who cry do so privately away from the ward to avoid being reprimanded. Hence, occupational and emotional coping have been learnt through their experiences (Feng et al., 2024). However, emotional and occupational coping are not considered effective enough in dealing with the negative emotions of grief and sadness, as Anguis Carreño et al. (2023) in their study noted that structured coping strategies/skills will help nurses after a child's death, rather than focusing on their emotions.

5. Implications and limitations

The study provides pertinent information on nurses' experiences during and after the provision of end-of-life care to a dying child in Nigeria. It highlights the importance of the inclusion of end-of-life care and coping strategies in undergraduate and postgraduate nursing curricula, which will improve the care of dying children and reduce the possibility of emotional torture, moral distress, and compassion fatigue among nurses. End-of-life care should be considered as important as medical-surgical nursing and maternal and child health nursing courses. Continuing education programmes on end-of-life nursing care should be mandatory for all nurses to be able to clearly define their roles and cope with the rigours of providing care, while meeting the physical and psychological needs of the child and parents.

Based on the findings of this study, the following recommendations are made: (1) Educators and clinicians should be trained in EOL care so that there can be a transfer of knowledge to student nurses. They should also be made to understand the importance of EOL care in healthcare, so that sufficient time is allotted to the course while in school; (2) Nurses should have regular psycho-therapy sessions to properly explore their feelings and emotions concerning a child's death; (3) Guidelines should exist in healthcare institutions on how to handle dying children and their family members, especially when breaking sad news. This is to help them have less feelings of guilt about the effectiveness of their nursing care.

This study, however, has certain limitations. Its focus on only two government-owned hospitals within a state in north central Nigeria, with a small sample of paediatric trained nurses, limits its generalizability to other regions or countries with different healthcare contexts.

6. Conclusion

This study has the following themes: end-of-life care training during nursing education, experience of end-of-life care as a practicing nurse, perceived contributing factors to child death, support to parents who lose their child, and coping strategies for managing grief after paediatric patient death. It concluded that in spite of the years of experience, nurses find it difficult to erase the memories of dead patients. Nurses truly feel the loss of their patients; however, they cannot truly grieve because it is deemed unprofessional. This may make them burdened with negative emotions. Work is a major coping mechanism for nurses to avoid having to grieve openly. It was also noted that a lack of education on EOL care exists. There is no continuing education given on EOL care and dying, and this affects nurses' ability to provide appropriate care to the dying patients. There is a dire need for stakeholders to continuously organize in-service education for nurses. Nurse educators should review the training curriculum for nurses to place more emphasis on caring for dying patients.

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Authors Contribution

OOO was involved in study conceptualization/design, data collection, and drafting of the manuscript. KEI was involved in conceptualization, data collection, drafting, editing, and proofreading. EOA was involved in the drafting of the manuscript, while IMO was involved in the critical review of the manuscript.

Conflict of Interest

This is to state that the manuscript was read and approved by all authors. The authors met the requirements for authorship, and the manuscript reflects the work of all contributors. There is no known conflict of interest in this manuscript.

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