Nurses' moral experiences with end-of-life care in a community hospital intensive care unit

Sandra Mei Yun Wong, RN

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School of Nursing
Faculty of Health Sciences
University of Ottawa

Abstract

Extant literature has identified how nurses perceive their role and their experience of providing end-of-life care (EOLC) in intensive care units (ICUs). However, there is an empirical gap in what is known about nurses' provision of EOLC in ICUs of community hospitals and in particular, their moral experiences in the provision of care. Using Thorne's (2008) Interpretive Description (ID), this study was designed to explore nurses' moral experiences in providing EOLC in an ICU of a large community hospital. Face-to-face, semi-structured, interviews were conducted with seven nurses who have had experience providing care to dying patients in an ICU of a large community hospital.

Findings of the study revealed an overarching theme of *"switching gears"*, which reflected the moral experiences of the participants as they shifted the focus of their identity and their responsibilities from saving lives to caring for dying patients. The shift in focus included participants being involved with *"making a patient palliative"*, *"providing dignity conserving care"*, and *"supporting families"*. Yet, participants encountered many *"struggles"* embedded in the community hospital ICU context that made it difficult for them to *"switch gears"*. These *"struggles"* included frequent transfers of dying patients out of the ICU, heavier patient assignments, and the multiple roles and responsibilities assumed by participants. This study enhances our knowledge and understanding about ICU nurses' identity, especially what they take responsibility for in the care of dying patients and their families. Furthermore, the study findings highlight the specific challenges nurses encounter in the community ICU context, while providing EOLC to patients and families. These findings bring about important implications to nursing practice, education and research.

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To Him be the glory.

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Table 1: Glossary of Terms

Term	Definition
Critical care/ Critical care nurses	An umbrella term representing the specialized health services that meet the needs of critically ill patients (Critical Care Services Ontario [CCSO], n.d). These specialized services may be situated in (including but not exclusive to): intensive care units (ICUs), coronary care units (CCU), post anesthesia care unit (PACU), and emergency department (ED) (Williams, 2009). Registered nurses (RNs) who work in these settings are considered to be critical care nurses (Williams, 2009).
Critically ill patients	Patients who have a life-threatening illness or condition facing physiological decline with risk of multi-organ dysfunction or imminent death (Adhikari, Fowler, Bhagwanjee, & Rubenfield, 2010)
End-of-life care (EOLC)	The provision of care that is often informed by larger value-based philosophies, which can include aspects such as promoting engagement in decision-making, providing psychosocial and spiritual support, as well as pain and symptom management for patients with life-threatening illness (Canadian Hospice Palliative Care Association [CHPCA], 2015). EOLC is provided during patients' final stages of death, and also includes the care of the body after death as well as bereavement care for the family (Canadian Nurses Association [CNA], CHPCA, & Canadian Hospice Palliative Care Nurses Group [CHPC-NG], 2015).
Goals of care	Discussions about the implementation and use of life-sustaining treatments, and the withdrawal or withholding of such treatments (Vanderspank-Wright, Roze des Ordons, & Hartwick, 2018).
Intensive care units (ICU)/ ICU nurses	Designated area(s) within hospitals where critical care services are provided (Canadian Institute for Health Information (CIHI), 2016a). There are different types of ICUs that care for specific patient populations: general (all patients), specialized (patients with a particular type of illness or injury), and pediatric and neonatal (CIHI, 2016a). RNs who practice exclusively in ICUs are also called intensive care nurses (Williams, 2009).
Large community hospitals	Generally located in communities of a population of 10,001 to 99,999. They are non-academic affiliated, tend to have more than 100 inpatient beds, and treat more than 2,700 acute and day-surgery cases per year (Ministry of Health and Long-Term Care [MOHLTC], 2006; Office of the Auditor General of Ontario, 2016; Rural Ontario Institute, 2013).
Life-sustaining treatments	Advanced medical interventions that maintain the basic human physiological requirements, which include but not limited to mechanical ventilation, hemodialysis, cardiopulmonary resuscitation, and inotropic and/ or vasoactive medications (Adhikari et al., 2010)
Level of care	A way of categorizing ICUs based on a number of factors, such as availability of skilled staff, the capacity to monitor critically ill patients, the presence of formal education/ training for staff, and the capacity for research/ quality improvement projects (Marshall et al., 2017). In Ontario, there are 2 categories of ICUs: level 2 (single failed organ system support, short term or invasive ventilation), and level 3 (most comprehensive, multiple organ failure support, short/ long term invasive ventilator support) (CCSO, 2015).
Model of care	Organizational approaches in managing patients in the ICU (Gottesman, 2010). In Ontario, there are two models of care: 1) "Open" model of care: general physicians care for assigned patients in the unit, and 2) "Closed" model of care: intensivists (physicians with critical care training) admit and manage all patients in the unit (CIHI, 2016a).
Moral experiences	Everyday lived encounters that "encompasses a person's sense …[of] values he or she deems important are being realized or thwarted" (Hunt & Carnevale, 2011, p. 659)
Moral identity/ Moral agency	An individual embodied with socially constructed values (identity), and the capacity (agency) to reflect, deliberate and enact his or her responsibilities (Doane, 2002; Peter & Liaschenko, 2004)
Rural/ Small community Hospitals	Generally situated in communities of less than a total population of 10,000. These hospitals are non-academic affiliated, have less than 100 patient beds, and treat less than 2,700 acute and day surgery cases per year (MOHLTC, 2006; Office of the Auditor General of Ontario, 2016; Statistic Canada, 2015)

Teaching/ academic hospitals	Generally located in urban metropolitan areas (population of more than 100,000). These hospitals are members of Council of Academic Hospital of Ontario (CAHO), academically affiliated with universities and dedicated to the teaching and training of health professionals (e.g. medical residents and fellows, nurses, respiratory therapists) (MOHLTC, 2006; Office of the Auditor General of Ontario, 2016).
Values	Standards or behaviours that an individual endorses, attempts to maintain, and deems important (Canadian Nurses Association [CNA], 2017a).
Responsibilities	Duties or obligations that are socially negotiated to which an individual accepts personal accountability for (Bjorklund, 2004).

Chapter 1: Introduction

1.1 Background

Every year, an increasing number of patients are being admitted and cared for within intensive care units (ICUs) of Canadian hospitals (Canadian Institute of Health Information [CIHI], 2016a). Patients admitted into the ICU are considered to be critically ill, requiring life-sustaining treatments after medical operations or for various illnesses including but not limited to myocardial infarction, septic shock and respiratory failure (CIHI, 2016a). Within the ICU, specialized care can consist of continuous hemodynamic monitoring and the initiation of life-sustaining treatments, such as mechanical ventilation, inotropic and vasoactive medications, and renal replacement therapy (Adhikari, Fowler, Bhagwanjee, & Rubenfeld, 2010; Marshall et al., 2017).

While many patients admitted to the ICU recover, the clinical reality is such that patients also die (Adhikari et al., 2010). Patient death in the ICU often results from the inability to recover from critical illness and frequently follows decisions to either withdraw or withhold of life-sustaining treatments (Adhikari et al., 2010). Mortality rates in ICUs vary internationally. For instance, in the United States, mortality rates range from 10 to 29% depending on patients' age and severity of illness (Society of Critical Care Medicine, 2017). In Canada, mortality rates in ICUs range from 9% to 20% (CIHI, 2016a; Heyland et al., 2015). Typically, there are higher rates of mortality in ICUs of teaching hospitals than community hospitals as they tend to be larger units, and care for a greater population of critically ill patients (Keenan et al., 1998). These mortality statistics reveal that the clinical reality of death and dying remains an overall pertinent issue in the context of ICUs.

As part of this clinical reality, nurses in the ICU provide end-of-life care (EOLC) for dying patients in their last days and hours of life (Espinosa, Young, & Walsh, 2008). The provision of EOLC is often informed by various value-based philosophies. For instance, a Palliative Approach to care guides nurses across all practice settings to promote active engagement in decision-making, provide psychosocial and spiritual support, as well as pain and symptom management for patients who are affected by life-threatening illnesses (Canadian Hospice Palliative Care Association [CHPCA], 2015). Similarly, the Canadian Nurses Association (CNA, 2017a) Code of Ethics informs nurses of their responsibilities to build therapeutic relationships, engage with patients and families regarding their wishes at end-of-life, and when patients are terminally ill or dying, to foster comfort, provide adequate relief of pain, and meet their cultural and spiritual needs. As nurses in the ICU provide EOLC based on such philosophies like a Palliative Approach to care and the CNA Code of Ethics, they are endeavoring to uphold both foundational and fundamental nursing values, such as compassion, and respect for the dignity of patients and families.

Nurses practicing in the ICU are often referred to as intensive care nurses, or more broadly, critical care nurses (Williams, 2009). The term critical care nurses includes nurses who practice in other specialized settings caring for critically ill patients, such as the Emergency Department (ED) and the Post Anesthesia Care Unit (PACU) (Williams, 2009) (See Table 1). Although there are some distinctions, these two terms (intensive care nurses and critical care nurses) are used synonymously throughout the thesis.

Extant literature has explored intensive care nurses' roles and experiences in providing EOLC. Many studies have described that intensive care nurses use a variety of strategies in an effort to be actively involved with patients, families, and the interdisciplinary team in end-of-life

decision-making, and to be a part of changing goals of care from a curative to palliative focus (Adams, Bailey, Anderson, & Docherty, 2011; Bach, Ploeg, & Black, 2009; Coombs, Addington-Hall, & Long-Sutehall, 2012). Other studies exploring intensive care nurses' role(s) after decisions to shift to a palliative focus have revealed their care to include conserving the dignity of the dying patient, as well as preparing and supporting the family for the loss of their loved one (Fridh, Forsberg, & Bergbom, 2009; Liaschenko, Peden-McAlpine, & Andrews, 2011; Ranse, Yates, & Coyer, 2012). Although not always explicitly discussed, these studies reveal intensive care nurses' values and beliefs. For instance, using a qualitative descriptive design, Fridh et al. (2009) explored intensive care nurses' experiences and perceptions of caring for dying patients with a particular focus on those who were unaccompanied (without family present) in the ICU. Fridh et al. (2009) described how intensive care nurses felt it was important for the unaccompanied patient to not be alone, and to receive the same kind of care as patients whose family were present at the bedside. Fridh et al. (2009) suggested that these nurses perceived an obligation to the unaccompanied patients to ensure they still experienced a dignified death. Although nuanced, the findings of this study as an example, illustrate that these intensive care nurses value fairness in their provision of care, and respect for the dignity of the dying person.

A moral perspective could be used to further explore and bring forth intensive care nurses' value-laden experiences of providing EOLC in the ICU. Within this moral perspective, there are related constructs of moral identity and moral agency. For nurses, their moral identity often situates them as moral agents – individuals embodied with values and responsibilities (Doane, 2002; Varcoe et al., 2004). Nurses' moral agency is an extension of their identity, which is their "capacity to recognize, deliberate/reflect on, and act on moral responsibilities" (Peter &

Liaschenko, 2004, p.221). Both nurses' moral identity and agency can be revealed through narrative expressions of who they are, and what they do (Doane, 2002; Peter & Liaschenko, 2013). Furthermore, these narrative expressions can facilitate the unveiling of the complexities in nurses' surrounding practice context (or work environment). Studies exploring ethical nursing practice have found nurses' moral identity and agency to be shaped and influenced (positively or negatively) by contextual factors (Doane, 2002; Rodney et al., 2009). For instance, Rodney et al. (2009) described how factors in the workplace, such as positive relationships and shared decision-making, facilitated and strengthened nurses' moral identity and their agency to care for patients and families. As such, part of exploring intensive care nurses' value-laden experience of EOLC with a moral perspective also requires consideration of their local context.

Understanding of intensive care nurses' experiences in providing EOLC has been informed largely by studies conducted in tertiary hospitals (Espinosa, Young, Symes, Haile, & Walsh, 2010; Ranse et al., 2012). Few studies have explored nurses' experiences of providing in EOLC within the context of ICUs in community hospitals (Gross, 2006; Sarti, Fothergill-Bourbonnais, Landriault, Sutherland, & Cardinal, 2015). There are various interpretations of what constitutes a community hospital. However, for the purpose of this discussion (and thesis), the following description of a large community hospital is used: geographically located outside of metropolitan areas, not academically affiliated, tend to have more than 100 patient beds, and treat more than 2,700 acute and day surgery cases per year (see Table 1) (Ministry of Health and Long-Term Care [MOHLTC], 2006; Office of the Auditor General of Ontario, 2016; Rural Ontario Institute, 2013).

A study by Sarti et al. (2015) explored and identified gaps in the provision of palliative care in a 10-bed community hospital ICU. Findings of the study suggested that healthcare

providers in the community hospital ICU held differing perspectives about palliative care than what is often described in studies conducted in tertiary hospital settings. Sarti et al. (2015) described these differences in perceptions to be related to the timing as well as the responsibility and role for leading end-of-life discussions with patients and families (Sarti et al., 2015). As a result of these perceptions, discussions and decision-making about end-of-life occurred inconsistently (Sarti et al., 2015). Furthermore, there were conflicting views among the healthcare providers as to whether dying patients should be kept in the ICU or transferred elsewhere in the hospital for EOLC (Sarti et al., 2015). The study also highlighted that there were factors within the ICU and the community hospital which possibly influenced the provision of palliative and EOLC, such as physician availability, frequent transfers to tertiary centres, and the priority in caring for critically ill patients (Sarti et al., 2015). Sarti et al. (2015) suggested that community hospital ICU providers may not always incorporate palliative and EOLC as part of their critical care practice as compared with practices in tertiary ICU settings.

Building on the insights provided by Sarti et al.'s (2015) study, further exploration of intensive care nurses' perspectives on their role and their experiences with providing palliative and EOLC in the community ICU context is required. As suggested by Sarti et al. (2015)'s study, there were factors unique to the community ICU context that influenced the provision of palliative and EOLC. By examining the context, it is possible to understand, in greater depth, what can enable or constrain community hospital ICU nurses' abilities to care for dying patients and their families, as well as the values that inform their care.

1.2 Problem Statement

While there have been studies exploring intensive care nurses' roles and experiences with respect to the provision of EOLC, few studies have been conducted in community hospital ICUs

(Sarti et al., 2015). Notably, this leaves an empirical gap related to what is known about intensive care nurses' role and experiences with EOLC in the context of community hospital ICUs. There are various ways of addressing this empirical gap, however, a moral perspective may be a relevant lens to explore these experiences. Previous literature on intensive care nurses' experiences with EOLC have alluded to some moral aspects of nursing practice, such as values in care and experiences of inner tension (Calvin, Kite-Powell, & Hickey, 2007; Espinosa et al., 2010). Yet, the extent to which these experiences have been explored from an explicitly moral perspective is limited. This warrants a more in-depth exploration into intensive care nurses' moral experiences with EOLC, particularly within a community ICU context.

1.3 Research Purpose

The purpose of this study was to explore nurses' moral experiences with EOLC in a community hospital intensive care unit.

1.4 Research Objectives

The objectives of this study sought to explore:

1. How do nurses describe their provision of EOLC in the community hospital intensive care context?
2. What do these descriptions reveal about the moral identities of the nurses who provide EOLC?
3. How does the community intensive care context shape nurses' moral agency with respect to the care of dying patients?

In order to explore the aforementioned objectives, Interpretive Description (ID) as articulated by Thorne (2008) was used. ID is a qualitative research method with a nursing disciplinary framework to explore relevant and practical clinical issues (Thorne, 2008). ID was chosen primarily because the subject of investigation of this study is explicitly situated in the

discipline of nursing, and the focus is on nurses' experiences with providing EOLC. The provision of EOLC is an ethical responsibility for nurses in all practice settings (CNA, 2017a). Furthermore, in this thesis, the findings and implications for nursing practice are developed and presented in a manner that can inform applicable knowledge for nurses in the community ICU, and related intensive care contexts.

1.5 Layout of the Thesis

In Chapter 2, relevant literature about death and dying in the ICU, and nurses' roles and experiences with providing EOLC is presented. In Chapter 3, the method of ID used in the study is described as well as the theoretical and disciplinary underpinnings and the researcher's own personal experiences brought to the study. The findings of the study are described in Chapter 4, while in Chapter 5, there is a discussion of the findings and their implications for nursing practice, education and research.

Chapter 2: Literature Review

In this chapter, the literature review that was conducted for this thesis is presented. There were two main objectives to the literature review: 1) to define concepts that were essential to the study, and 2) to critically appraise the existing knowledge in nurses' experiences with EOLC in ICU contexts. For the literature review, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed databases were used for the primary search of articles. Key search terms included: end- of-life care, withdrawal/withholding of treatment, palliative care, terminally ill and dying. Keywords used to represent the sample and setting of interest included: intensive care units, hospitals, community hospitals, and critical care/ intensive care nurses. Articles were screened and narrowed down to English-language publications. No time limits were applied as a range of articles were sought for a comprehensive literature review. In addition to databases, grey literature, such as government or organizational publications and statistics, were utilized to gain a broad understanding of the ICU context, intensive care nursing, and EOLC.

The literature review is organized and presented in the following ways. First, a brief description of ICUs, community hospitals, and death and dying within these contexts is provided. Second, the roles and responsibilities nurses assume in the care of dying patients and families are described. Third, previously published studies exploring nurses' experiences with providing EOLC in both tertiary and community ICU contexts are discussed. In the closing of this chapter, a critical reflection and summary of the existing knowledge is offered.

2.1 Intensive care units

ICUs fall under the umbrella term critical care and they are designated areas within hospitals (teaching and community based) where specialized care is provided for patients with

the goal of recovery (CIHI, 2016a; Truog et al., 2001). ICUs serve patients who are critically ill after surgery or those with various pre-existing or unexpected life-threatening illnesses, such as trauma, myocardial infarction, complications from oncology treatments, and sepsis (CIHI, 2016a). These patients often experience multi-organ dysfunction and face the risk of imminent death (Adhikari et al., 2010). Thus, the priority within ICUs and amongst the interdisciplinary team is to ensure critically ill patients recover from their life-threatening illness or condition and prevent further physiological deterioration and death (Adhikari et al., 2010; Truog et al., 2001).

Every year, a growing number of patients are being admitted to and cared for in Canadian hospital ICUs. Statistics from the CIHI reported that in 2013 to 2014, there were more than 230,800 adult ICU admissions in Canada (the province of Quebec was not included), which was a 12% increase in comparison to 2007 to 2008 (CIHI, 2016a). Furthermore, it is becoming more common for patients' course of hospitalization to include a stay in the ICU, because of the severity and complexity of their illness (CIHI, 2016a). For example, CIHI (2016a) reported that in 2013 to 2014, 11% of all adult patient hospitalizations in Canada also accounted for admissions into the ICU. In addition, there are more patient admissions related to exacerbations and complications from underlying chronic illnesses (CIHI, 2016a).

In the ICU, the interdisciplinary team can include a number of health and allied health professionals such as: physicians, intensive care nurses, respiratory therapists, pharmacists, dietitians and social workers (Gottesman, 2015). This team provides specialized care for critically ill patients and often consists of the close monitoring and initiation of life-sustaining treatments, including but not limited to mechanical ventilation, hemodialysis, cardiopulmonary resuscitation, and inotropic and/or vasoactive medications (Adhikari et al., 2010; Bandrauk, Downar, & Paunovic, 2018). These life-sustaining treatments are specialized measures that are

used to maintain vital physiological organ function (Bandrauk et al., 2018). In Canada, for example, mechanical ventilation is a commonly used life-sustaining treatment for patients experiencing respiratory failure, and it is considered an invasive measure where oxygen is delivered through an artificial airway such as an endotracheal tube (CIHI, 2016a). Patients receiving mechanical ventilation are at risk of a number of complications, such as infections, pneumothorax and lung injury (American Thoracic Society, 2017). Due to the associated potential risks and complications, the highest nurse to patient ratio is usually implemented, where typically, one intensive care nurse cares for one patient who is mechanically ventilated (Gottesman, 2015). As illustrated with the life-sustaining treatment of mechanical ventilation, the care provided in the ICU is complex, often technologically advanced, and resource intensive in terms of staff and costs (Canadian Association of Critical Care Nurses [CACCN], 2017a; CIHI, 2016a; Curtis & Vincent, 2010).

While there are similarities across ICUs, the ways in which these units are structured and organized can vary. For example, in the province of Ontario, there are two categories of ICUs: Level 2 and Level 3 (Critical Care Services Ontario [CCSO], 2015). Level 2 ICUs are capable of treating patients post-operatively or with single organ failure, using short term mechanical ventilation (less than 48 hours) (CCSO, 2015, MOHLTC, 2006). Level 3 ICUs provide the most advanced critical care services and can manage patients with multi-organ dysfunction and patients requiring long term mechanical ventilation (CCSO, 2015). Yet, even within this broad categorization of levels, the capacity of ICUs may differ in terms of the number of beds, equipment, available medical specialities and models of care. For example, some Level 3 ICUs may offer various life-sustaining treatments (i.e renal replacement therapies and extra-corporeal membrane oxygenation), while other Level 3 ICUs may only have capacity to care for patients

on mechanical ventilation (CCSO, 2015). ICUs may also adopt certain medical specialities like cardiology and trauma, and therefore, these ICUs focus on caring for patients with specific types of illness or injury (Gottesman, 2015). There are two models of care that are utilized in ICUs across Canada and they are labelled "open" (p.3) and "closed" (Gottesman, 2015, p.3). Many ICUs in teaching hospitals (located in metropolitan areas) operate with a "closed" (p.3) model of care. The latter implies that the unit is staffed by an interdisciplinary team and led by intensivists, who are physicians that have ICU training (Gottesman, 2015). In contrast, there are other ICUs that use an "open" (p.3) model of care, where physicians without specific ICU training (such as general practitioners and hospitalists) have access and care for their patients in the unit. Furthermore, in an "open" (p.3) model of care, there may be less of an interdisciplinary approach (Gottesman, 2015). These variations in the organization and capacity of ICUs can have implications in the overall delivery of care for critically ill patients and their health outcomes.

2.2 Community hospitals

In Canada, approximately one fifth of the population live in rural areas (Statistics Canada, 2011). Rurality within Canada is generally conceptualized based on traditional definitions of low density in a geographic location and distance to other dense populations (Canadian Rural Revitalization Foundation [CRRF], 2015). Yet, the Canadian rural landscape is diverse. Canadians living outside of large metropolitan areas reside in communities of various sizes from small towns to small cities (CRRF, 2015). For instance, 20% of the province of Ontario population (2.6 million Ontarians) live in communities of less than 100 residents to populations of 100, 000 (CRRF, 2015).

Community hospitals provide essential health services for Canadians residing in rural areas. While there are no universal descriptions of community hospitals, it is generally accepted

that they are not academic institutions, meaning they are not affiliated with universities in the teaching and training of medical students or fellows (Ministry of Health and Long-Term Care [MOHLTC], 2009). In the province of Ontario, there are two sizes of community hospitals: small (or rural) and large (Office of the Auditor of Ontario, 2016). The size of community hospitals can be further differentiated by the number of inpatient beds and the number of patients they treat per year. For instance, the MOHLTC (2009) categorizes non-academic hospitals into two groups: 1) fewer than 100 inpatient beds (small community hospitals), and 2) more than 100 inpatient beds (large community hospitals). Furthermore, the MOHLTC also considers the number of patients treated by measuring the number of acute and day surgery cases the community hospital performs per year (Office of the Auditor of Ontario, 2016). The MOHLTC classifies small community hospitals as having less than 2,700 acute and day surgery cases per year, and conversely, larger community hospitals as having more than 2,700 cases (Office of the Auditor of Ontario, 2016). Although these classifications have been primarily used for auditing, they reveal a wide variability between community hospitals.

Small and large community hospitals in Ontario are connected to a region-wide network of critical care services. For example, the Champlain Local Health Integration Network (LHIN) is a regional network that has a catchment area covering approximately 18,000 square kilometers, and includes a total of 13 community hospitals (MOHLTC, 2006; Office of the Auditor of Ontario, 2016). Of these 13 hospitals, 9 (5 large and 4 small) of them have their own respective ICUs, varying in the number of beds (ranging from 2 to 12), equipment available, staffing and model of care (MOHLTC, 2006; Office of the Auditor of Ontario, 2016). While there are differences between these 9 community hospital ICUs, they often serve as first point of care for patients who require critical care services (CCSO, 2015).

In 2014, Sarti et al. conducted a study examining the needs in an ICU of a community hospital. Specifically, the researchers used a mixed methods approach, and identified various gaps in care for critically ill patients, one of which was the provision of palliative care (Sarti et al., 2014). In their results, the researchers found that within an 11 month period, the ICU of the community hospital had 884 patient admissions, of which 121 patients were mechanically ventilated (Sarti et al., 2014). However, of the 121 patients requiring mechanical ventilation, 94 of these patients were transferred to the nearest referral hospital (a designated teaching hospital in the region) (Sarti et al., 2014). While this was a significant proportion of critically ill patients being transferred between the community and referral hospitals, the finding was also important in shedding light on the role ICUs in community hospitals play in responding to critically ill patients. Sarti et al. (2014) aptly demonstrated that the ICU of the community hospital was the first place to stabilize and begin to meet the physiological needs of patients prior to transferring them out to another facility. This is a role that many ICUs of community hospitals assume as part of contributing to the regional network of critical care services, and ensuring patients receive the most appropriate care (CCSO, 2015).

2.3 Death and dying in ICUs

Over the last few decades, advances in medicine and technology in the ICU have contributed to many patients recovering from their illnesses or injuries (Mark, Rayner, Lee, & Curtis, 2015). Yet, at the same time, death and dying remain a clinical reality in both the ICUs of teaching and community hospitals. Recent data from the CIHI (2016a) suggests that the mortality rate in ICUs of all Canadian hospitals is 9%. However, previous studies have shown mortality rates to be up to 20% in ICUs of Canadian teaching hospitals (Heyland et al., 2015). Internationally, mortality rates range from 10 to 29% depending on patients' age and severity of

illness (Capuzzo et al., 2014; Society of Critical Care Medicine, 2017). Since patients in the ICU are critically ill, they may die suddenly from their illnesses, such as acute lung injury or septic shock (Adhikari et al., 2010). However, patient deaths in the ICU may also occur following decisions to shift goals of care from recovery (or cure) to a palliative focus (Truog et al., 2001; Vanderspank-Wright, Roze des Ordons, & Hartwick, 2018). Specifically, the process of shifting goals of care includes discussions concerning the implementation of life-sustaining treatments, as well as the withholding or withdrawing of such treatments (Vanderspank-Wright et al., 2018). Withholding of life-sustaining treatments is frequently viewed not initiating further medical therapy; whereas withdrawing of life-sustaining treatments is often described as the active cessation and removal of medical therapy, such as mechanical ventilation, and inotropic/ vasoactive medications (Bandrauk et al., 2018; Rocker et al., 2005).

Process and practices of withdrawal or withholding of life-sustaining treatments in ICUs vary significantly both within Canada and globally. In a systematic review, Mark et al. (2015) examined 56 studies conducted in ICUs internationally and found a substantial variance from 0 to 84% in the incidence of withdrawal of life-sustaining treatments, and an overall average of 50.8%. The researchers suggested numerous factors that may explain variability in the prevalence of withdrawal of life-sustaining treatments in ICUs, such as patient demographics, patient's values and religion, physician background, and institutional culture (Mark et al., 2015). Within Canada, Keenan et al. (1998) studied the incidence of withdrawal or withholding of life-sustaining treatments between ICUs of teaching (n=3) and community (n=6) hospitals. The results revealed the incidence of withdrawal or withholding of life-sustaining treatments to be similar in both ICU settings (68% in teaching hospital and 71% in community hospitals) (Keenan et al., 1998). However, there was a greater proportion of patient deaths due to withholding of

life-sustaining treatments in ICUs of community hospitals compared to teaching hospitals (12% vs. 4% respectively, p=.004). The researchers postulated that this result could be due to the nature of ICUs in community hospital, where there may be more familiar relationships between physicians and families, and thus, allowed for more open discussion about whether to pursue life-sustaining treatments for patients (Keenan et al., 1998). Furthermore, the researchers also suggested that ICUs of teaching hospitals have a greater volume of critically ill patients already on life-sustaining treatments, and consequently, would likely involve decisions about withdrawal rather than withholding (Keenan et al., 1998). These two studies (Keenan et al., 1998; Mark et al., 2015) reveal withholding and withdrawing life-sustaining treatments to be common practices inherent to EOLC in ICUs. As such, death and dying in the ICU can present quite differently than in other clinical contexts.

2.4 Critical care nursing

Critical care nursing is a recognized area of specialty nursing practice in Canada (CNA, 2017b). The CIHI (2016b) reported that in 2016, there were 19,372 critical care nurses, which accounted for approximately 7.6% of all registered nurses in Canada. Critical care nurses are registered nurses (RNs) who have specialized training and knowledge to care for adult, pediatric, or neonatal patients with life-threatening illnesses or injuries in the setting of ICUs (teaching and community based) (CACCN, 2017b). According to Critical Care Services Ontario (CCSO, 2017), recent practices involving the training of critical care nurses in Ontario includes a minimum of 8 weeks (or 300 hours) of didactic and clinical hours. Critical care courses are offered in colleges and hospitals, where critical care nurses are taught topics like the physiology of critical illness, advanced nursing assessment and intervention skills (Critical Care Secretariat,

2006; CCSO, 2017). Furthermore, critical care nurses are also trained in their respective workplaces with preceptorship experiences (CCSO, 2017).

In the ICU setting, critical care nurses work collaboratively with the interdisciplinary team to meet the various physical, psychosocial, cultural and spiritual needs of the patients and families (CACCN, 2017a). There are 7 practice standards developed by the CACCN (2017a) that guide critical care nursing practice in Canada:

(1) Critical care nurses use advance skills and specialized knowledge to continuously assess, monitor and manage patients for the promotion of optimal physiological balance.

(2) Critical care nurses promote and facilitate optimal comfort and well-being in a highly technological environment that is often unfamiliar to patients and families.

(3) Critical care nurses foster mutually beneficial partnerships with patients and families based on trust, dignity, respect, communication and collaboration. The patient defines family.

(4) Critical care nurses provide care that adheres to evidence-informed guidelines and established safety standards and protocols when providing care in a high-risk environment.

(5) When the goal of care changes from life-sustaining therapies to end-of-life, critical care nurses support patients and families through this transition.

(6) Critical care nurses promote collaborative practice in which the contribution of the patient, family and each interprofessional team member is solicited, acknowledged and valued.

(7) Critical care nurses provide leadership by fostering a culture conducive to collaboration, quality improvement, safety, professional growth, well-being, and responsible resource utilization.

These practice standards reflect critical care nurses' clinical role, and their competencies. In conjunction with these practice standards, critical care nursing is underpinned by the nursing

values and ethical responsibilities outlined in the Canadian Nurses Association Code of Ethics for Registered Nurses (CNA, 2017a). These primary nursing values include (CNA, 2017a): (1) Providing safe, compassionate, competent and ethical care; (2) Promoting health and well-being; (3) Promoting and respecting informed decision-making; (4) Honoring dignity; (5) Maintaining privacy and confidentiality; (6) Promoting justice; and (7) Being accountable. Like all RNs in Canada, critical care nurses endeavour to enact these fundamental nursing values as they care for patients and families, including at the end of life.

2.5 Critical care nurses' role in caring for dying patients

Nursing professional associations (CACCN and CNA) have addressed critical care nurses' role and their ethical responsibilities to care for patients facing life-threatening illness and/or imminent death, as well as their families. Furthermore, these nursing professional associations suggest that critical care nurses be competent in providing EOLC (CACCN, 2017a; CNA, 2017c). For instance, part of the CNA critical care speciality certification requires critical care nurses to be knowledgeable and competent of the evidence-informed interventions that support the shift in goals of care, and enable the care of dying patients (CNA, 2017c). As such, the critical care nursing role intersects with a palliative approach to care, as well as EOLC (CNA, 2017c).

One of the values-based philosophies that underpins the provision of EOLC is a palliative approach to care. The Canadian Hospice Palliative Care Association (CHPCA, 2015) describes a palliative approach to care to include: promoting active engagement in decision-making, providing psychosocial and spiritual support, and pain and symptom management for patients who are affected by life-threatening illnesses. Specifically, EOLC incorporates all these elements of a palliative approach to care, but it is provided at patients' final stages of death (last days and

hours of life), and continues until death and includes the care of the body and bereavement of the family (Canadian Nurses Association [CNA], Canadian Hospice Palliative Care Association [CHPCA], & Canadian Hospice Palliative Care Nurses Group [CHPC-NG], 2015).

2.5.1 End-of-life decision-making. As previously mentioned, discussions and decision-making in the ICU centre around goals of care as they evolve over the illness trajectory, and specifically concern the implementation, withdrawal or withholding of life-sustaining treatments (Truog et al., 2001; Vanderspank-Wright et al., 2018). For clarity, some institutions have organized goals of care into particular categories that detail the type of life-sustaining treatments to be implemented or withheld/ withdrawn (Vanderspank-Wright et al., 2018). Yet, it is important to recognize that establishing goals of care is complex, and requires collaboration and ongoing communication between the interdisciplinary team and patients/ families (Vanderspank-Wright et al., 2018).

A number of studies have explored critical care nurses' role with end-of-life decision-making in ICUs within Canada (Bach et al., 2009) and internationally (Calvin, et al., 2007; Gallagher et al., 2015; Langley, Schnollgruber, Fulbrook, Albarran, & Latour, 2014). In addition, there are studies that have examined the roles and experiences of the interdisciplinary team (physicians and critical care nurses) with end-of-life decision-making in the ICU (Coombs et al., 2012; McAndrew & Leske, 2015). These studies revealed varying perspectives, roles and responsibilities shared between physicians and critical care nurses, as well as some tensions among the interdisciplinary team that often occur during end-of-life decision-making (Coombs et al., 2012; McAndrew & Leske, 2015).

Evidence from current literature suggests that critical care nurses use several strategies to be actively engaged with end-of-life decision-making (Adams et al., 2011; Bach et al., 2009;

Calvin et al., 2007; Peden-McAlpine, Liaschenko, Traudt, & Gilmore-Szott, 2015). Bach et al. (2009), for instance, described that critical care nurses often assumed the role of providing information and explaining the patient's condition and the plan of care to families/substitute decision makers (SDM) in ways that facilitated their understanding. Similarly, research has also shown that critical care nurses facilitate communication and collaboration between families and physicians. For example, Calvin et al. (2007) described how critical care nurses acted as intermediaries, relaying their observations of the patients' changing condition to families and physicians. In addition, critical care nurses coordinated "patient care conferences" (p.146) with families and the interdisciplinary team to ensure a consistent message was communicated, and that all who were involved understood the patient's situation, particularly the lack of recovery (Calvin et al., 2007).

Critical care nurses also use their communication skills to help families to come to acceptance in changing goals of care to a palliative focus. A recent narrative study by Peden-McAlpine et al. (2015) described these nurses as having conversations with families, helping them recall the patients' end-of-life wishes and reminding them that they are "the voice for the patient" (p.1154). In doing so, critical care nurses helped families to see that their actions were an extension of the patient's autonomy (Peden-McAlpine et al., 2015). Critical care nurses' roles of providing information and facilitating communication and collaboration often enabled end-of-life discussions to occur, and aided in shifting goals of care to a palliative focus.

2.5.2 EOLC in the ICU. Researchers have also explored critical care nurses' roles after a decision has been made to shift goals of care to a palliative focus. These studies reveal that these nurses intently provide care that conserves the dignity of the dying patient. While the conservation of dignity is a focus of nursing care throughout an ICU stay, the following studies

focused specifically on how nurses enacted this type of care at the end-of-life. For instance, Fridh et al. (2009) described critical care nurses moving away from performing highly technical tasks to concentrate on relieving patients' pain or suffering through the administration of analgesic and sedative medications. Likewise, Efstathiou and Walker (2014) found that critical care nurses also provide non-pharmaceutical interventions, such as bathing and repositioning, in efforts to promote patient comfort. Studies have also described critical care nurses as being concerned for patients dying alone without the presence of family members (Fridh et al., 2009). For example, Fridh et al. (2009) depicted how nurses provide compassionate care to dying patients by being present at the bedside until their death. These studies highlight how critical care nurses aptly perceive their role in ensuring comfort, dignity, and presence for the dying patient.

Another significant focus for critical care nurses in EOLC is caring for the family. Several studies have illustrated that critical care nurses create space for the dying patient and their family (Liaschenko et al., 2011; Ranse et al., 2012). Liaschenko et al. (2011) elaborated on the ways critical care nurses transformed patient rooms from a technical environment into a more ambient and peaceful one with personalized rituals, such as music and aromatherapy. Liaschenko et al. (2011) have suggested that this transformation of space was a way for nurses to prepare the family for the imminent death of their loved one. Similarly, studies have described how critical care nurses personalize families' experiences (Ranse et al., 2012; Vanderspank-Wright, Fothergill-Bourbonnais, Brajtman, & Gagnon, 2011). Vanderspank-Wright et al. (2011) reported on how critical care nurses took opportunities to provide memories for families, such as taking the patient outside to experience the sunshine for the last time. Ranse et al. (2012) described how critical care nurses spent time with family members "getting to know" (p.8) the patient and

responding to their questions about the patient's dying process. Findings from these studies illustrate critical care nurses to be focused on facilitating a positive experience for families.

2.6 Critical care nurses' experiences of providing EOLC

2.6.1 Quantitative studies.

Quantitative studies that were found in the literature review focused particularly on exploring the barriers and facilitators with providing EOLC as perceived by critical care nurses (Beckstrand & Kirchhoff, 2005; Beckstrand, Lamoreaux, Luthy, & Macintosh, 2017; Kirchhoff & Beckstrand, 2000). For instance, Kirchhoff and Beckstrand (2000) conducted a quantitative study in the United States, sampling critical care nurses who were at the time members of the American Association of Critical Care Nurses (AACN). Kirchhoff and Beckstrand developed and used a self-administered questionnaire (64 items on a 0 to 5 point Likert scale and 2 open ended questions) to study these nurses'(*n*=199) perceptions of "obstacles" (p.97) and "helps" (p.97) in the provision of EOLC. These critical care nurses rated obstacles for their intensity (from 'not at all' to 'large') and rated supports for helpfulness (from 'not helpful' to 'extremely'). Findings showed that nurses were most concerned about the following "obstacles": dealing with families continually seeking information via telephone or families exhibiting angry behaviours; coping with differing perspectives from family members and physicians regarding patient's prognosis, end-of-life wishes and use of life-support treatments; and working with organizational factors, such as lack of time to provide EOLC and poor unit design (Kirchhoff & Beckstrand, 2000). Results also revealed that these critical care nurses perceived the following supports as most helpful: making a patient's death easier for the family, providing a peaceful and dignified bedside scene, and promoting family acceptance of death (Kirchhoff & Beckstrand, 2000).

A more recent study was conducted by Beckstrand et al. (2017) to examine whether critical care nurses' perceived obstacles with EOLC have changed since the study by Kirchhoff and Beckstrand (2000). Beckstrand et al. surveyed critical care nurses (n=509) using similar methods (self-administered questionnaire and through AACN). The results showed current perceived obstacles with EOLC were similar to those previously reported, and were primarily related to relationships with families and physicians (Beckstrand et al., 2017). Perceived "obstacles" that increased with more frequency and intensity over the intervening 17-year time period included: "family not accepting what the physician tells them about prognosis" (p.101), p=0.000, "family not understanding with the implications of life-saving measures mean" (p.101) p=0.019, and "visiting hours that are too liberal" (Beckstrand et al., 2017, p.101), p=0.024. Beckstrand et al. made several recommendations that could potentially mitigate these perceived barriers, such as improving health literacy (for patients and families), improving physician/team communication, and ensuring patient's wishes were solicited and actualized as written. Results of perceived obstacles from this study and previous studies (Beckstrand & Kirchhoff, 2005; Kirchhoff & Beckstrand, 2000) reflect the complexities critical care nurses encounter when providing EOLC in the ICU. For example, the perceived obstacle of working with physicians who have differing perspectives about patient's prognosis and treatment may be viewed as a logistical challenge, but also has the potential to be a source of conflict in values between critical care nurses and physicians. Thus, these quantitative studies of barriers and facilitators with EOLC provide a basis for more in-depth exploration of the challenges and ensuing implications experienced by critical care nurses when caring for dying patients in the ICU.

2.6.2 Qualitative studies.

In the literature reviewed, a total of 21 studies were found: 18 studies of qualitative design, one study of mixed methods, and two systematic reviews of qualitative evidence. These studies examined critical care nurses' experiences with EOLC through various methodologies, including descriptive explorative, narrative, phenomenology, grounded theory, and qualitative evidence synthesis. The majority of these studies were conducted after the year 2000 and settings included ICUs in Canada and internationally. In particular, there were recent studies that explored nurses' experiences with EOLC in more than one country and cultural context (Endacott et al., 2016; Gallagher et al., 2015), and other studies that examined the experiences of various interdisciplinary professionals with EOLC (Coombs et al., 2012; McAndrew & Leske, 2015). Due to large number of studies found, seven were selected to be discussed in greater detail as they provided a range of perspectives with critical care nurses' experiences with EOLC.

The following portion of the literature review is organized as follows: 1) End-of-life decision-making and transition from curative to EOLC (Coombs et al., 2012; Gallagher et al., 2015; Kirchhoff, Spuhler, Walker, & Hutton, 2000); 2) EOLC after a decision for palliation (Coombs, Fullbrook, Donovan, & Tester, 2015; Efstathiou & Walker, 2014; McMillen, 2008); and 3) Overarching themes of critical care nurses' experiences (Vanderspank-Wright, Efstathiou, & Vandyk, 2017).

2.6.2.1 End-of-life decision-making and transition from curative to EOLC. Over the last two decades, there has been an increasing number of studies that have explored the challenges experienced by critical care nurses with respect to end-of-life decision-making and the associated transition away from life-sustaining treatments to EOLC. For example, Kirchhoff et al. (2000) conducted a cross-sectional descriptive study that examined critical care nurses'

experiences from 3 aspects: 1) their perspectives of what is "good" (p.37) EOLC; 2) their experiences with the transition from curative to EOLC; and 3) their perceived barriers in providing quality EOLC. A total of 21 critical care nurses from ICUs of two different hospitals in the United States participated in the study (Kirchhoff et al., 2000). Participants were divided into focus groups, where researchers moderated and administered a semi-structured group questionnaire. Results revealed that critical care nurses perceived the transition from curative to EOLC to be a "grey area" (p.40), and consequently, they experienced professional and personal "dissonance" (p.40) or conflicts (Kirchhoff et al., 2000). Kirchhoff et al. described that critical care nurses struggled to communicate with the family about the patient's worsening condition while at the same time trying to maintain the family's hope. Critical care nurses also experienced personal conflicts; some questioned the "morality of the extraordinary measures" (p.40) to prolong patients' lives, while others were uncertain of what was best for patients; continued treatment or EOLC (Kirchhoff et al., 2000). The researchers suggested that critical care nurses experienced distress during the transition from curative efforts to EOLC not only as a result of the personal and professional dissonance, but also because the perceived timing and need for the transition varied among physicians and families (Kirchhoff et al., 2000). As such, researchers recommended future studies to also include perspectives of other health professionals and families in the transition from curative care to EOLC (Kirchhoff et al., 2000).

A study was conducted by Coombs et al. (2012), where they examined the challenges for interdisciplinary healthcare professionals in facilitating the transition from active treatment to EOLC in the ICU. The study was conducted in two ICUs of teaching hospitals in England (Coombs et al., 2012). Researchers first performed a retrospective case note review of all patients who died in the ICUs (from 2008-2009) and then they recruited critical care nurses

(*n*=13) and physicians (*n*=13) who were involved in caring for these patients (Coombs et al., 2012). Participants were interviewed by researchers about the end-of-life decisions made and the process of treatment withdrawal in each of those clinical cases (Coombs et al., 2012). Findings of this study revealed three stages in the transition from intervention to EOLC: "making a diagnosis of dying" (p.523) (identifying patients who will not survive), "managing end-of-life consensus" (p.523) (getting all the different medical and nursing teams in agreement for EOLC), and "pushing the door open to facilitate family grieving" (p.524) (introducing an end-of-life focus to families) (Coombs et al., 2012). Highlighted among these stages were the varying perspectives between physicians and critical care nurses that contributed to the complexities of end-of-life decision-making. For instance, physicians often focused on mortality and morbidity issues, whereas critical care nurses valued considering patients' pre-admission quality of life, functional recovery after discharge, and perception of patient/family suffering during end-of-life discussions and decision-making (Coombs et al., 2012). Further, while critical care nurses acknowledged that consensus was required for EOLC, they described being frustrated when they perceived the decision-making process to be prolonged (Coombs et al., 2012). In those circumstances, critical care nurses felt like they were inflicting pain and suffering as they continued carrying out life-sustaining treatments for the patient (Coombs et al., 2012). Researchers identified limitations of the study design to include: self-selecting sample of participants and a potential bias as many of physicians were interviewed more than once (Coombs et al., 2012). However, results from this study are helpful as they revealed the various inter- and intra-personal challenges that physicians and critical care nurses faced within the transition from a curative focus to EOLC (Coombs et al., 2012).

A more recent study by Gallagher et al. (2015) explored critical care nurses' decision-making practices in ICUs of different cultural contexts. Their study had a total of 51 critical care nurses from the following countries: Brazil (*n*=10), England (*n*=9), Germany (*n*=10), Ireland (*n*=10) and Palestine (*n*=12) (Gallagher et al., 2015). Critical care nurses participated in semi-structured interviews with researchers in their respective countries (Gallagher et al., 2015). Using grounded theory, the researchers described the findings in an overarching theme of "negotiated reorienting" (Gallagher et al., 2015, p.798), which is reflective of the actions taken by critical care nurses to reorient the goals of care and to initiate the transition from curative measures to EOLC. Critical care nurses in this study described seeking consensus about the patient being at end-of-life. For example, many of the nurses described having "courage" (Gallagher et al., 2015, p.798) in soliciting the family's understanding of the situation, and in expressing their views to physicians about the patient's deteriorating condition. Findings from this study were slightly different from Coombs et al. (2012), where consensus seeking was primarily between physicians of various medical services. Furthermore, in certain contexts like Brazil and Palestine, critical care nurses were not able to participate in consensus seeking or end-of-life decision-making due to physicians' preferences and practices (Gallagher et al., 2015). In circumstances where patient prognosis was uncertain, critical care nurses expressed apprehension and discomfort in participating in decision-making related to end-of-life and withdrawal of life-sustaining treatments as they felt it would be a form of euthanasia (Gallagher et al., 2015). This finding builds on previous studies (Coombs et al., 2012; Kirchhoff et al., 2000) particularly in regards to critical care nurses being aware of the implications associated with end-of-life decision-making, and whether to continue or withdraw life-sustaining treatments. In addition, results from this study suggest that critical care nurses' level of certainty (in terms of patient prognosis and being

at the end-of-life, and the futility of life-sustaining treatments) can influence their perceived obligation to patients and families in assisting with end-of-life decision-making and with the transition from curative measures to EOLC. While this study explored cross cultural contexts and end-of-life decision-making, Gallagher et al. (2015) have suggested future studies to examine the impact of critical care nurses' cultural and religious beliefs in their involvement with end-of-life decision-making.

2.6.2.2 EOLC after a decision for palliation. A number of studies have also explored critical care nurses' experiences after a decision has been made for EOLC. These studies have focused on critical care nurses enacting the withdrawal of life-sustaining treatments and their care practices for dying patients and their families.

McMillen (2008) conducted a study using grounded theory to explore critical care nurses' experiences with caring for patients who had their treatment withdrawn. A total of eight nurses from an ICU in England participated in semi-structured interviews with the researcher (McMillen, 2008). There were two main themes that resulted from the study: "The nurse's role" (p.254) and "Perceptions about the withdrawal of treatment" (McMillen, 2008, p.257). In the latter theme, McMillen described nurses being conflicted and stressed when decisions and withdrawal of treatment were made too quickly *or* when they were prolonged. For these nurses, they believed it was important for those involved to have the 'right' timing when it comes to the withdrawal of treatment (McMillan, 2008). Furthermore, McMillen described nurses as feeling upset and sad, particularly when they were withdrawing treatments from young patients or patients that they knew for some time. These findings suggest that, for some nurses, the experience of withdrawing treatment is associated with emotional difficulties and ethical complexities (McMillen, 2008).

Efstathiou and Walker (2014) explored the experiences of intensive care nurses who had provided EOLC to patients and families after a decision was made to withdraw treatment. Participants in the study (*n*=13) were from neurosurgical, trauma and general ICUs of a large academic hospital in the United Kingdom (Efstathiou & Walker, 2014). In semi-structured interviews, participants were asked about their perceptions and experiences of providing EOLC (Efstathiou & Walker, 2014). The researchers interpreted intensive care nurses' overall experiences as "doing the best to facilitate a comfortable and dignified death" (Efstathiou & Walker, 2014, p.3190). The findings revealed that these nurses were engaged in a number of practices, such as providing physical care to the dying patient, and facilitating opportunities for the family to be with their loved one (Efstathiou & Walker, 2014). Yet, while they enacted these practices, intensive care nurses also experienced many emotions, and uncertainty with respect to the approach to take when carrying out withdrawal of treatment (Efstathiou & Walker, 2014). Efstathiou and Walker suggested that there appeared to be at times a lack of clear communication between physicians and intensive care nurses about the withdrawal of treatment processes following decision for EOLC. Other times, intensive care nurses experienced conflicts with delaying the act of withdrawal of treatment for families to be present at the bedside, and whether this was 'right' for the patient (Efstathiou & Walker, 2014). This was similar to the results from McMillen's (2008) study, where the timing of withdrawal of treatment was especially concerning to intensive care nurses.

Coombs et al. (2015) conducted a mixed methods study using surveys and focus groups to explore intensive care nurses' (*n*=220) experiences and attitudes towards EOLC, in particular their beliefs, their involvement with decision-making and their perception of EOLC practices. A cross sectional survey questionnaire was sent to nurses, who worked in ICUs of four large

tertiary hospitals in New Zealand (Coombs et al., 2015). These intensive care nurses ranked their level of agreement (from 'strongly disagree', 'do not know', to 'strongly agree') with 16 statements about EOLC practices (Coombs et al., 2015). The top three EOLC practices that the majority of intensive care nurses strongly agreed with were: "The patient should always be given the opportunity to receive last rituals that are appropriate to the religious and spiritual beliefs of the patient and family" (p.85); "The patient should be provided with effective pain relief" (p.85); and "Family or friends of the patient should be permitted to visit any time, day or night" (Coombs et al., 2015, p.85). Yet, intensive care nurses also had varying responses for certain EOLC practices, such as continuing nutrition/fluid support (strongly disagree 56.1%, strongly agree 20.4%), providing passive limb exercises (strongly disagree 31.1%, strongly agree 46.9 %) and performing endotracheal suctioning to maintain the airway of the patient (strongly disagree 25.5%, strongly agree 60.2%) (Coombs et al., 2015). As part of the mixed methods design, there were four focus groups held with intensive care nurses (*n*=18), and they reiterated many of the findings regarding EOLC practices (Coombs et al., 2015). For instance, some participants perceived nutrition and fluid support to be a comfort to families, while others believed it could cause increased respiratory secretions and distress for the patient (Coombs et al., 2015). Even though there were different perspectives, Coombs et al. suggested that intensive care nurses perceived EOLC practices to be centered on promoting patient's comfort. These study findings build on previous literature, particularly in the type of practices intensive care nurses carried out in their care of the dying patient and their family. The theme of uncertainty regarding some EOLC practices remains consistent with other studies (Efstathiou & Walker, 2014).

2.6.2.3 Overarching themes of critical care nurses' experiences. Vanderspank-Wright et al. (2017) conducted a systematic review on the experiences of critical care nurses who have

cared for patients and families throughout the process of withdrawal of life-sustaining treatment. Modelled on the Joanna Briggs Institute systematic review methods, Vanderspank-Wright et al. examined a total of 13 studies (12 qualitative and 1 mixed-methods) that met the inclusion criteria. They interpreted and synthesized findings into four themes: "Navigating complexity and conflict" (p.17), "Focusing on the patient" (p.17), "Working with families" (p.17), and "Dealing with emotions related to treatment withdrawal" (p.17) (Vanderspank-Wright et al., 2017). In the first finding "Navigating complexity and conflict" (p.18), Vanderspank-Wright et al. explained how several studies reveal critical care nurses' experiences of interpersonal conflict with physicians and families in the time leading up to the decision-making, and during the withdrawal of treatment. The other findings of "Focusing on the patient" (p.23) and "Working with the families" (p.23) analyzed studies that show how critical care nurses intently focus on providing comfort for the dying patient, and facilitating positive families' experiences during the withdrawal of treatment (Vanderspank-Wright et al., 2017). In the last finding "Dealing with emotions" (p.23), Vanderspank-Wright et al. reviewed studies that describe the many emotions experienced by critical care nurses (such as feeling upset, and exhausted) during the withdrawal of treatment. Findings of this systematic review provided a comprehensive overview of critical care nurses' experiences with withdrawal of treatment (before and after) and highlighted they are the primary agents of carrying out withdrawal of treatment (Vanderspank-Wright et al., 2017).

The qualitative studies and the systemic review on qualitative evidence discussed as part of this literature review raised several important issues. First, the context of death and dying in the ICU has changed from being the result of trauma or sudden cardiac events to those involving patients with chronic illness and an elderly population (Coombs et al., 2012). Second, while critical care nurses may feel frustrated and encounter conflicts with families and physicians,

studies (Coombs et al., 2012; Gallagher et al., 2015) have also revealed critical care nurses experienced inner conflicts, particularly with participating in end-of-life decision-making. There has been increasing recognition that critical care nurses have their own views and beliefs about patients' well-being at the end-of-life. Studies conducted in several cultural settings (Coombs et al., 2012; Gallagher et al., 2015) revealed that critical care nurses' views and beliefs were often contextualized within their religious framework or social norms. Third, studies (Coombs et al., 2015; Efstathiou & Walker, 2014) highlighting critical care nurses' experiences after end-of-life decision-making revealed aspects of uncertainty and emotional labour with the care of dying patients and their families. Although some of these studies alluded to critical care nurses' experiences as being 'moral', these studies, however, were limited in terms of the analysis or discussion as to how critical care nurses' values influenced the provision of EOLC. Furthermore, another limitation to these qualitative studies is that they were primarily conducted in ICUs of teaching hospitals.

2.7 Community critical care nurses' experience with EOLC.

Studies exploring critical care nurses' role and experiences with EOLC have also included ICUs of community hospitals (McClement & Degner, 1995; Noome, Dijkstra, van Leeuwen, & Vloet, 2016). However, these studies rarely make any distinctions in terms of description or analysis between the ICUs of community hospitals and those in teaching hospitals. Two studies were found in the literature search to be explicitly conducted in ICUs of community hospitals (Gross, 2006; Sarti et al., 2015).

Using a quantitative design and replicated methods from earlier studies (Kirchhoff & Beckstrand, 2000), Gross (2006) explored critical care nurses' perceived barriers and facilitators with EOLC in the context of ICUs of a 300-bed community hospital in the United States. A

questionnaire (25 items of 'perceived barriers' and 23 items of 'perceived facilitators' on 5 point Likert scale) was distributed, and a total of 30 critical care nurses participated (Gross, 2006). Results from this study found that critical care nurses perceived the following to be "extremely large" (p.97) obstacles: "employing life-sustaining measures at families' request although patient had signed advanced directives requesting no such care" (p.98); "some physicians who are overly optimistic to the family about the patient surviving" (p.98); and "the nurse having to deal with angry family members" (Gross, 2006, p.98). Gross discussed that the differences in perceived obstacles from this study may be due to less experienced (*M*=5.75 years) critical care nurses compared to previous study samples, such as Beckstrand and Kirchhoff (2005) where the study sample of critical care nurses had more experience in ICU (*M*=15.4 years). Gross suggested that it was possible that the critical care nurses in their study may not have yet found ways to work with physicians or families in end-of-life decision-making. Critical care nurses also perceived facilitators to be similar as other studies (Beckstrand & Kirchhoff, 2005; Kirchhoff & Beckstrand, 2000) where they found it was extremely helpful to have physicians agreeing with the direction of care, to have family acceptance of patients' death, and to be able to provide a peaceful dignified death scene.

As previously mentioned, Sarti et al. (2014) conducted a mixed method study to explore the gaps in the provision of critical care in the ICU of a Canadian community hospital. Sarti et al. used numerous methods to collect quantitative (community hospital database, questionnaires and simulations) and qualitative (interviews, focus group, and on-site walk through) data, and they identified the provision of palliative care to be an area needing improvement. Findings revealed that healthcare providers of the community hospital ICU held differing perspectives about palliative care, specifically regarding the timing and the responsibility of initiating end-of-life

discussions with patients and families (Sarti et al., 2015). For instance, in the focus groups, critical care nurses expressed difficulty in collaborating with physicians to address end-of-life issues, which was similarly expressed in the study by Gross (2006). Due to a number of factors, including communication issues and differing perspectives, discussions and decision-making about end-of-life occurred inconsistently with patients and families (Sarti et al., 2015). The study also highlighted how contextual features of the community hospital ICU influenced the provision of palliative and EOLC, such as through physician availability, frequent transfers to tertiary centres, and the priority in caring for critically ill patients (Sarti et al., 2015). Sarti et al. (2015) suggested that community hospital ICU providers had not yet incorporated palliative and EOLC as part of their critical care practice as compared with their counterparts in urban and academic ICU settings. Building on this study's insights, Sarti et al. suggested further exploration of community intensive care nurses' perspectives on their role and their experiences in the provision of palliative and EOLC is needed.

2.8 Critical reflection and summary of literature

In the literature review conducted, two studies (Gross 2006; Sarti et al., 2015) were found to be specifically conducted in ICUs of community hospitals. Both of these studies suggest intensive care nurses' perceptions and experiences with EOLC to be different from their counterparts in ICUs of teaching hospitals. Thus, further exploration of intensive care nurses' experiences with EOLC is needed within the community ICU context.

The literature review also revealed various aspects of intensive care nurses' experience with EOLC. Findings from quantitative studies indicate that critical care nurses experience a number of barriers with EOLC, particularly conflicts with physicians and families (Beckstrand & Kirchhoff, 2005; Beckstrand et al., 2017; Gross, 2006; Kirchhoff & Beckstrand, 2000). Many of

the qualitative studies described critical care nurses to experience conflicts related to end-of-life decision-making (Kirchhoff et al., 2000), uncertainty with certain EOLC practices and withdrawal of treatment (Efstathiou & Walker, 2014; Coombs et al., 2015), as well as emotional labour while caring for dying patients and their family (Efstathiou & Walker, 2014; McMillen, 2008).

While some of these studies described conflicts with end-of-life decision-making and obligations to dying patients and families, they had limited exploration or analysis as to how ICU nurses' values guided their provision of EOLC. In many of the studies reviewed, the moral aspects of ICU nurses' experiences were nuanced within a variety of contexts. Therefore, it was necessary in the majority of instances, to read between the lines of described experiences in order to appreciate the impact of nurses' values on their moral engagement and agency with respect to palliative and EOLC in the ICU. In the next chapter, the concepts of morality, moral identity and moral agency, and how these concepts are embedded in extant literature will be discussed. From this literature review, it is evident that future studies which account for the moral dimensions of nurses' practice in an explicit way will be valuable to better understand the ethical complexities critical care nurses' experiences with EOLC, including in the community ICU context.

Chapter 3: Methods

The following chapter provides an overview of the research methodology including the design, its methodological underpinnings, sample, setting of the study and the procedures taken for data collection, analysis, and participant protection. The theoretical and disciplinary influences, as well as the researcher's personal experiences brought to the study, are elaborated on. The conceptual notions of moral experience, space and place that informed the design of the study, and the interpretation and discussion of the findings are also presented.

3.1 Research design

Interpretive Description (ID) is a qualitative research approach with a focus on exploring human phenomena that are relevant and practical to a discipline (Thorne, 2008). ID was initially developed by Dr. Sally Thorne, and two graduate students, Sheryl Reimer Kirkham and Janet MacDonald-Emes in 1997. Their initial goal was to propose a qualitative research method that was geared towards the discipline of nursing, and not borrowed from other qualitative research traditions, such phenomenology, grounded theory and ethnography (Thorne, Kirkham, & MacDonald-Emes, 1997). ID incorporates both "inductively derived description" (p.47) as well as an interpretive perspective, and therefore allows researchers to observe and document, but also to seek patterns, relationships and underlying meanings within the human phenomena of interest (Thorne, 2008).

With ID, researchers can generate knowledge with clinical significance and that contributes to the overall scholarship of a discipline (Thorne, 2008). For example, Stevenson, Jack, O'Mara and LeGris (2015) used ID to explore psychiatric nurses' personal experiences of patient violence in the context of inpatient work. Using ID, the researchers were able to add insights to the overall phenomenon of patient violence by describing how it was experienced by

nurses, and by highlighting the contributing factors (patient, nursing and unit-related) to this problem (Stevenson et al., 2015). Other studies utilizing ID have explored clinical issues, such as nurses' care of critically ill, non-sedated, mechanically ventilated patients in the ICU (Laerkner, Egerod, & Hansen, 2015), and intraoperative nursing care (Kelvered, Öhlén, & Gustafasson, 2011). For the current study, ID was selected for its disciplinary framework as well as its applicability to explore clinical issues. Furthermore, the use of ID was fitting, because the subject of investigation was to explore nurses' experiences with their provision of EOLC.

3.2 Methodological assumptions

ID is underpinned by a constructivist inquiry paradigm (Thorne, 2008). An inquiry paradigm refers to "a set of beliefs" (p.107) that define what researchers acknowledge as reality, their relationships to the subject of investigation, and their methods of seeking knowledge about that subject (Guba & Lincoln, 1994). Researchers who incorporate study designs underpinned by constructivism assert a relativist ontology wherein reality is socially constructed (Guba & Lincoln, 1994). For example, the researcher acknowledges that people experience and hold multiple subjective constructions of realities based on their social context (Guba & Lincoln, 1994). As such, one of the assumptions of constructivism is that people are the experts in their experiences and in their constructions of reality. Relating to epistemology and methodology, the second assumption is that the researcher is active in interacting and carrying out dialogue with people to gain insight about the subject of investigation (Guba & Lincoln, 1994). By being engaged and reflecting on the discussions, the researcher creates a more sophisticated and evolved perspective about the subject of investigation from his or her previous understandings (Guba & Lincoln, 1994).

3.3 Theoretical Scaffolding

When using ID, the researcher is an active participant in the process and is both instrumental in forming the investigation as well as the interpretation of the findings (Thorne, 2008). Thus, it is important that the researcher engage in reflection and acknowledge upfront any influences brought to the study (Thorne, 2008). Thorne (2008) has labelled this process as "Theoretical Scaffolding" (p.54) and has suggested three elements to consider: 1) theoretical allegiances, 2) disciplinary positioning, and 3) personal positioning. The following descriptions are the researcher's theoretical and disciplinary influences, and personal experiences brought to the study.

3.3.1 Theoretical influences

Despite Thorne's (2008) suggestion that studies using an ID design are not required to be explicitly located within one form or another of theorization, the researcher intently used theory in this study to inform the design, the interpretation, as well as the discussion of the findings. Eakin (2016) has suggested and emphasized the importance of theory-centered qualitative research in applied sciences, whereby the use of theory is not a subordinate priority to solving practical health problems, but rather an imperative focus of the methodology. For this study, the researcher used two theoretical lenses - nursing ethics and nursing geography. Specifically, within nursing ethics and the construct of moral experience, concepts of moral identity and moral agency are explored. Furthermore, in the lens of nursing geography, ideas about space and place in nursing are also considered. In the following section, these theoretical lenses in relation to their conceptual underpinnings and their applicability to the study are discussed.

3.3.1.1 Nurses' moral identities. While there are various meanings associated with nursing ethics, it can be broadly understood as the philosophical scholarship and formal study of values,

virtues, and responsibilities that guide nurses in their practice and that contribute to the overall betterment of the health and well-being of people within society (CNA, 2017a; Yeo, 2010). In recent years, some nursing scholars have argued feminist ethics is relevant and helpful in approaching the everyday moral issues encountered by nurses (Storch, Rodney, & Starzomski, 2013). Within feminist ethics, morality is viewed to be context specific and continuously developed through interpersonal relationships (Walker, 1998). Furthermore, morality is seen to be closely related to identity as it reflects who people are, their beliefs and their perceived responsibilities which are in essence expressed as moral identities (Peter & Liaschenko, 2013; Walker, 1998).

Nurses construct their own moral identities through narrative expressions of who they are, what they believe and what they do (Doane, 2002; Peter & Liaschenko, 2013). For instance, studies have revealed nurses' moral identities to be reflected in the stories they tell and to be characterized by positive values, such as caring for others, relieving suffering, providing choice for patients, and ensuring patient and family well-being (Peter et al., 2016; Rodney et al., 2009). With these positive values, Rodney et al. (2009) suggested that nurses work toward an overall moral good, by doing the right or best course of action in the situation and with those involved. While nurses' moral identities can be positively constructed, nurses can also hold moral identities that are damaged (Peter et al., 2016). Liaschenko and Peter (2016) described that nurses can destructively identify with master narratives (or cultural stories) that inferiorly represent nurses and that prescribe them with certain values and practices. For example, these master narratives can be societal stereotypes of nurses as typically women, subordinates to physicians, and virtuous caregivers (Peter & Liaschenko, 2013). As nurses internalize these

master narratives, they can hold damaged moral identities whereby they may perceive themselves as not having any capacity to carry out the moral good in their responsibilities.

Nurses' moral identities are closely related to moral agency (Liaschenko & Peter, 2016). Peter and Liaschenko (2004) described moral agency as "the capacity to recognize, deliberate/reflect on, and act on moral responsibilities" (p.221). In a study by Varcoe et al. (2004), nurses identified with being moral agents as they recognized their moral responsibilities, such as practicing competently and protecting patients' safety. Varcoe et al. (2004) elaborated that nurses in their study described that they gained moral knowledge of what was 'right' or 'good' through academic, professional, and personal experiences, such as formal nursing education and religious teachings (Varcoe et al., 2004). Similarly, in an earlier study by Doane (2002), she found four ways in which nurses' moral identities had taken form: narrative, dialogical, relational and contextual (Doane, 2002). Within the narrative form, nurses shared both personal narratives of acting ethically and master narratives of what it meant to be an ethical nurse (Doane, 2002). The dialogical form of nurses' moral identities developed through reflections on inner tensions about 'what is right' in particular situations (Doane, 2002). In the relational form, nurses' moral identities were constructed from certain experiences of personal and professional relationships (Doane, 2002). Lastly, in the contextual form, nurses' moral identities were shaped and influenced by their surrounding social-political work environment. In Doane's (2002) study, for instance, she described forces in nurses' work environments, such as limited resources and a biomedical focus, and elaborated on how these forces influenced the way nurses took action. At times, these forces disempowered nurses to act morally and consequently, damaged their moral identities (Doane, 2002). For instance, in her study, nurses working in the operating theatre described their experiences of providing care to patients and meeting the

competing demands of the surgeries performed to be immensely stressful, demoralizing, and undermining their perceptions of themselves as moral agents (Doane, 2002). In contrast, however, Rodney et al. (2009) described how relational factors in the workplace, such as supportive collegial relationships and shared decision-making, facilitated nurses' moral agency resulting in strengthened moral identities. Both of these studies demonstrate that elements in nurses' practice environments have the potential to either positively enhance or negatively constrain their moral agency, and ultimately their moral identities.

Nurses' moral identities and moral agency are concepts that provide a theoretical lens that can be used to explore community ICU nurses' experiences with EOLC. For instance, studies have shown that ICU nurses are involved in EOLC by assisting in the decision-making process, addressing goals of care, and by providing dignity conserving care for the dying patient and family (Bach et al., 2009; Fridh et al., 2009). Although not always explicitly discussed as *moral*, these studies reveal nurses' values, perceptions of responsibilities, and commitments in caring for dying patients. For example, while participating in the decision-making process, many ICU nurses perceived their role as protecting the patient from suffering and harm (Bach et al., 2009). When this value was challenged, various ICU nurses enacted their moral agency through advocacy, for example, by voicing out their concerns to attending physicians and members of the interdisciplinary team (Bach et al., 2009).

By intently using this theoretical perspective in the research study, accounts of participants' experiences with EOLC can be framed in terms of who they identify themselves to be, what is important to them, and how they take action for what they believe in. This approach can be beneficial as it explicitly puts forth how nurses, as moral agents, experience the complexities of providing EOLC in a community ICU. Further, the approach can bring to light

nurses' moral agency amidst the community ICU context. This context, in turn, can be viewed and explored using the theoretical concepts of space and place.

3.3.1.2 Space. Malone (2003) analyzed spatial dynamics with the assumption that all humans have certain dimensions, and furthermore, proximity and distance to other people and to places have significance and meaning in the way they are experienced. Malone (2003) theorized space as the proximity or distance within the nurse-patient relationship. She described three levels of proximity: physical, narrative and moral (Malone, 2003). Physical proximity refers to the physical touch and nearness between the nurse and patient through daily nursing care, such as assessments and interventions for comfort (Malone, 2003). Narrative proximity is relational in nature and implies that the nurse hears and knows the patients' biographical story and their meaning of illness, and then relays this knowledge on to those who also care for the patient (Malone, 2003). Moral proximity occurs when the nurse develops both physical and narrative proximity. Specifically, the nurse gains situated knowledge of the patient through physical intimacy and relational connection, and perceives the patient as a person (Malone, 2003). In certain situations, the nurse uses this situated knowledge, interprets and takes a moral course of action on behalf of the person (Malone, 2003). These three levels of proximity in the nurse-patient relationship are interrelated, temporal (time-dependent) and can be affected by spatial structures, which are the localized institutional or organizational structures (Malone, 2003).

Malone (2003) suggested that spatial structures are not neutral, but rather operate under ideologies of power and economics (such as commodity exchange). Malone theorized that certain changes within these spatial structures can constrain proximity and subsequently, render more distance within the nurse-patient relationship. For instance, Malone described how reduced length of hospital stay for patients has shortened the time available for nurses to spend directly

caring for them, and eliminated certain traditional nursing practices, such as "backrubs" (p.2321), which provided nurses an opportunity for assessment, providing comfort, and relationship building with the patient. Malone also highlighted that changes in spatial structures, like reduced length of hospital stay, disrupts the levels of proximity in nurse-patient relationships, and instead emphasize efficiency and productivity in nursing work. Furthermore, she argued that consequences of the latter were detrimental to nursing as the changes threatened the moral engagement of nurses, particularly in taking up moral responsibility for the provision of care for patients (Malone, 2003).

Malone's (2003) conceptualization of space and its three levels of proximity (physical, narrative, and moral) are relevant to nurses' provision of EOLC in the ICU. Extant literature has highlighted nursing care for the dying patient in the ICU to include symptom management, physical care and psychosocial support (Efstathiou & Walker, 2014; Ranse et al., 2012). In order to provide these aspects of EOLC, nurses need to maintain a nearness (or proximity), and a physical intimacy with the dying patient. However, nurses also engage in other proximities as well. For example, in a qualitative study by Ranse et al. (2012), they described nurses' intent to "get to know" (p.8) the dying patient (particularly if he or she was unable to communicate) by listening to the stories shared by family members. This relational interaction allowed ICU nurses to gain knowledge of the personhood of the dying patient and to adjust their care accordingly (Ranse et al., 2012). This example demonstrates a narrative proximity that is sustained between the ICU nurses and the dying patient. In the same study, there were ICU nurses who also took the time and effort to assist in creating memories for the patient's family with the intent of facilitating a positive experience for them (Ranse et al., 2012). It can be suggested that these ICU nurses also maintained a moral proximity by taking actions, like creating memories and this

would be in keeping with the dying patient and his or her families' desires, preferences and values. Austin (2012) also highlighted this aspect of nurses' moral proximity with patients and families. She explained that nurses and other professionals are positioned "up close to the most profound aspects of human existence: birth and death, pain and suffering… It is the predicament of health professionals that their roles involve participating in momentous decisions that deeply affect the lives of patients and families" (Austin, 2012, p.29). ICU nurses' enactment of EOLC through physical, narrative and moral proximity has significant implications for dying patients and their families.

Malone's (2003) conceptualization of space can be helpful in this current research study in ways that align with the nursing ethics concepts previously discussed. First, the concept of spatial dynamics in the nurse-patient relationship provides a lens to explore possible ways community ICU nurses are morally engaged in caring for dying patients and their families. An awareness of Malone's (2003) three levels of proximity is important, because it has the potential to facilitate the interpretation of participants' moral experiences that might not otherwise be seen. Second, the concept of spatial dynamics within localized structures (or work environments) can provide reasoning as to why community ICU nurses' moral agency with EOLC may be inhibited or enhanced. In this research study, participants' stories and descriptions of how they enact EOLC for dying patients and their families may be nuanced within the context of relationships and social systems, and how they were able or unable to navigate elements in the workplace in order to provide EOLC. Lastly, the analysis of participants' community ICU context may illuminate how it continues to reinforce, either positively or negatively, their moral identities and their moral agency.

3.3.1.3 Place. In nursing geography literature, the concept of place has diverse meanings and it is often used inconsistently (Carolan, Andrews, & Hodnett, 2006). For example, Bender, Clune and Guruge (2009) described place in community nursing to be geographical locations, but also people's social and cultural experiences associated with those locations. Carolan et al. (2006) described their understanding of place to be a setting of healthcare services, a healing environment for patients, and the social environment that influences nursing care. For this current study, the concept of place will be explored through the constructs of 'place of death', and nurses' experiences with providing EOLC within a community ICU.

Place of death is not exclusive to nursing but also in health geography literature (Castleden, Crooks, Schuurman, & Hanlon, 2010). Place of death is generally described in terms of the locations of peoples' deaths and the associated experiences and meanings (Carolan et al., 2006). The ICU is generally perceived as a non-traditional place for dying compared with traditional places, such as hospices and palliative care units, which are purposefully designed for the care of dying patients (Liaschenko et al., 2011). In contrast, the purpose of the ICU is often prioritized as a place to save patients with life-sustaining treatments and to avoid death (Endacott et al., 2016; Liaschenko et al., 2011). Yet, as previously discussed, death is a common occurrence in ICUs of all Canadian hospitals. While death is a possibility at any point of patient's stay in the ICU, most often death occurs following a deliberate change in the direction of care from providing life-sustaining treatments to withdrawing or limiting them and actively implementing EOLC (Endacott et al., 2016; Johnson, Cook, Giacomini, & Willms, 2000; Liaschenko et al., 2011). This change in the goals of care or ICU outcomes is a process whereby physicians, nurses and other allied healthcare professionals are able to create and foster a

"natural" (p.284) or a 'good death' for patients in the ICU as opposed to an alternative one with prolonged suffering and loss of dignity (Johnson et al., 2000).

A good death has been characterized in a number of ways in critical care nursing literature. For instance, in Bratcher's (2010) study, nurses described a good death to be: not dying alone, being free of pain and suffering, and accepted by patients and/or family. Additionally findings reported from various studies have described that a good death includes providing an appropriate care environment or spaces in the ICU for the dying patients and their families (Beckstrand, Callister, & Kirchhoff, 2006; Brennan, Prince-Paul, & Wiencek, 2011; Endacott et al., 2016; Liaschenko et al., 2011). For example, in a study by Ranse et al. (2012), nurses transformed the patient's room with the objective of creating an intimate and peaceful place. Specifically, nurses removed monitors and machines, implemented softer lighting, and added music, photos and other personal items into the room to help families spend time with the dying patient (Ranse et al., 2012). These nurses were changing the place of the ICU to be more appropriate for dying, where the patients' personhood and dignity are maintained (Ranse et al., 2012). Although nurses perceived the ICU as a non-traditional place for death and dying, they also viewed it was important that dying patients stay in the ICU (Liaschenko et al., 2011). In the study by Liaschenko et al. (2011), some of the nurses perceived the transferring of dying patients out of the ICU to be a displacement, which was disruptive to the continuity of care, the relationships already established, and to the experience of death. For these nurses, it seemed like maintaining a place for the dying in the ICU was significant in achieving a good death for patients.

The construct 'place of death', together with the associated meanings of whether and how a 'good death' is possible in this place, are important considerations for this research study. First,

these ideas can assist with the interpretation of how the participants may provide EOLC in specific ways in the community ICU. For instance, participants may allude to nurses' practice of transforming the patients' rooms during EOLC, which then can be interpreted and explained by a belief of accommodating the death and dying of patients in a place where it is often perceived undesirable or unexpected. Second, these ideas can help with the interpretation of how participants perceive barriers in providing EOLC in the community ICU. These barriers may relate to particular views about the purpose, function and how death occurs in the place of the community ICU.

3.3.2 Disciplinary influences

As a researcher, I locate myself in the discipline of nursing. I believe that nursing is fundamentally a moral practice, and that nurses are moral agents. For instance, nurses' practice is underpinned by values and reflects ethical commitments to care for patients, families, and communities (CNA, 2017b). Within nursing practice is the provision of palliative and EOLC, which is also guided by moral principles, such as fostering comfort, alleviating suffering, and preserving the dignity of the dying patient and the family (CNA, 2017b).

3.3.3 Personal experiences

I entered this study with previous clinical knowledge and nursing experiences of caring for patients and families in a tertiary critical care unit, most specifically a cardiac intensive care unit. Part of my experience has included providing palliative and EOLC to dying patients and their families in this setting. For example, one of the most poignant experiences I have had, was caring for a young patient with end-stage heart failure. I looked after this patient for several shifts and developed a trusting relationship with him and his family. I carried out an increasing number of life-saving treatments as the patient's illness worsened and until several of his organs

were failing. On several occasions, I participated in family discussions, and I communicated the patient's condition and his response to treatment with the attending physicians and the family. At the bedside, I sat with the patient and his family as they received difficult news, and as they faced each step of the dying process. I struggled at times with what to say about death, and I experienced deep sadness and grief for them as I witnessed their agony and their loss. I was present in some of the patient's last moments of alertness as he came to an acceptance of his nearing death, and as he said his final goodbyes to each of his family members. I felt privileged to witness and to be a part of those moments. The experience taught me invaluable lessons of who I was as a person and as a nurse, and it laid the foundation for my interest in caring for dying patients in the cardiac and critical care context.

I have also intimately experienced some of the challenges of providing palliative and EOLC in a cardiac intensive care unit. I have encountered situations where I felt conflicted with the timing of some discussions between the interdisciplinary team, patients and families for palliative and EOLC. For instance, I have taken care of dying patients where all life-saving measures were exhausted before the option of palliative and EOLC was considered or discussed. I have also faced situations where it was difficult to advocate for my patients' wishes, because of different priorities held by the interdisciplinary team. Through these challenges, I have become more aware of the values that underpin my own perspectives and actions, but also those of others. As such, these experiences continue to influence my desire and my motivation to study EOLC issues in a critical care context.

Having reflected on the literature review, the disciplinary and theoretical perspectives, the following summarize my assumptions about nurses' moral experiences with EOLC in a community hospital ICU, which influenced my conduct of this study:

1. Nursing is a value-laden profession. Nurses are accountable for their actions to patients, families, communities and society at large.
2. Nurses are people embodied with values and with responsibilities, and they are motivated to act ethically, aspiring to what is right, good, and just.
3. One of the areas of responsibility for nurses is the care of dying patients. Nurses carry out various aspects of EOLC that are underpinned by specific values, such as dignity and informed decision-making.
4. The ethical practice of nurses can be influenced by a number of factors in a community hospital ICU context, such as the pressures of time, the limitations of resources, and collegial support. These factors can constrain or support nurses' ability to act ethically, particularly with the provision of EOLC.

3.3 Setting

This study was conducted in the critical care unit (CCU) of a community hospital located in Ontario, Canada. This is a large community hospital that has approximately 200 patient beds and serves a rural catchment area including neighbouring towns, as well as a First` Nations population (MOHLTC, 2006). At the time of the study, the community hospital did not have a palliative care specialist or a palliative care consult team. Furthermore, the community hospital was in the process of developing a medical assistance in dying (MAiD) policy.

The CCU is the only intensive care unit (ICU) within the community hospital and it has less than 15 beds (exact number withheld to protect confidentiality). Two beds in the unit are used for emergencies and for temporary patient stabilization. Based on the Critical Care Service Ontario (CCSO, 2015), the CCU is considered a Level 3 ICU with the capability of providing invasive mechanical ventilator support. The unit is equipped to have up to four patients on

mechanical ventilators, and any additional patients requiring mechanical ventilation are transferred out to a teaching hospital. Although patients are able to receive renal replacement therapies, such as continuous renal replacement therapies (CRRT) in some Level 3 ICUs, this CCU is not equipped for that type of care.

The CCU generally serves a mixed medical and surgical adult patient population with occasional pediatric patients. For instance, patients are admitted to the CCU with life-threatening illnesses, such as myocardial infarction and sepsis, as well as injuries and worsening of pre-existing illnesses, like chronic obstructive pulmonary disease (COPD) and diabetes mellitus. As such, the medical care of these patients in the CCU is managed by intensivists (physicians with critical care training).

While the study was conducted in a CCU, participants frequently used the abbreviated terms CCU and ICU synonymously to describe the unit. However, from this point onwards, the term ICU will be used for consistency and to avoid confusion with Coronary Care Unit, which is typically abbreviated to CCU.

As should be clear from the theoretical underpinnings described above, an appreciation for the moral dimensions of nurses' EOLC practice requires an understanding of the contexts in which they work. As such, a preliminary contextual description was conducted. This preliminary description (sections 3.3.1 and 3.3.2) includes a depiction of the nurses' physical work space and a description of the nursing staff, their general roles and responsibilities within the unit and in other spaces of the hospital. Additional contextual detail about the community ICU is presented in the findings section of this thesis (Chapter 4).

3.3.1 Mapping of the ICU

This ICU is similar to other teaching ICUs in many respects. All patient rooms in the ICU are private. Each room has a patient bed, a mounted cardiac monitor, and sometimes other equipment (e.g. mechanical ventilators or intravenous (IV) pumps). Some of these private rooms are adjacent to each other and have sliding doors between them. Since the ICU is shaped like a rectangle, the private rooms either face other rooms or the nursing station (see Figure 1). The nursing station is equipped with desks, chairs, telemetry monitors, computers, and shelves. Staff move in and out of the nursing station throughout their shifts. Sometimes staff will station a small desk or portable workstation computer at the entrance of the private room, where they are able to more closely monitor and maintain close physical proximity to the patient. The main doors of ICU are off to the side and are locked to the public. Visitors need to call in to the unit for access and visitation. A small family room with seating is located outside the unit doors.

Figure 1. Map of the ICU

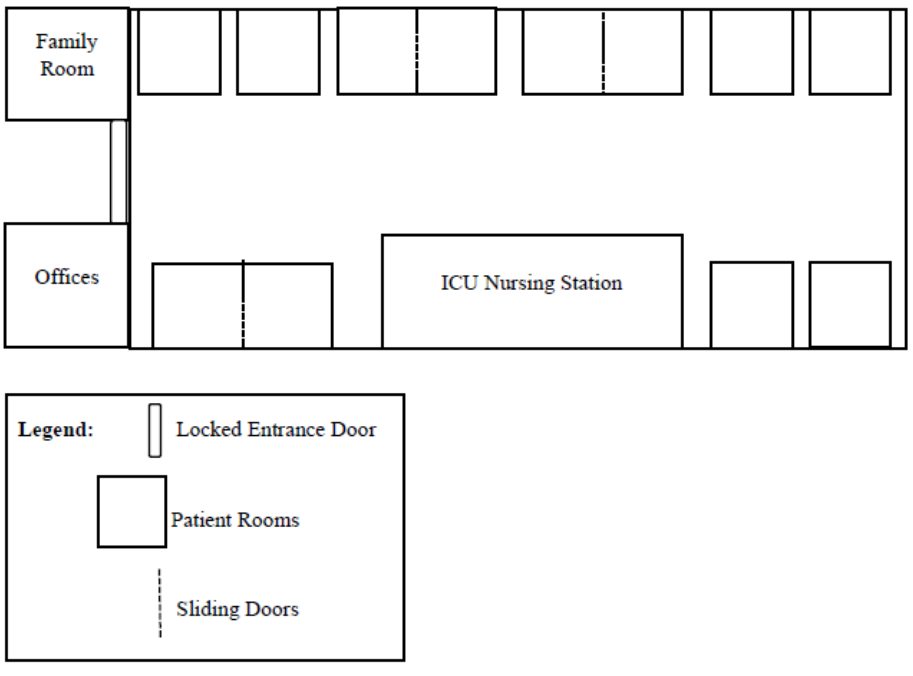

Figure 1. An approximate schematic drawing of the physical layout of the ICU.

3.3.2. Nursing Staff.

At the time of this study, the ICU was staffed with less than 40 registered nurses (RNs) (exact number withheld to protect confidentiality): almost two thirds of these were full-time, and others were part-time and casual. The nurse to patient ratio in the ICU was usually one nurse to two patients, but the ratio could vary depending on the acuity of the patients. For example, in situations where patients were mechanically ventilated, the ratio was one nurse to one patient.

On every shift, there were three roles assigned to nurses. The three roles were assigned by rotation so that all nurses shared the associated responsibilities (see below). The only exception is the Charge Nurse role which was usually assigned to nurses who had more experience in the ICU.

The three roles were "Charge Nurse", "Telemetry Monitoring", and "Codes". The "Charge Nurse" was primarily responsible for managing the beds in the ICU, but also fulfilled several other responsibilities such as creating the patient assignment for the next shift, delegating and assisting in the coverage of breaks for nurses. The nurse assigned to "Telemetry Monitoring" was responsible for overseeing 10 patients on portable telemetry throughout the hospital. As part of this role, the nurse was tasked with assessing, intervening, and documenting any cardiac issues experienced by patients and any cardiac rhythm changes noted on the telemetry monitors (located in the nursing station). The "Codes" role encompassed a nurse who was responsible for responding to and attending to "codes" throughout the hospital, including the medical and surgical floors, as well as the Emergency Department (ED). There were a number of designated "codes", such as "code blue" signalling patient cardiac arrest and "code stroke" for patients experiencing stroke symptoms. The ICU nurses were also tasked with responding to "code ERTs" (Emergency Response Team), which were initiated by nurses throughout the hospital for

patients whose clinical condition have worsened physiologically (e.g. having shortness of breath, dropping blood pressure, unable to maintain airway), thus requiring emergency assessment and intervention. These "codes" were usually announced overhead in the hospital paging system, and then responded to by a critical care team that included the assigned nurse from the ICU, a nurse from the emergency department (ED), and an intensivist if they were available.

3.4 Sample

In an ID study design, predicted sample sizes can vary depending on the nature of the research question, and the frequency of the observed phenomenon (Thorne, 2008). Purposive sampling in ID is defined as a "representative sampling technique" (p.90) in which the aim of the researcher is to select a setting and participants that would have experienced the phenomenon of interest (Throne, 2008), in this case, RNs who have had experiences caring for dying patients in the ICU. Seven participants were included in this study.

3.4.1 Eligibility Criteria

The following inclusion criteria were used for the sampling and the recruitment of participants. Participants were required to: (1) be a Registered Nurse (RN) employed and working in any capacity (full time, part-time or casual) in the ICU of the community hospital; (2) have previous experiences in caring for dying patients in this ICU; and (3) be English speaking.

3.4.2 Recruitment

Recruitment of participants occurred after the ethics approval was received from the University of Ottawa Research Ethics Board (REB) and the study site's research committee. The researcher created specific recruitment materials, such as a flyer (see Appendix A), business cards (see Appendix B) and website (see Appendix C), to provide information about the study to potential participants.

In the recruitment phase, the researcher coordinated with the unit manager for dates to enter the unit and meet with potential participants. During these scheduled times, the researcher met with nurses on the unit, and briefly introduced herself and the study's overall purposes, benefits and the participation required. The researcher extended invitations to participate in the study to nurses who met the inclusion criteria and they were provided with business cards. With permission from the unit manager, the researcher also posted flyers on the bulletin board in the nursing station to inform nurses of the study. Potential participants were encouraged to contact the researcher via phone, email, or through the website for more information or to confirm their interest in participating.

When nurses contacted the researcher, a meeting was scheduled at a time and location of their preference. At the beginning of the meeting, the researcher reviewed with each participant the written consent form (see Appendix D) that outlined the study's purpose, the participation required, associated risks, and the confidentiality of data. Participants were given time to review the consent form and to ask any questions regarding the study and their participation. The researcher responded to any questions that participants raised. When participants agreed to be involved, two copies of the written consent forms were signed by both the participant and the researcher. One copy was for the researcher to retain and the other copy was for the participants to keep for their records. The researcher also collected participants' contact information (phone numbers and email) for future communication related to follow-up interviews (described below). The researcher designated a numeric code for each participant on the respective signed written consent formed.

3.4.3 Participant characteristics. In this study, there were seven participants, all of whom worked in the ICU at the time and had experiences in caring for dying patients in the ICU

context. The age range of participants varied: 20 to 30 years of age (*n*=1), 31 to 50 years (*n*=3), and 51 to 65 years of age (*n*=3). In terms of the years in nursing experience, participants ranged from 1.5 to 34 years. The majority of the participants (*n*=6) had at least a decade of experience in critical care, and five of whom had worked (part-time or full-time) in the study ICU for more than ten years. The majority of the participants had completed additional training in critical care (associated with a hospital or college), and had a diploma in nursing as their highest educational level. About half the participants identified that they had palliative care education either through their formal nursing studies or through seminars. Participants were asked to name a nursing role with which they self-identify - all self-identified as ICU nurses.

3.5 Procedure for Data Collection

The researcher conducted data collection through initial and follow-up interviews with participants. Initial interviews were semi-structured in nature (see Appendix E for interview guide). Demographic data was collected at the beginning of the initial interviews. The researcher asked questions from the interview guide, and participants were free to elaborate and to discuss as they wished regarding the phenomenon of interest.

Follow-up interviews were conducted with participants approximately six months after the initial interviews. The objective of the follow-up interviews was to clarify and explore in greater depth some of the findings. Participants were encouraged to reflect and to provide feedback. The researcher made attempts to contact all participants, however, only four were available for the follow-up interviews.

All interviews were conducted at locations and at times of participants' preference. The interviews were face to face and were audio-recorded. Initial and follow-up interviews were both approximately 60 to 90 minutes in duration depending on the participants' articulation of the

phenomenon of interest. The researcher made field notes during each interview. These field notes were the researcher's observations, thoughts, and questions that were used for further reflection of the data collected.

3.6 Data Analysis

Data stored on the audio-recording device was downloaded onto a password secured laptop device within 6 hours of each interview. This audio file was reviewed and transcribed verbatim by either the researcher or by a professional transcriptionist. Once transcripts were completed, the researcher reviewed them against the audio recordings to ensure accuracy. Early management of the transcribed data included reading, making notes, and removing any specific identifiers from transcripts.

In ID, data analysis is an iterative process of immersing, analyzing and reflecting on the data that was collected (Thorne, 2008). Thorne (2008) suggests that specific analytical techniques can be borrowed from other traditions, such as grounded theory and narrative approaches, to assist with the analysis of data (Thorne, 2008). In this study, the analytic technique "Thematic Networks" (p.387) outlined by Attride-Stirling (2001) was used to guide the beginning parts of the data analysis. Thematic Networks provided a way of organizing ideas in a web-like network that allowed for the development of three levels of analysis from basic pieces of data to categories of data and to overarching interpretative themes (Attride- Stirling, 2001).

First, the researcher began by generically coding the transcribed data by adding certain descriptors, such as "physical care", "psychosocial care", and "values", to pieces of data. These codes and their applicable texts were then organized into larger categories, derived from the research objectives, like "EOLC description" and "moral identities". Once initial descriptive

groupings were made, the researcher then noted patterns, relationships and tentative linkages within data. As patterns and relationships emerged to become interpretative themes, the researcher reflected and verified them against the objectives of the study with the purpose of identifying stronger and weaker linkages in the data (Thorne, 2008). For instance, there were several discussions amongst the researcher and the thesis supervisors regarding the interpreted themes, such as what do nurses value and who they perceive themselves to be. The researcher then conducted follow-up interviews in which preliminary interpretive themes were further explored with participants. These interpretive themes were then refined, and organized into a thematic analysis, one of the products of ID (Thorne, 2008). A thematic analysis extends beyond a surface level description of themes, and provides new perspectives in the way the themes are presented in the larger context of the known phenomenon (Thorne, 2008).

3.7 Methods to ensure rigour

Key principles mentioned by Thorne (2008) to ensure rigour and quality in this current study were closely followed. These principles include epistemological integrity, representative credibility, analytic logic and transferability (Thorne, 2008).

3.7.1 Epistemological integrity. The researcher was honest with the constructivist epistemological assumptions throughout the study. For example, the researcher conceptualized the findings only from the data in the interviews, and acknowledged any personal biases that may have affected the interpretation of the data (Thorne, 2008).

3.7.2 Representative credibility. For representative credibility, the researcher engaged with the data for a length of time (approximately 18 months) (Thorne, 2008). Additionally, participants were contacted to partake in a follow-up interview, where the researcher shared preliminary themes of the study with the participants. These follow-up interviews allowed

participants to confirm, to further discuss and challenge whether the findings were representative of their experiences (Thorne, 2008).

3.7.3 Analytic logic. The researcher kept a journal dedicated to expressing her own perspectives (experiences, feelings or values) and to documenting key decisions made in the research process of data collection and analysis. This journal was used as an audit trail, an account of the logic behind data construction and analysis, and as a means for reflexivity (Polit & Beck, 2012; Thorne, 2008).

There was also a thesis committee who provided guidance for the study. This thesis committee was composed of Dr. Brandi Vanderspank-Wright (thesis supervisor), Dr. David Kenneth Wright (thesis supervisor), Dr. Frances Fothergill-Bourbonnais (committee member), and Kelley Tousignant (committee member). Both Drs. Vanderspank-Wright and Fothergill-Bourbonnais are experienced in conducting nursing research focused on palliative and EOLC in critical care environments. Dr. David Wright is experienced in conducting nursing ethics research focused on the moral practice of nurses with EOLC and Kelley Tousignant has experiences with palliative care outside of the critical care setting. Both Dr. David Wright and Kelly Tousignant also provided other perspectives on the conceptualized themes in the study. All members of the committee have brought knowledge and experience in conducting qualitative research in nursing.

3.7.4 Transferability. There was consideration of transferability, which is a measure of the applicability of the study findings to other similar contexts (Guba & Lincoln, 1994; Polit & Beck, 2012). A thick description of study setting (unit structure), basic demographics of participants (number of participants, years of nursing experience and years in study unit), and general interaction between the researcher and the participants was provided (Polit & Beck,

2012). This thick description allows readers to discern whether the findings of the study are transferable into other contexts (Polit & Beck, 2012). These four overall strategies, epistemological integrity, representative credibility, analytic logic and transferability were used to maintain integrity throughout the study.

3.8 Ethics and Human Participant Protection

Research ethics approval for this study was sought from the University of Ottawa Research Ethics Board (REB). An administrative ethics review was also approved by the study site's research committee. Prior to data collection, the written consent form (see Appendix D) detailing the study purpose, the participation required, associated risks, and confidentiality of data was given and reviewed with each participant. The researcher answered participants' questions and emphasized that their participation was voluntary and they had the right at any time to withdraw their participation from the study or refuse to answer any questions. To ensure the privacy of participants, numeric codes were designated for each participant on the respective written consent form. These numeric codes were used in transcripts, and then subsequently changed to pseudonyms for the aesthetic purposes of study presentation and for the protection of confidentiality. All other identifiers, such as specific names and places, were struck from the transcripts. Details of any particular experience or incident shared were edited to ensure participants will not be identified.

Data stored in the digital audio-recorder was downloaded within 6 hours of an interview. Upon successful download, data in digital audio-recorder was deleted. Hard copies of signed written consent forms and transcripts were stored in key locked cabinets of the secured offices of Drs. Brandi Vanderspank-Wright and David Wright. Any electronic data (i.e transcripts and audio files) was also stored using two levels of security. For instance, the laptop devices used

were password protected and the documents themselves were password protected (with different passwords) and encrypted. Each professional transcriber signed a confidentiality agreement (see Appendix F) prior to receiving the data and he or she was accountable for ensuring privacy and confidentiality of the data. A total of four professional transcribers provided transcription services for this study. Data will be stored for the duration of the conservation period (minimum of five years) beginning after the thesis defense. When data from this study is to be disposed, electronic data will be securely deleted and physical data will be shredded through confidential waste by the University of Ottawa.

Chapter 4: Study Findings

In this chapter, nurses' moral experiences with providing EOLC, as shared by the participants and interpreted by the researcher, are described. These participants were registered nurses employed in an ICU of a large community hospital located in Ontario, Canada. Study findings (see Figure 2) were derived from the analyzed data collected in both initial and follow-up interviews with participants.

Figure. 2 Themes and subthemes

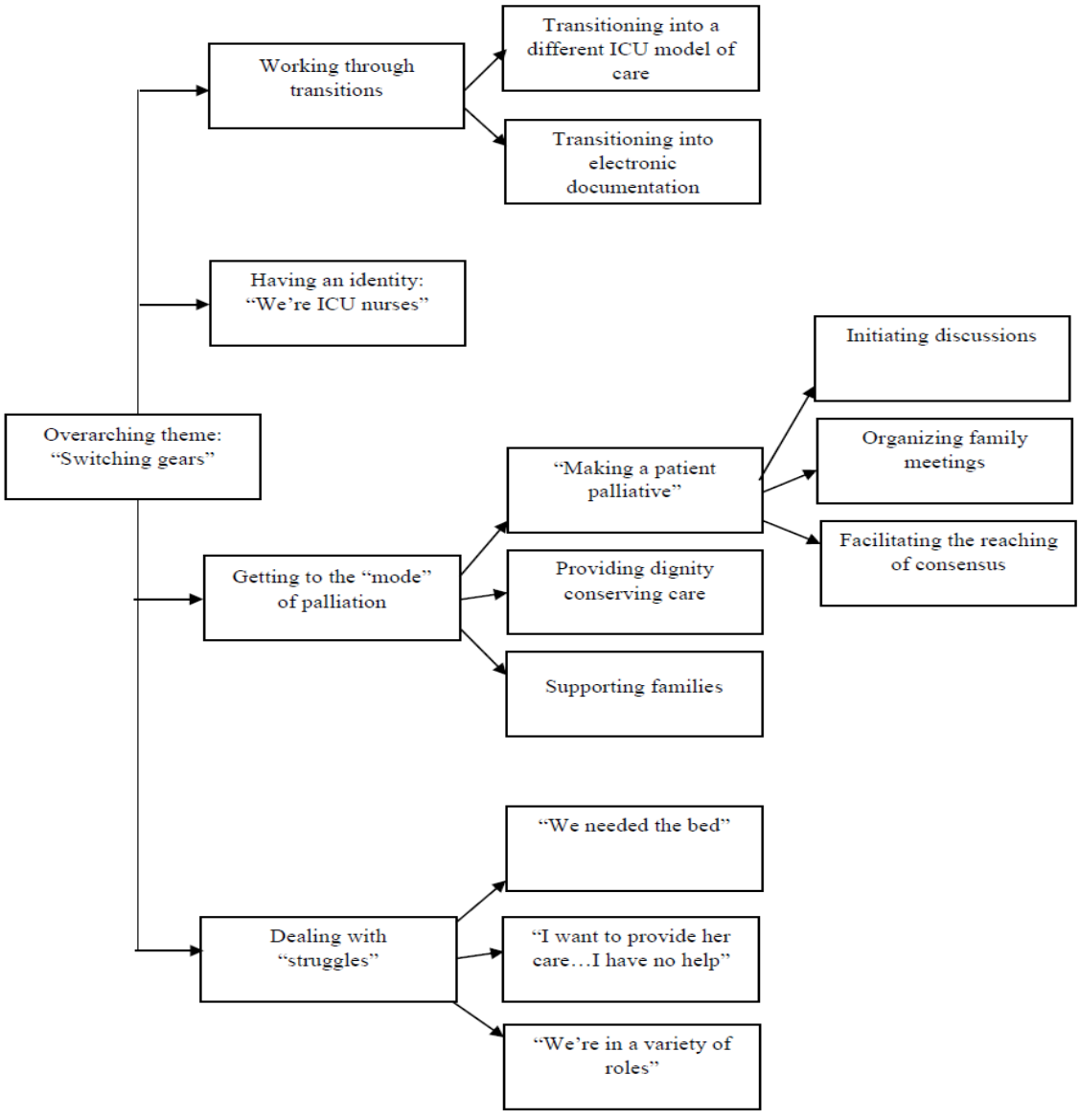

Figure 2. Organizational schematic of themes and subthemes of the study.

The findings presented are in accordance with the research objectives of describing nurses' provision of EOLC and their moral identities, and examining how the community ICU context shapes their moral agency. Direct quotes from participants are used to support findings. To begin, the overarching theme of this study is described.

4.1 Overarching theme: "Switching gears"

Nurses' overall moral experience with providing care to dying patients can be described metaphorically though the image of *switching gears.* Particularly, after transitioning into a different model of care in the ICU, participants' stories revealed that their identity and their responsibilities were primarily centered on "saving lives". As such, "switch[ing] gears" was a decisive and at times, sudden shift for participants to focus their responsibilities from saving patients' lives to caring for dying patients. One of the participants, Catherine reflected, *"I always want to save everybody to a certain extent … and if it doesn't work, reality sets in… a decision* [for palliation] *has to be made. And then, you try to switch gears and you go to that mode"*. "Switching gears" began when participants recognized the "reality" that it was no longer possible to save a patient's life, and that death was inevitable. At this point of realization, participants were actively involved with end-of-life decision-making, which was often referred to as "make palliative". Once families reached a consensus for palliation in collaboration with the interdisciplinary team, the patient officially "became palliative". Participants then completely "switched gears" and began in the "mode" of providing care that intently conserved the dignity of the dying patients and supported their families. Participants' experiences of "make palliative", providing dignity conserving care, and supporting families involved many "struggles" that made it more challenging to "switch gears". These struggles were embedded in participants' interactions with the community ICU context, and they included frequent transfer of dying

patients, heavy patient assignments, and multiple roles that they as intensive care nurses were expected to assume.

4.2 Working through transitions

In order to fully appreciate the participants' moral experiences, it is important to elaborate on the context of the study setting. Participants transitioned through two organizational changes: the shift in model of care in the ICU and the implementation of a community hospital-wide electronic health record (EHR). This description of participants' transition provides a "snapshot" of the ICU context that contextualizes an analysis of nurses' identity, and their experiences with providing EOLC.

4.2.1 Transitioning into a different ICU model of care

The first organizational change that occurred was the shift in model of care in the ICU. Prior to 2015, the ICU operated under an "open" model of care where patients were primarily managed by physicians without critical care training (namely hospitalists). These physicians had their own medical practices and specialities. In 2015, the ICU transitioned to a "closed" model of care. Intensivists were hired and began managing the care of patients in the ICU. At the time of the study, there were 4 intensivists and they rotated weekly to manage the ICU. With the "closed" model of care, the intensivists were the only physicians admitting patients to the ICU.

Even though the transition from "open" to "closed" model of care was primarily a change in physicians, it affected nurses and their practice in the unit. Prior to the transition, nurses functioned in a highly autonomous role. Catherine, for instance, described how nurses worked with minimal physician presence in the unit. She elaborated, "*You* [nurses] *were pretty much flying solo, because the docs weren't around. You had your docs…come in the morning, do their rounds, write their orders and then leave. And then you just phone them for whatever else you*

needed". Catherine's use of the expression "flying solo" suggested that nurses often autonomously managed to care for patients as the physicians were infrequently present in the ICU. Yet, even while "flying solo", nurses were limited in their abilities as well as in resources to care for patients who were critically ill and at high risk of physiologically declining (i.e patients who were hemodynamically unstable or unable to maintain a patent airway and requiring mechanical ventilation). Prior to the "closed" model of care, participants explained that they frequently needed to transfer these patients to other teaching hospitals for treatment.

Since the transition, nurses have been practicing in a context where their role has changed and where patient complexity has increased. Participants described that they have had to evaluate and adjust their responsibilities and their role as they were now regularly working with the intensivists. Melanie's description (below) revealed that the intensivists were much more involved and present in the care of patients compared with the previous physicians. For instance, these intensivists were performing "a lot of procedures" (such as central line and temporary pacemaker wire insertions) to help stabilize and manage patients' critical illness. Specifically, the intensivists' role has resulted in previously transferred patients to remain now in the ICU for the treatment of their critical illness and underlying diseases. From a biomedical perspective (pathology and disease focus), nurses were now also responsible for the care of "sicker" and more complex patients in the ICU. Melanie explained:

> *Since the new doctors have come, we tend to keep sicker people, whereas prior… they'd* [patients] *be shipped out… we're tending to keep the vented patients…now these doctors… they can do a lot of procedures… they are more comfortable keeping them* [patients]*… sometimes they* [patients] *are there a lot longer…*

Furthermore, as part of the care for critically ill patients, the nurses were now working with a larger interdisciplinary team composed of other allied health professionals, such as pharmacists, dieticians, physiotherapists and respiratory therapists. The participants described that they worked with the interdisciplinary team during daily rounds, which were detailed discussions about the plan of care for patients. Participants also described their role in daily rounds to include sharing the results of their "head to toe" assessments, and discussing any ongoing clinical issues the patient was experiencing. Although participants discussed being involved during rounds, they felt that their voices and their concerns about the patients' care were sometimes restricted by the formalized process of these team discussions, which as Karen described, "seemed more robotic". Karen elaborated:

> *A year and a half ago… we didn't have rounds with the team… the physician and the nurse… would go into* [the patient's room] *and discuss* [his or her care]*...and now that we've gone to the team, there's more people, a bigger group… our* [nurses'] *part is only to offer our head to toe* [assessment] *and how the* [patients'] *day has gone…it seems more robotic.*

Even though the participants described needing to adjust to working with an interdisciplinary team and caring for more critically ill patients, they were also experiencing positive changes from the shift in the model of care. With critically ill patients staying longer in the ICU, nurses were able to more consistently care for them, and to be a part of their journey of recovery. Catherine commented, *"So it's nice that we get to see a whole big continuity of care…We've had a lot of good success stories because we've hung onto them* [patients]*"*.

4.2.2 Transitioning into electronic documentation

The second organizational change occurred in 2016, which was a hospital-wide initiative to replace the previous medical record system with a new EHR. This EHR system provides clinicians with the ability to document electronically, in real-time; the system is comprehensive and includes all aspects of the patients' chart, such as diagnostics, medical orders, medication administration records (MAR), and physician and nursing notes.

As participants transitioned to using the EHR, they were experiencing changes in their workspace and workflow. For example, prior to the EHR, nurses had spent a significant portion of their time at the nursing station reviewing and documenting in patients' charts, as well as monitoring the cardiac telemetry. However, since the EHR, the participants described that they completed much of their work on the portable workstations located within or near patient rooms. Emily described (below) how nurses used these portable workstations ("computers on wheels") for medication administration. Emily's description of scanning the medication, and looking at the computer suggested a large proportion of the nurses' attention and time while at the bedside were focused on the EHR rather than on the patient. Furthermore, Emily's description also highlighted that nurses used the EHR "to manage their day". This was significant as it seemed to imply that the specific assessment forms, medical orders and other records on the EHR directed how nurses organized their priorities in the nursing care. Emily elaborated:

> *We've got these big computers on wheels… and you wheel them around… and it's all your patients' charts on this… when you go into the room to administer meds, you have to bring the computer and you have to scan each medication, look at your computer, scan the medication…the patient* [is] *there just looking at us…at any given time… nurses are on the computer trying to manage their day.*

Even at an early stage of the implementation of the EHR, participants were making suggestions about areas needing improvement. Emily discussed that nurses had group debriefing meetings with the manager where they raised concerns about balancing the responsibilities of using the EHR, and ensuring patients were still receiving the care that they needed. As such, nurses suggested increasing staffing (more staff on every shift) to ensure that they had time to use both the EHR and provide care. Emily explained:

> *So we'll talk about it, somethings' got to be done…We're thinking of up staffing …which will be a huge help…because I don't have a buddy to turn my patient with, because everybody is here and there…and we're always… trying* [to] *figure out what the computer is doing.*

Working through the two organizational changes had emotional ramifications for the participants. For instance, Emily shared how nurses felt overwhelmed and stressed with the responsibilities of caring for critically ill patients, while at the same time, managing the new EHR. For many nurses, it was difficult to adapt to all the changes within a short period of time, and they felt at times emotionally and mentally drained. Emily reflected:

> *There's been a lot of tears shed at work … you get so overwhelmed, the patients are so acute, and we've got so much going on with all the new changes, people are in tears, people are on edge, and people aren't themselves. So it's really… not easy…it's a big transition phase...*

In summary, this contextual analysis reveals that while nurses are still learning and going through the transition of the two organizational changes (the shift in model of care and the implementation of EHR), they also made significant adjustments. Nurses' roles at bedside evolved from working autonomously to collaborating with intensivists and the interdisciplinary

team in the care for patients. Specifically, nurses' practice focused much more on meeting the biomedical needs of critically ill patients. At the same time, nurses have also had to adopt electronic processes as part of their nursing work. For nurses, the transition into these two organizational changes had a substantial impact on their sense of identity and their experiences with EOLC.

4.3 Having an identity: "We're ICU nurses"

In this section, the focus shifts from an examination of the ICU context towards a closer look at nurses' identity and their values. This discussion includes how nurses perceived themselves, what they believed to be important, and for what they assumed responsibility. This aspect of the findings highlights how the participants' nursing identities were shaped in light of the recent organizational changes.

On a surface level, most participants identified themselves as "ICU nurses". However, at a deeper level, participants' descriptions revealed that there were meanings associated with calling themselves "ICU nurses", particularly with respect to their training, their work in the ICU and the values underlying this work. For instance, participants shared that they were formally trained in critical care through either courses associated with a hospital or college. They were educated about how to care for patients with critical illness in the ICU setting. Their specialized knowledge acquired through their training and experience seemed to set them apart from nurses who worked in different settings within the hospital. Since the shift in model of care, participants also viewed their nursing practice in the ICU as focusing particularly on carrying out life-sustaining treatments. For example, nurses competently administrated inotropic medications, and carefully monitored their patients receiving mechanical ventilation or cardiac telemetry. While

nurses' specialized knowledge and their practice brought significance to who they were as "ICU nurses", their identities were multifaceted, and complex.

For many participants, their nursing identity seemed to be centered on saving patients' lives. Beth, for example, described, *"For my job in an ICU, we do everything we can to save people, not end their lives"*. Participants told stories that often began with providing life-saving care to critically ill patients. For instance, Melanie spoke about a time when she was taking care of a very unstable patient who recurrently had cardiac arrhythmias. She explained that her responsibilities were to insert IV access and simultaneously, apply defibrillation when the patient had a lethal cardiac arrhythmia. She described:

> *So, I'm trying to get IVs on him* [patient], *and the doctor says, 'oh you… have to defibrillate again'. I just remember thinking…'this man can't die'…So I'm defibrillating…I'm doing my best.*…[I'm] *trying so hard to keep this man alive.*

In reflection, Melanie had expressed that it was a stressful situation, but at the same time, she believed it was important for her to do her best in carrying out the responsibilities, so that the patient would be able to continue to live. Many participants found meaning in being able to provide care that sustained and extended the lives of patients who were critically ill. Catherine elaborated, *"We've given them* [patients] *a new lease on life for a little while"*.

Since a large focus of their nursing identity was intent on saving lives, some participants expressed that it was difficult at times to also identify with their responsibilities of caring for dying patients and their families. Melanie described situations when nurses were doing everything they could to save patients' lives, but then quickly shifting the focus to withholding and withdrawing life-sustaining treatments, and providing palliative and EOLC. She explained, *"I find it very hard…saying letting people go, but you have such a mentality, that you're doing*

everything to keep them alive, that it's somewhat difficult to be an ICU nurse and a palliative care nurse…". The way Melanie expressed how she struggled to be both an ICU nurse and a palliative care nurse seemed to convey the idea that these were two separate identities in terms of responsibilities and purpose. For Melanie, she associated a palliative care nurse identity with "letting people go", or in other words, focused on caring and allowing patients to die. For several participants, they perceived this aspect of "letting people go" to be seemingly incompatible with their critical care nursing identity of saving patients' lives.

By strongly identifying with saving patients' lives, participants also struggled with death and dying. Beth shared how it was challenging for her when she cared for patients who she thought "shouldn't have" died or those who died unexpectedly. Beth explained:

> *I want them* [patients] *to live… I feel it as a loss myself if somebody dies on me that shouldn't have died or wasn't expected to die. I take that personally and I take it home with me...* [I ask myself], *'Is there something we missed? Is there anything we could have done…*[or] *should have?'…And then, you're on to the next shift… never dealing with it or problem-solving it.*

As Beth described, she experienced a sense of a personal loss when caring for patients who died unexpectedly. While the experience of caring for these patients elicited many reflective questions for Beth, it also seemed that she was not necessarily able to work through her thoughts and feelings about what occurred due to the lack of time after patients' death, and the competing responsibilities.

Two participants, Beth and Melanie, shared a story that illustrated their experience with caring for patients who died unexpectedly. Beth and Melanie began the story about a young patient in his 30s, who had recently undergone a laparotomy for his abdominal ascites. At the

time of the procedure, biopsies were taken and sent to be tested for malignancy. However, prior to the biopsies results returning, the patient was admitted to the ED within a few days for severe respiratory distress and worsening abdominal ascites likely due to cancer. Melanie was involved in this patient's care when a code ERT was called. At this point, the patient was described to be critically ill and in a lot of pain, and there seemed to be only two options: either providing life-sustaining treatments (such as mechanical ventilation) or palliation. Understanding the urgency of the situation, Beth shared that she and her colleagues supported Melanie in how to care for this patient, especially in managing his pain. Beth elaborated, *"We're bouncing off each other what to do in the situation…*[how to] *make him comfortable…"*.

As Melanie provided care for this patient, the physicians made arrangements for him to be admitted to the ICU. Yet, at the same time, discussions occurred between the physicians and the patient and family about the diagnosis and prognosis of the cancer. From these discussions, they made the decision to withhold life-sustaining treatments and to provide palliation. The patient had one last wish to get married to his fiancé, and that same day, a wedding was arranged at the hospital. In the end, the patient and his fiancé were married shortly before his death. Even though, Beth was primarily supporting Melanie's care for this patient, she reflected over the situation. *"We* [nurses] *were all traumatized… it was a circumstance where you don't know and where it becomes an immediate, an acute situation or you have to palliate…so that's hard"*. Beth's use of the word "traumatized" suggested that this was an upsetting experience for nurses, because of how sudden the patient death occurred.

Yet, there were also some participants who did not identify as strongly with the focus of saving patients' lives. Karen, for example, described how she enjoyed working in ICU and taking care of critically ill patients, but that she struggled with "trying to keep everybody alive".

For Karen, she perceived that not all patients could be saved from their critical illness, and that the "technology" (or life-sustaining treatments) was at times prolonging inevitable death. In these situations, Karen had conflicted beliefs and feelings about providing life-saving care to patients, who were dying and at the end-of-life. She explained:

> *There is a great emphasis working in an* [ICU] *to save people and it seems to be at all costs… I thoroughly enjoy critical care… but … as people are living longer, and they have more co-morbidities, and technology is such – we're trying to keep everybody alive… sometimes… it's going against my ethics, my beliefs and just my emotions…I think there's a conflict with me, with some of what I see going on in the* [ICU],*… some of the* [patient] *cases that we have are truly end-of-life.*

For Karen, it seemed like she desired to include providing palliative and EOLC to be a more significant part of her nursing identity. Karen described that it was important to her that patients and families have discussions about end-of-life, especially prior to being critically ill. Yet at the same time, she recognized that not everyone was as comfortable as she was about discussing palliative and end-of-life. Karen added:

> *I probably lean further to palliative care, even though I am an ICU nurse…I've often said…* [people] *need to discuss end-of-life, it should be more of an open topic, palliative and end-of-life… I find it frustrating, because I'm comfortable with it, and I guess not many are…*

Other participants like Emily, for instance, described herself as a "new nurse" working in a critical care area. She did not refer to herself as either an intensive care nurse or a palliative care nurse. Emily explained that she was still trying to gain the skills to work with critically ill

patients. She also seemed to emphasize that part of her nursing identity included patient advocacy. She explained:

> *I'm so new… I don't even consider myself an ICU nurse yet… I'm a new nurse… working in ICU… But I'm a big patient advocate and I think you really need that in an ICU setting, when your patient is at their most vulnerable…at the end of the day to me, it's all about my patient…what they want…what they would appreciate…*

While there were differences, participants' identities were evolving and ultimately shaped by the changing context of the ICU. Notably, since the change from "open" to "closed" model of care, nurses were working with intensivists, whose goals were to also save patients' lives. One of the participants described, *"They* [physicians] *get into the mode of where we can save everyone…they're fresh in their careers… they want to help people"*. Participants remarked that many of the intensivists approached treating patients' critical illness differently than previous hospitalists. Catherine explained that the intensivists wanted to keep critically ill patients in the unit, and to provide them with various treatments. She elaborated:

> *It's different to watch them* [physicians], *because they want to keep these people* [patients] *here, they want to treat them, and treat them properly, and they're going …onto their phones… and* [getting] *more information… and* [seeing] *what we can do for them* [patients] *here, versus shipping them to bigger centres…*

With nurses and intensivists working together, it seemed like the focus of "saving patients' lives" became a shared value and a central priority. Karen described, *"It's like you walk through that door* [of the unit], *we're going to save you at all costs"*. For participants who did not identify as strongly with an exclusive focus on "saving lives", they were sometimes faced with having to

reconcile their desire to provide EOLC with the more overarching priorities and focus of the community ICU.

4.4 Getting to the "mode" of palliation

This section begins with an overview of the metaphor of "switch[ing] gears", and then details various aspects of nurses' moral experience, such as participating in end-of-life decision-making, and providing EOLC.

Since participants' identity generally focused on saving patients' lives, they had to "switch gears" when it came to caring for dying patients and their families in the ICU. Catherine, for example, described how she desired to "do everything" to save patients' lives. However, she also realized that there was a point when saving patients' lives was not possible, and a decision for palliation and EOLC "has to be made". It seemed that it was after a decision for palliation that nurses "switch[ed] gears" and entered a "mode" of providing palliative and EOLC. Catherine's use of the word "switch gears" and "mode" suggested that it was not a natural progression for nurses, but rather a decisive shift in the focus of their identity and responsibilities from saving patients' lives to caring for dying patients. Catherine explained,

> *I always want to save everybody to a certain extent. I like to give them that option. I'd like to do everything we can and if it doesn't work, that's fine… reality sets in… a decision* [for palliative] *has to be made. And then, you try to switch gears and you go to that mode.*

As nurses recognized the patients' deteriorating clinical condition and the various active treatments provided for patients that were intended to "save", they then viewed an obligation to be involved with "mak[ing] a patient palliative", providing dignity conserving care for patients and supporting the families.

4.4.1 "Making a patient palliative".

Participants' stories revealed that there were two trajectories of patient deaths in the ICU. The first trajectory was that patients died while on active treatments (i.e. life-sustaining therapies); the second trajectory was that patients died following collaborative decisions to shift the focus of care to EOLC. Participants' descriptions of caring for dying patients revealed the latter to be the more prevalent trajectory in the ICU. Participants described the act of changing the focus to palliative and EOLC as "make palliative" or in other instances, "deemed palliative" or "become palliative". For instance, Melanie explained that patients are not admitted to the ICU as patients receiving palliative care, but rather they were "made palliative" over time. She elaborated, *"I mean they* [patients] *never really start out palliative. So if I'm coming onto a shift, they've* [patients] *been made palliative at some point over their admission to ICU"*. Participants' use of the language "made palliative" reflected an active and coordinated decision-making process to shift the focus of care to promote a "good death" for patients.

The process to "mak[ing] a patient palliative" was multifaceted, and involved physicians, nurses, patients and families. From participants' descriptions, there seemed to be three stages in "mak[ing] a patient palliative": initiating discussions, organizing family meetings, and facilitating the reaching of consensus. In the first stage, participants described that nurses actively reflected about the patients' clinical situation, and brought their concerns to the intensivists and the interdisciplinary team. When there was an agreement amongst members of the interdisciplinary team to discuss end-of-life with patients and families, family meetings were arranged and held. At this stage, participants were involved in family meetings, but often as observers, while intensivists primarily took the lead in these meetings. In the last stage of facilitating the reaching of consensus, participants supported patients and families in their

decision-making outside of family meetings by communicating information and providing them time. When families themselves reached an agreement and made decisions to withdraw or withhold active treatment and to provide palliative and EOLC, patients "became palliative", and nurses provided dignity conserving care and supported families.

4.4.1.1 Initiating discussions.

Nurses' participation in "mak[ing] a patient palliative" frequently began with understanding the perspectives and preferences of patients and families. Emily described how it was important for her to clarify patient and families' wishes regarding resuscitation (i.e code status). Emily explained, *"So I always try to bring it* [code status] *up with my patients… and clarify it with them,… a lot of times people want something for short term but not long-term, and that's very important to address."* Emily's explanation revealed that addressing code status not only meant nurses coming to know patients and families' wishes, but also understanding their desires and perceptions of the future.

As nurses sought to understand the perspectives and preferences of patients and families, they also reflected and thought through the patients' clinical situation and whether the active treatment was still aligned with patients' known preferences or in their best interest. Beth explained her thoughts as she reflected on the patient's clinical situation:

> *Are we doing the right thing for this patient?" is what we want to know…By the time they* [patients] *get to the ICU, we should have a treatment plan of where they're going…If it changes, patient becomes critical, you re-evaluate again. You always re-evaluate.*

When there were changes in patients' clinical situations or in their preferences regarding code status, sometimes nurses tried to initiate a discussion with physicians or the larger

interdisciplinary team. Karen, for instance, described an interaction she had with a patient and her family, where they raised concerns about still desiring active treatments. Karen explained, *"So she* [daughter] *asked, 'where do we go from here… it's been four week, is* [this] *going to get any better? Or is this what we're going to keep doing, because she* [patient] *doesn't want this'…"* After this interaction, Karen described that she approached the intensivist with the patient and family's concerns. She added:

> *And in this case, it hadn't been revisited by perhaps the physicians, but the family along the way, and the patient had realized that maybe this is not what I want in life. Or at the end-of-life…So I approached* [the intensivist] *with it, but it just didn't work into the schedule or the timing…The comment made to me* [by the intensivist] *was, 'I can't deal with that now, and you brought this up with them'.*

For Karen, it was important to speak up about the patient and family's concerns, and to have a discussion with the intensivist addressing these concerns. However, in this particular situation, Karen's advocacy was met with resistance in terms of the intensivist's time schedule and priorities.

Initiating discussions also seemed to depend on the readiness of the intensivist, nurse and other members of the interdisciplinary team to engage with patients and families about end-of-life decisions. For some participants, this first stage of "mak[ing] a patient palliative" was challenging, because there was sometimes ambiguity and uncertainty about the patients' prognosis. For instance, Beth described, *"the hardest time I…have* [is] *getting to the decision point, '…is death inevitable here, or are we just going to keep doing things …* [and] *adding on* [treatments]*?"*.

During the initiating discussion stage, participants shared that at times there were conflicts between intensivists and nurses regarding when to approach patients and families with end-of-life decision-making. Karen explained how nurses were in close proximity to "hear" and listen to the perspectives and stories of patients and families. Elaborating on the previous story of her interaction with the patient and the daughter, Karen explained, *"It is the bedside nurse who… hears the stories* [that] *families speak to…*[and] *the patient will speak it… and so the conflict seems to be greater with the physicians* [who] *want to do even more interventions"*. Since nurses spent the most time of all healthcare professionals at the bedside, they perceived more readily the need to address end-of-life with patients and families. However, nurses were sometimes met with intensivists' reluctance and their desire to continue with active treatment for the patient.

Other times, conflicts were mitigated with meetings between members of the interdisciplinary team. Karen shared a story of taking care of a patient, who frequently came to the ICU for complications of his illness. With each admission, Karen became more familiar with the patient's life story, his social situation, and his illness trajectory. During one particular admission, Karen was caring for this patient, who had become very ill and was supported by various life-sustaining treatments. Karen became increasingly concerned with the patient's declining health, and she felt obligated to advocate for the patient's needs. She sought to have the patient's substitute decision maker more involved, and furthermore, to have a meeting to discuss the patient's situation. Karen described the meeting and conversations that took place with the intensivists and ethicists:

> *A meeting was called for that afternoon… it was involving …our ethicists,… and it was also involving 2* [intensivists]... *and myself…They addressed the patient's issues, his diagnosis, his frequent admissions, and the lack of*

> *…communication that we had with the family…So the conversation and the result of it all was that there was support- the* [ethicist] *reiterated that … there was legal support and directives that the* [intensivists] *could be taking.*

At the end of the meeting, the interdisciplinary team had a plan for how to proceed with the patient's care, which reduced ambiguity and conflict. This plan was then proposed in a family meeting with the patient's substitute decision maker. As Karen reflected on the situation, she felt that she had advocated for the patient not only as someone she was caring for, but as a person she had come to know. She said, *"I tried to do something for* [patient's name]*, and I did. And besides offering him care at the bedside, I looked out for him. I had a connection with him."* For Karen, her closeness and familiarity with this patient allowed her to initiate discussions with other members of the interdisciplinary team and advocate on his behalf about goals of care.

4.4.1.2 Organizing family meetings.

When there was an agreement among members of the interdisciplinary team to discuss end-of-life decisions, formal family meetings were organized. Family meetings included intensivists, nurses, other members of the interdisciplinary team, and the patient's family. Participants explained that most times, patients were not able to be involved with family meetings or decisions about end-of-life due to the severity of their critical illness. As such, families were mostly involved in making decisions on behalf of the patient.

Nurses seemed to take a more observant role during family meetings. Participants described these meetings to be primarily physician-led and to entail discussions about the patient's illness, the overall prognosis, the medical treatments provided, and the options for end-of-life, such as withholding or withdrawing treatments. For instance, Emily described how the intensivists sometimes led these discussions in family meetings with a lot of clinical information.

Emily stated, *"I think they* [intensivists] *tell the family… in the discussion, 'this is the diagnosis, these are the risk factors', and a lot of times, they'll* [intensivists] *say, 'this could happen, but we can still do this in the meantime'..."* The way Emily described these discussions suggested that intensivists frequently approached family meetings with a focus on biomedical priorities, particularly assessing certain risk factors (e.g. intubating and mechanically ventilating a patient with end-stage lung disease) and giving recommendations of the various medical treatments that could be given despite the possible outcomes for the patient.

Yet, there were also times when it seemed the intensivists were more forthcoming in discussing end-of-life during family meetings. Jennifer shared how some intensivists would approach the discussion with the family about the futility of the medical treatments and the ultimate outcome of death for the patient. In these discussions, the intensivists seemed to imply that the patient was imminently dying, and to more openly offer the family with the options of withdrawing active treatment, and providing palliative and EOLC. Jennifer explained:

> *With the doctors* [and] *…with the family… they say... 'this is what's happening, kidney is shutting down, the heart is failing, …we're tried all these measures, and it's still not helping.…there's no further things that can be* [done] *to keep the person going… it's going to all amount to the same end result* [of death].

Family meetings were generally comprised of intensivists discussing clinical information and families responding to the options provided. While some families made decisions about end-of-life during the first family meeting (based on the information provided), others needed time to reflect and to deliberate among themselves about the various options presented. Melanie described how families reacted in many different ways: arguing, changing their minds, and

discussing end-of-life options. From Melanie's description, it seemed that families often needed time to come to an agreement about their loved ones' end-of-life. She elaborated:

> *So we try to do a family meeting… and then some of the families know what they want; some have to discuss; some argue, some change their mind… and sometimes doctors will… say 'I don't think this going to be … a good outcome'… and some families will go with that, and some* [families]*, they want to try for a few more days...*

4.4.1.3 Facilitating the reaching of consensus.

Nurses were actively involved in supporting patients (when they were conscious and able to communicate) and families in their decision-making outside of formal family meetings. For instance, nurses translated clinical information for patients and families in ways they could better understand. Catherine described how nurses provided patients and families with information about the disease process, and the extent that patients' bodies were affected by disease. Catherine also shared how nurses reiterated and conveyed a similar message as intensivists, but without the medical language or "jargon". She explained,

> *"They* [patients and families] *don't understand the seriousness of the disease.… My job is to let them know how sick they are. Doctors can tell them what their chances of survival are; I'm not going to do that… We just support what* [the physicians] *say and reiterate it in layman's terms, because there's a lot of … people out there that …don't understand this* [medical] *jargon".*

While it seemed like nurses provided a similar message as intensivists, there were also differences. As Catherine pointed out, the intensivists specifically spoke to patients and families about "chances of surviv[ing]" the illness or prognosis. Catherine and her colleagues, in

particular, took responsibility for providing information that appropriately informed patients and families' knowledge and understanding about their clinical situations.

As mentioned previously, families often made decisions about treatment and care at the end-of-life on behalf of the patient. In these instances, participants discussed the clinical situation, and encouraged families to be the patient's voice. Melanie explained that she talked with families and guided them to think about what the patient would have wanted in the given circumstance, and to enable his or her end-of-life preferences. For Melanie, it was important for families to respect and to facilitate patients' preferences in end-of-life situations. She added:

> *I try to say … you have to put yourself… into the loved ones's* [place]*…some people have had conversations and know what their family member's wishes are, and I just say, you are just giving them their wishes, because they can't communicate right now.*

However, there were times when families felt overwhelmed, and perceived decisions to withdraw or withhold treatment to be against their beliefs. During these times, Melanie discussed that she provided families with support and reassurance that they were doing the best in the given circumstance, and that they were not harming or abandoning the patient. Melanie explained:

> *Some families…say,' oh I know my mother wouldn't want this* [medical treatments]*, but I can't say no, because then it's like I'm killing her'. So it's hard… So, just trying to help support them* [family] *in knowing that they are not giving up on them.*

Some families needed time to reflect about the situation, and to discuss the options of continuing, withholding or withdrawing treatment at the end-of-life. Nurses provided this time to families, during which they continued providing them with information. Emily shared how the

process of decision-making with families would not be rushed. She elaborated, *"Generally, we will never rush something or pressure the family. We'll just keep them updated, and try, as nurses to be very honest with them."* Emily seemed to recognize that there were significant implications to end-of-life decisions, and as such, families needed time to make those decisions. As nurses provided time and information to families, they respected families' right to deliberate, and to make decisions about their loved ones' care at the end-of-life.

Subsequent family meetings were held when families wanted to revisit discussions or when they were ready to make decisions about end-of-life options. In these family meetings, families were able to express their decisions to the interdisciplinary team. Families' decisions to withhold or withdraw treatment and to provide palliative and EOLC were finalized with the consensus of the intensivists, nurses and others involved. Participants often described this consensus with the expression of "everybody was on the same page". At this point, the interdisciplinary team then developed with families a plan to actualize the decisions made. Catherine, for example, described what one particular family decided as a plan after the decision for palliation was made. She explained, *"The family wanted no food, no* [regular] *meds…no picks for the glucometer, no lab tests… make her* [patient] *comfortable, give her pain medication if she needed"*. Participants explained that plans agreed to during family meetings were in part realized by the implementation of existing palliative care directives ("standing orders"), which included directives for pain and symptom management, and the withdrawal of life-sustaining treatment (such as mechanical ventilation), as well as the discontinuation of other medical interventions, like the continuous monitoring of vital signs, enteric feeds, and blood work. Nurses implemented these palliative care directives as part of the care for their dying patients.

4.4.2 Providing dignity conserving care.

When end-of-life decisions were made during 'family meetings' and patients officially "became palliative", nurses completely "switch[ed] gears" focusing on caring for dying patients. This care was intently provided by nurses to preserve the dignity of the dying patient, and specifically, this care included comfort measures for the dying patients.

The comfort measures were provided by nurses with the intention of maintaining the patients' physical appearance, and to relieve any discomfort or pain experienced. Jennifer described the following comfort measures that she and her colleagues provided to patients receiving palliative and EOLC:

> *What do we do? Comfort measures. When they're* [patients] *deemed palliative,… we always do our care anyway, but turn them every 2 hours, put one of those special mattresses on the bed to prevent any sores. Heels- things to make sure their heels don't touch. The ears, make sure the ears are not folded and cutting in the back of their* [ears]*...Eye drops, in their eyes to lubricate. Mouth care, often… because their mouths are very, very dry. The spray… we've seen, just to help… decrease the gasping.*

Although the comfort measures were considered a part of the usual nursing care, Jennifer added that comfort measures met the specific needs of dying patients, such as alleviating their dry mouths and their breathlessness. The provision of comfort measures for dying patients was also a way for nurses to respect the personhood of the individual. Catherine described how she provided the comfort measures with an approach of empathy. She recalled:

> *I just try to put myself in their position. Do I want my hair combed? Do I want my teeth done? You know, my hips might get sore if I'm on one side, so I hope somebody turns me often.*

The way Catherine provided the comfort measures emphasized that it was more than fulfilling her responsibilities, rather, it was a way for her to purposefully conserve the dignity of the dying patient.

4.4.3 Supporting families.

The psychosocial support for the family was often about nurses facilitating a positive experience for family members as they grieved for their loved one. An aspect of facilitating a positive experience was creating a place that was welcoming for family members to be with their loved one. Melanie shared that family members were often uncertain of how they should be at the bedside and they worried being in the way of the staff:

> *The large part is support for the family, and just not being the barrier – allowing them, because a lot of families are like, 'oh, I'm sorry, I'm in your way', but it's like 'No, you're not in my way. You come, you hold', whatever the family needs- just really trying to make that the easiest transition for them, … to just be together and try to help them through it, because it's a very hard, … they don't know what to do… if they should be there or shouldn't…*

For Melanie, she recognized that part of a positive experience for family members was for all of them to be physically close to the patient and to have a place to grieve and to spend the time together. As such, Melanie invited family members to be comfortable and to be present with the patient. Similarly, Catherine described nurses providing comfort by allowing the patient's family members into the shared areas (or places) of the unit, such as the kitchen.

> *Be respectful of their wishes, you know. The wife wants – or the family members want a cup of tea… and they're not allowed in our kitchen, then let them in your kitchen. Let them make a cup of tea; it goes a long way… I just think comfort for everybody.*

Catherine felt it was important to meet the family's needs and to ensure their comfort as they stayed at the bedside with the patient.

Nurses facilitated a positive experience by interacting with families. As nurses interacted with family members, they were able to meet their informational needs. For example, Karen discussed how difficult it can be for family members to experience their loved one dying. She elaborated:

> *Because it's very frightening for families... the emotional loss that they are dealing with, but then the fear of different noises, the agonal breathing, or suctioning, or … the rattle that they hear, so you can … go in and hold their hands, and say, this* [is] *what we expect.*

For some family members, the experience of being with or seeing a person dying was foreign and "frightening" to them. Karen described guiding and supporting the family members in terms of expectations of the dying process. Nurses were also intentional in the ways they interacted with families. Catherine shared that she and her colleagues had conversations with family members, particularly in listening and exchanging stories with them. She explained:

> *I think most of us, and myself included, just take a little more time to interact with the family, talk to them, and… they talk about old times, and good times, and trips that they went on when they were with their parent… and they relate a lot to us, so we tell them a lot of our stories if they're pertinent.*

By interacting and getting to know family members, nurses were able to show care and concern for them and the patient in personalized ways. In addition, as Catherine highlighted, nurses' engagement with family members was reciprocal, particularly as they shared relevant stories with families.

Yet, there were times where the families could not be with the patient or were not present at the bedside. Melanie shared how she interacted with the families in those circumstances. She reflected, *"Then some families… can't be there… they don't want to see it, they can't see it. So trying to make sure that they know that if they're not there, I'm going to be there and sitting with the patient"*. Though these situations were not considered ideal, Melanie seemed to respond with empathy. She provided reassurance to families that regardless of their situation that she would be present with their loved one at the bedside, and that they would not be alone in their dying process.

As the previous sections demonstrated, in "switch[ing] gears" and providing EOLC, nurses took responsibility for the dignity-conserving practices with patients and families. In so doing, they enacted values that are foundational to nursing ethics, such as building supportive and therapeutic relationships, and providing compassion.

4.5 Dealing with "struggles"

Participants' stories revealed that they encountered many challenges when it came to caring for dying patients and their families within the context of the ICU. Some of these challenges or "struggles" included the transfer of dying patients, the heavy patient assignments, and the various roles that they assumed. In response to these struggles, participants shared that they took various actions, such as advocating, collaborating with others, and sharing responsibility, in order to promote a "good death" for patients and families.

4.5.1 "We needed the bed".

Most participants recognized that it was beneficial to keep dying patients and their families in the ICU rather than to transfer them to the medical floor. There seemed to be two main reasons for this. First, participants explained that the private rooms in the ICU provided an ideal space for dying patients and their families to spend their remaining time together. A participant elaborated, *"We have… private rooms in the ICU, so that lends to… a bit better… privacy and dignity... in a four bed ward in a palliative stage* [for patients], *there's no privacy, because there's …other patients and… families"*. Nurses felt it was important for dying patients and their families to have the privacy to grieve, and to be with each other. Therefore, they believed that it was a better experience for dying patients and their families in to be in private rooms, and not need to share the space with other people. Secondly, some of the participants believed that having dying patients and their families stay in the ICU allowed for continuity of care. Beth explained, "*We have a rapport with the patient, a rapport with the family, it's important that they stay in that bed…give us* [nurses] *the time to do the work"*. Using the words "rapport" and "invested", Beth illustrated how nurses developed and nurtured relationships with patients and families over the course of their admission into ICU. As a result, Beth felt it was important for dying patients and their families to stay in the ICU to benefit from these relationships; to receive care from nurses who knew them and were invested in them.

While many participants felt it was important to keep dying patients and their families in the ICU, they also expressed that it was often not possible to do so. Karen described a situation where she had to transfer a palliative patient to the medical floor. She added:

> *Mostly now, with the acuity of the patients that are coming in, very seldom you would see a palliative care patient remain in ICU until such time that they do*

> *die… Unfortunately, we transferred a gentlemen out last weekend, at 1:30 am and he passed away at 5:30, but we needed the bed. So those circumstances are hard too because you kind of uproot the family and have them move… I feel bad doing that, but again, it's based on priority.*

Karen shared her disappointment about the palliative patient being transferred shortly before his death. She recognized that the transfer was a disruptive experience for the dying patient and the family since they had to move from one place to another and receive care from other staff for only a few hours. Yet, Karen also expressed that they "needed the bed" for another patient, who was deemed a higher priority in the ICU because he or she was critically ill and required active treatment. Participants explained that decisions to admit critically ill patients, based on "priority", were frequently made by intensivists and administrators (i.e. unit managers and supervisors responsible for bed management) on the basis of physiological status.

For many participants, they found these situations of transferring dying patient to be a source of conflict, because they recognized the value of both providing life-sustaining treatments, and palliative and EOLC to patients in the ICU. However, they were often constrained in their ability to satisfy each of these two values simultaneously. Many participants shared that the transfer of dying patients occurred as a result of a finite number of ICU beds. One participant explained how patients would be transferred out of the ICU to make room for other critically ill patients to be admitted:

> *What ends up happening sometimes when you have to transfer out… maybe they* [patients] *aren't quite ready to go out, but we're at capacity* [in the ICU], *we have no choice, we have to move people sometimes, and just because the emerge is swamped,… there's a lot of acuity there.*

The way the participant described being "at capacity" implied that nurses were working with a finite number of patient beds, and as such, their prioritization of the unit beds and transferring patients (particularly dying patients) was out of necessity.

Participants discussed various actions they took when it came to the dilemma of transferring palliative patients to the floors. Beth shared how she and her colleagues advocated for the patient to stay a little while longer in the ICU, especially if he or she was imminently dying. Beth explained:

> *We…say no, you're not getting that bed yet. We put our foot down, you* [intensivists] *wanted the patient in ICU, we're going to keep them here, we sometimes have to stand up and advocate, but it's a fight… to palliate in the ICU...*

Beth and her colleagues voiced their concerns to the intensivists and those in administration to prioritize the dying patient and their families. It seemed that nurses' advocacy enabled certain dying patients and their families to stay in the ICU for their remaining time together. For other nurses, there was a sense of making the best out of the necessity of transferring dying patients. Emily explained that she and her colleagues collaborated with bed management and the manager to arrange a semi-private or private room for the dying patient. Emily added:

> *It's an ongoing thing we all know the* [palliative] *patient will be transferred.…*I *always call bed management, and say, 'if they could please reserve a single or semi-private room for this patient'; and I will ask my manager, 'can you please just put a flag up, you know'*

Even though it was not the ideal to transfer, Emily recognized that a single or semi-private room on the floor was a better alternative than a 4-bed ward room for dying patients and their families

in terms of privacy. Participants' advocacy and collaboration with others illustrated their desire to continue facilitating a positive experience for the dying patients and their families.

4.5.2 "I want to provide her care… I have no help".

Participants discussed that it was a normalized practice in the ICU for nurses to have a heavier patient assignment if one patient was dying. Emily explained, "*When you have the palliative patient, because they are not active treatment, maybe you're not running drips,…all this stuff and sometimes you have a heavier load of other patients, because that one* [palliative patient] *doesn't require as much interventions".* Participants shared that the "heavier load of other patients" often included taking care of another one or two critically ill patients, along with the dying patient in the ICU. Emily shared a situation when she had such an assignment:

> *I had a patient on BIPAP… didn't require intubation, but very end-stage COPD (Chronic Obstructive Pulmonary Disease)…confused…pulling off everything, … agitated, so I had that one,… then I had this palliative patient in this end, and then I had a* [patient with] *DKA (Diabetic Ketoacidosis) across* [the unit]*, which of course you're doing sugars every hour, right? The lab work, the drips…the whole bit that goes along with the DKA…and then the other nurses are so busy, that when I want to go in and turn her* [palliative patient] *and I want to provide her care…I have no help.*

While Emily wanted to provide care for her palliative patient, she felt she was pulled away more frequently to care for her other two patients, because they were acutely ill. The nuanced use of the words, "of course" and "right" used by Emily implied an understanding of a greater weight in carrying out the medical treatments for the other two patients than the interventions for the palliative patient. Emily went on to describe that she was able to provide care for the palliative

patient but only with the help of the patient's family members. However, in reflection, Emily expressed frustration in not being able to commit to care for the palliative patient in the same way as her other patients. She voiced, *"I just felt so horrible, because this is not how it should be."* Emily described she felt that she should have been there to promptly attend to the needs of the palliative patient, and to be present with her and her family in the last few hours. Yet, for Emily, it was difficult to fulfill those responsibilities, because the needs of the dying patients and families were juxtaposed to the priority of carrying out life-saving care for other critically ill patients.

There were many factors that contributed to heavy patient assignments. Participants described that there was not enough staff to accommodate for one nurse to care for one dying patient and his or her family. Melanie explained that the only situation when nurses might be enabled to focus all their care on a single dying patient was when the patient who became palliative was receiving mechanical ventilation. She elaborated:

> *In our ICU…if they're on a ventilator, then we have only the one patient. So if they were to be on a ventilator, and then extubated and made palliative, sometimes we will be able to just have that one patient, but depending on the staffing situation, then you might be taking another* [patient] *admission...*

Yet, as Melanie described, this situation was dependent on the overall staffing (the number of nurses per shift), and whether there were other patients to be admitted into the unit. Again, nurses were working with limited resources (i.e. staff and finite number of ICU beds) such that they felt they had to prioritize one-to-one nurse patient ratios for those receiving mechanical ventilation.

As mentioned previously with Emily's quote (see p.91), heavy patient assignments also occurred because of the emphasis to efficiently care for patients. Emily's use of the descriptors "not running drips and all this stuff" and "doesn't require interventions" suggested that patients were frequently reduced to their biomedical needs. As such, there was a perception among the participants that administrators and some staff assumed that since dying patients were not "active treatment", they required less time or effort to be cared for. With this perception, nurses' patient assignments and care were organized in accordance to what was seen as most efficient in terms of staffing and workload. Yet, in the reality of heavy patient assignments, dying patients were rarely prioritized.

Participants discussed various actions that they have taken to cope with a heavy patient assignment. For instance, nurses explained that they adjusted their priorities in care. Catherine shared how she reprioritized:

> *I find depending on the family and depending on the level of anxiety or what's going on in the palliative room… I sell my other patients short. Because it's just, 'You know what, I've got a big family in the other room, and the lady is not doing well or whatever, so can you hold on a little bit longer for a bath or something'… I have to tell my other people to wait, if they can. Simple things.*

Although Catherine at first described "selling her other patients short", she later explained that she was willing to delay meeting some of their needs in order to attend and support the family of the patient receiving palliative care. From Catherine's explanation, it seemed like there was some flexibility for nurses to adjust their priorities in care and to respond accordingly to the situation. However, there also appeared to be limitations as to what could be reprioritized in the context of

the ICU. Catherine mentioned only "simple things", such as baths could be delayed. Otherwise, nurses still had to prioritize meeting the needs of the critically ill patients.

At other times, participants described their colleagues stepping in to help fulfill perceived responsibilities towards dying patients. Melanie described that her colleagues would assist her, for example, by "watching" her other patients, while she spent time with the grieving family of the dying patient. She shared, *"Our coworkers…are there to help you…with time management…to help you do things, or…watch another patient for a little bit, while you go and spend time with that family that need support"*. From Melanie's description, there was a sense of working together and sharing some of the responsibilities among the nurses to ensure that the dying patients and their families still had their needs met. However, this sharing of responsibility seemed to be dependent on the complexity of other nurses' patient assignments and whether they were capable to help. As demonstrated by Emily's earlier story of caring for a dying patient and two other critically ill patients simultaneously, there were times when other nurses could not provide help and she had to rely on the family members.

Participants also described that their colleagues would provide help when a patient had died, and a newly admitted patient arrived in the unit within a short time. Emily described, *"It's sometimes overwhelming, you'll just have a patient that has passed, and you're getting a new admission at the same time…you think could they not wait…Like to me…this is someone's* [patient that died] *father, mother…"* For Emily, spending time with the grieving family was important. Emily discussed how her colleagues would help with the new patient admitted to the ICU, while she finished caring and providing support for the grieving family of the patient who had just died. She added, *"We work so well together. If I am dealing with a patient that has just*

passed, another nurse will step in with the new patient…, so I can finish what I am having to do [with the grieving family].*"*

4.5.3 "We're in a variety of roles".

Nurses were practicing in an ICU context where they assumed various other roles aside from being at the bedside, such as "charge nurse", "telemetry monitoring" and "codes". Using the metaphor of multiple hats, Emily described that nurses often had more than one role, and multiple corresponding responsibilities both within and outside the ICU. As Emily described, this was "stressful" and a "burden" for many nurses. She elaborated:

> *We carry more than one hat at a time… At the end of the day, someone and something gets set aside and that's a big burden, and I think it's very stressful for nurses to carry…We're in a variety of roles , and then have to switch and take on another, it's very difficult.*

As nurses assumed various roles, they contended with limited time, unpredictability, and numerous responsibilities in the community ICU context. Earlier, a story was shared by Melanie and Beth about caring for a young patient, who ended up dying shortly after he was married. The following elaborates on Melanie's account of these events.

Melanie described that she began her day caring for a patient who was mechanically ventilated in ICU. In the middle of the day, an emergency code ERT was called and Melanie went to respond as she had been assigned as the designated person on "Codes". She described:

> *My vent* [patient in ICU] *was pretty sick, but he wasn't heavily sedated, so we had been communicating all day. And then they had called a code ERT, and I was on codes that day, so I went down and met T* [patient in Emergency Department]*, and he was quite sick.*

For a short while, she cared for this patient in the ED as he was having severe respiratory distress and abdominal pain. In the meantime, discussions between members of the interdisciplinary team occurred, and plans were made to move this patient from the ED to the ICU. As such, Melanie left the patient to return back to the ICU in preparation for the transfer. Melanie explained that because of the number of patients already on mechanical ventilators, a patient had to be transferred out to accommodate for the other patient from the ED to be admitted, and in this case, it was her patient who was already in the unit and on mechanical ventilation support. *"The plan was for T* [patient in the Emergency Department] *to come to ICU, but because we were already over bedded, we had to transfer someone out, so that person was going to be my vented patient"*. Melanie prepared and transferred her patient in ICU out to another hospital, while decisions were made to not proceed with further active treatments for the patient in Emergency Department. Melanie described that the patient died shortly after decisions were made and after he was married to his fiancé. Melanie shared:

> *Even though, I'd only met T* [patient in the Emergency Department] *for a brief time, I felt like we had really connected, and so I went down to speak with the family and gave my condolences. I had a lot of emotions that day. Also I think cuz* [because]*… I lost T* [patient in the Emergency Department]*, and then my other patient* [in ICU] *who I had a good rapport with that morning, is now being flown away, and the family now has that commute. It's a lot of stress, you worry about a lot of things, and … then you don't have time to get over it, and then you're getting the next sick patient from the floor… so all that in one day is a lot…*

With her previous patient being transferred to another centre and the patient in the ED having died, Melanie was to care for the next admitted patient because she now had the empty room in the ICU.

Melanie's story reveals several important dimensions of the nursing role(s) in this setting, and how these impact EOLC. First, there was unpredictability regarding the patient emergencies that are present in the community hospital, which influenced Melanie's work and her responsibilities. Melanie had little time or involvement in the discussions and decisions made in terms of the movement of patients. In this case, these discussions and decisions seemed to be coordinated by the intensivists and administrators. Secondly, Melanie's responsibilities as an ICU nurse were spread beyond the confines of the ICU space to other spaces within the community hospital. This was apparent as Melanie was expected to care for two patients, one in the ICU and the other in the ED. Melanie not only had to fulfill her responsibilities, but also the moral obligations she had with these patients and families in terms of relationships. For example, in Melanie's quote, she used words like "rapport" and "lost" which reflected the relationships she held with her patients. Yet, the lack of time and involvement in decisions for their care affected her experience, where she described feeling "a lot" of stress and sadness from many of the events during the day.

Melanie's story was revealing of the community ICU context, where there was frequently limited time, an emphasis to care for critically ill patients, and a reliance of the organization on the skills and experiences of these nurses. While Melanie's story focused on the care of the dying patient outside of the ICU, the complexity of this community ICU context would also affect nurses' provision of EOLC within the unit.

4.6 Summary of findings

Nurses' moral experiences with EOLC in this community ICU context were dynamic, yet at the same time, complex and involved many challenges. The initial description of the community ICU context revealed participants to be experiencing two organizational transitions: the shift in model of care in the unit, and the implementation of a community hospital-wide EHR. Participants' experiences with these institutional changes shaped their perceptions of what was important, and their sense of identity, which was *primarily* focused on saving patients' lives. Participants viewed their practice and responsibility to be centered on collaborating with the interdisciplinary team and meeting the needs of patients who were critically ill. Yet, as participants encountered situations where they needed to provide EOLC, their moral experiences were reflected in the metaphor "switch[ing] gears", where they needed to shift the focus of their identity from saving lives to intently caring for dying patients and their families. By "switch[ing] gears", participants were better able to engage in "mak[ing] a patient palliative", providing dignity conserving care and supporting families, which were underpinned by specific values, such as building therapeutic relationships, providing compassion, and ensuring dignity for dying patients and their families. However, participants' moral experiences with EOLC were confronted with many "struggles" in the community ICU context, which included the frequent transfers of dying patients out of the ICU, the heavy patient assignments, and the multiple roles participants assumed. These struggles were not only sources of conflict for participants, but they also made it more challenging for participants to "switch gears", and to fulfill their responsibilities of caring for dying patients and their families in the ICU.

Chapter 5: Discussion and Implications

In this chapter, the findings of the study and their implications are discussed with the support of relevant literature. In the latter half, the limitations of the study are explained, and recommendations for future nursing practice, education and research are also offered.

5.1 "Switching gears"

The overarching theme of switching gears revealed that participants shifted the focus of their identity and their responsibilities from saving lives to caring for dying patients in the ICU. This finding resonates with previously published literature that has detailed nurses' experiences in being involved with the transition from 'cure' to 'comfort' (Coombs et al., 2012; Gallagher et al., 2015; Thompson, McClement, & Daenick, 2006). For instance, Thompson et al. (2006) used a metaphor of "changing lanes" (p.91) to describe the various strategies that nurses on medical units used to facilitate a shift in goals of care from delivering acute treatment to a palliative focus. "[C]hanging lanes" (p.91) emphasized that nurses needed to be active in making the transition between the two seemingly distinct aspects of care: acute treatment (intended to cure) and palliative care (Thompson et al., 2006). Likewise, in the current study, switching gears suggested that participants' involvement with the transition from 'cure' to 'comfort' was a deliberate response to patients' and families' circumstances. At the same time, findings revealed that participants encountered a number of struggles, such as frequent transfers of dying patients out of the ICU, heavy patient assignments, as well as being responsible for multiple roles and managing competing priorities, which made it challenging for them to switch gears and be in the *"mode"* of providing care to dying patients and their families.

5.2 Identity: "We're ICU nurses"

As previously explored, nurses' moral identities are constructed through narrative expressions of who they are, what they do, and what they believe (Peter & Liaschenko, 2013; Peter et al., 2016). In this current study, nurses' moral identities were reflected in participants' descriptions and stories. Many participants identified most with being *"ICU nurses"* and saving patients' lives. Yet, the findings revealed that these participants' identities were complex, socially constructed, and encompassed their values and responsibilities.

Participants' identities were shaped by their training, their critical care practice, and their relationships with patients, families and other professions, such as their physician colleagues. Doane (2002) suggested that nurses also formed their moral identity through a process of valuation (meaning making), particularly in interaction with others. This was exemplified a number of ways in the current study as participants discussed the significance of their role, relationships and work. Although participants practiced intensive care in the previous 'open' unit, the way they perceived themselves and their practice *now* differed in the setting of a 'closed' unit. In Chapter 4, it was described how participants collaborated with the intensivists, assumed a changed role in caring for the critically ill patients, and collectively shared a priority of saving patients' lives. This new 'closed' practice context and relationships with intensivists contributed greatly to the development of participants' identities, and what they recognized as important in being ICU nurses. Catherine, for example, had shared that it was meaningful to provide care that gives those who are critically ill *"a new lease on life for a little while"*.

While participants were developing their identities as ICU nurses and saving patients' lives, they were also confronted with situations where they needed to care for dying patients and their families. In these situations, participants' identities seemed to be challenged. This was

highlighted in the findings, when Melanie, for example, described how it was difficult to be both an *"ICU nurse"* and a *"palliative care nurse"* simultaneously, because each of these were different in terms of *"mentality"* and responsibilities. For many of the participants, it seemed like their ICU nurse identity was incompatible with that of a palliative care nurse. This insight is in contrast to some of the literature that has previously described ICU nurses as embracing their responsibilities of caring for dying patients and their families, and perceiving their care as a "privilege" (p.7) and "honour" (Ranse et al., 2012, p.7). Additionally, this also raises questions about whether participants actually need to perceive themselves as palliative care nurses to care for dying patients.

Other studies have explored the meanings of being a nurse in particular contexts. For example, Davis, Fothergill-Bourbonnais, and McPherson (2017), using interpretative phenomenology, explored the lived experiences of being an oncology nurse in an adult inpatient context. Davis et al. (2017) interpreted the meaning of this experience as investing in the lives of patients and families, particularly in being with and supporting them in their journey with cancer (Davis et al., 2017). A key finding that is particularly relevant to this current study is the aspect of time, and how oncology nurses recognized their role in caring for the patient throughout the trajectory of cancer, including in death (Davis et al., 2017). Davis et al. (2017) described that nurses gained experience, and built skills and knowledge over time, which ultimately facilitated the development of their identity as 'oncology nurses'. Secondly, although these oncology nurses were not specialized in palliative care, they were cognizant of the life-limiting illness trajectories, and willing to "journey" (p.11) over multiple hospitalizations with patients and families through diagnosis, treatments, and through to death (Davis et al., 2017). This longitudinal perspective in the practice context of oncology allowed these nurses to identify

more closely with their role of providing palliative and EOLC for patients and their families. However, in this current study, since the transition to a 'closed' unit, participants may have been focused on further developing their identity of being ICU nurses. Participants may not have had the time to fully recognize and realize other aspects of their identity and role, such as the care of dying patients. Furthermore, participants seemed to primarily encounter and care for patients and families during the episode(s) of their critical illness, and were less likely to follow patients (and their families) through their recovery or decline in health. Findings detailed participants' responses, such as feeling upset, in caring for patients who they thought *"shouldn't have died"* or those who died unexpectedly. These responses are similar to the findings in Verlarde-García et al. (2016), where ICU nurses' experiences of death and dying would "clash" (p.8) with their expectations for patients to recover. Yet as suggested by Coombs et al. (2012), end-of-life is a possible trajectory for many patients in ICU as a result of their critical illness.

Findings in this current study also revealed participants' identity to have other foci, and involve their personal values and beliefs. Doane (2002) suggested that nurses' collective values and identity at times conflicted with their own individual beliefs about what was 'right'. Karen spoke about having conflicted beliefs and feelings in providing life-saving care to patients at the end-of-life, and believing that she would *"lean further to palliative care"* in her identity even though she was an ICU nurse. Doane, Pauly, Brown and McPherson (2004) explored the meaning of ethics among nursing students, nurses providing direct care, and advance practice nurses. Doane et al. (2004) described how nurses providing direct care experienced uncertainty with how to integrate their personal values into practice situations, whereas advanced practice nurses were more readily integrating their personal and professional selves to be moral agents. In this current study, although Karen was able to express her personal beliefs about palliative and

EOLC, she seemed to struggle in reconciling them with the professional identity of being an ICU nurse and saving lives in the new practice context.

5.3 Promotion of palliation and the provision of EOLC

Participants promoted palliation and ensured EOLC by participating in *"mak*[ing] *a patient palliative"*, *"providing dignity conserving care"*, and *"supporting families"*.

5.3.1 "Making a patient palliative".

Findings detailed how participants were involved in the decision-making process and/or making a patient palliative, in which there was a change in goals of care from active treatment to withholding or withdrawing life-sustaining treatments and providing palliative and EOLC. Similarly, Gallagher et al. (2015) described this decision-making as "negotiated reorienting" (p.794), whereby nurses shifted goals of care and core practices from 'cure' to 'comfort'. In this current study, findings revealed three stages of making a patient palliative: *"initiating discussions"*, *"organizing family meetings"*, and *"facilitating the reaching of consensus"*.

When initiating discussions, participants sought to clarify patients' known preferences for end-of-life, to reflect and to have conversations about the patients' clinical situation with the intensivists and the larger interdisciplinary team. A number of studies have likewise documented how prior to initiating discussions with physicians, ICU nurses elicited information about the patients' quality of life prior to hospitalization and their known end-of-life wishes (Long-Sutehall et al., 2011; Peden-McAlphine et al., 2015). While some studies (Coombs et al., 2012; Liaschenko et al. 2011; Long-Sutehall et al., 2011) discussed the ICU nurses' role to also include coordinating and communicating with physicians of various medical specialities to reach an understanding of the patient's prognosis, participants of this current study did not describe this particular aspect as part of their role. This omission could be due to the fact that within the

community hospital context, there were fewer medical specialities and no existing palliative care team.

Findings highlighted how participants prompted discussions with the intensivists when they perceived a change in the patients' clinical status or when concerns were expressed from patients and families regarding wishes for resuscitation. This was exemplified with Karen's story in approaching the intensivist with the patient and family's concerns about still desiring active treatment. Yet, while participants made efforts to have discussions with intensivists, they were also met with resistance, such as competing priorities in care, and differing of perspectives between medicine and nursing. Recall in Chapter 4 how Karen was told by the intensivist, *"I can't deal with that now, and you brought this up with them* [family]*"*. Similar experiences were shared by McAndrew and Leske (2015), where nurses felt like they were not heard by physicians or were "chasing" (p.367) them to have a discussion about goals of care. McAndrew and Leske (2015) suggested that these situations were obstacles to intentional and good communication between nurses and physicians.

While participants spoke about the importance of family, they did not discuss their role prior to or during family meetings, and it is a limitation of this study that they were not further prompted to describe their role. Previous studies have detailed how nurses prepared both families and physicians for 'care' conferences by finding out their views on the patient' situation, assessing their readiness for a discussion, and setting up expectations to transition in goals of care from 'cure' to 'comfort' (Coombs et al., 2012; McMillen, 2008; Peden-McAlpine et al., 2015). As such, it would seem nurses could play an important role prior to family meetings.

Participants' descriptions revealed family meetings were primarily intensivist-led, and involved providing clinical information and treatment options to families. Jennifer's description

had highlighted, for example, how intensivists framed death, *"this is what's happening, kidney is shutting down, the heart is failing,… there's no further things that can be* [done] *to keep the person going…"*. Participants may have perceived these discussions to be biomedical in focus and under the intensivist's jurisdiction, and as such, this perception may have possibly deterred them from being more active during family meetings. Gallagher et al. (2015) described how nurses were often very cautious in how they communicated information, and feared crossing over what seemed to be "medical domain" (p.800). Yet, at the same time, other authors have posited that nurses' positioning in everyday care of patients and families gives them essential knowledge that should be shared in interdisciplinary contexts, and in particular, family meetings (McAndrew & Leske, 2015; McMillen, 2008; Wright & Brajtman, 2011).

Findings also revealed how participants were involved in reaching consensus, which was getting everyone to come to an agreement and making end-of-life decisions, such as withdrawing or withholding treatment, and providing palliative and EOLC. In this stage, participants' descriptions revealed that they translated information, encouraged families to be the patient's voice, and allowed time for decision-making. This is similar to extant literature that has previously described nurses as using a variety of communication strategies to help families understand the patient's clinical situation, and make decisions based on their knowledge of the patient or any previously expressed end-of-life wishes (Adams et al., 2011; Peden-McAlpine et al., 2015). In this current study, several participants used the expression of having *"everybody on the same page"* to indicate reaching a consensus among the family, intensivists, nurses, and members of the interdisciplinary team to change the goals of care to a palliative focus. In other studies, the expression of having "everyone on the same page" (Brooks, Manias, & Nicholson, 2017, p.164) referred more to the ways the interdisciplinary team collaborated and

communicated together whereby all members shared a similar understanding of the goals for the patient (Vanderspank-Wright et al., 2011). These variations may again be due to differences in context, where in teaching hospitals there are frequently more medical specialities and referral teams involved in negotiating shared goals for the patient (Liaschenko et al. 2011). While this expression of having *"everybody on the same page"* seem to be at different points of the transition from 'cure' to 'comfort', the emphasis of the expression remains that it is a continual and intricate process of collaboration and engagement involving physicians, nurses, patients and families to make end-of-life decisions (Vanderspank-Wright, Roze des Ordons, & Hartwick, 2018).

Findings from this study showed that once everybody was on the same page and the patient became palliative, plans were developed during family meetings with respect to withholding/ or withdrawing treatments, and pain and symptom management. Participants then implemented these plans as part of their care for the dying patients and their families. Recall how Catherine enacted the plan of one particular family, *"The family wanted no food, no* [regular] *meds…make her* [patient] *comfortable, give her pain medication if she needed"*. This resonates with a number of studies that suggest nurses play an active role in operationalizing withdrawing or withholding of treatments, and providing palliative and EOLC that promotes a 'good death' (Coombs et al., 2012; Gallagher et al., 2015; Long-Sutehall et al., 2011).

5.3.2 Providing dignity conserving care and supporting families

In this current study, participants perceived EOLC (after a decision for a palliative focus) to mean providing comfort for the dying patients, and psychosocial support for the families. In particular, participants emphasized the importance of conserving the dignity of the dying patient and their families in all aspects of EOLC. While dignity is a central value in nursing practice, it

seemed for participants that they were especially attentive and responsive to respecting and maintaining patients' dignity at the end of their life. Söderberg, Gilje and Norberg (1997) found that the concept of dignity for ICU nurses meant caring for patients as human beings, bringing families together, and reframing and transforming difficult situations into "beautiful ones" (p.139). Söderberg et al. (1997) suggested that enacting these meanings of dignity required ICU nurses to be sensitive, engaged and to take personal responsibility for their actions. Findings from this current study showed how participants sought to maintain the dying patients' physical appearance, and to relieve any discomfort or pain that they experienced by providing *"comfort measures"*. This aspect of EOLC has been previously discussed in literature as nurses moved away from performing highly technical tasks to providing more humanistic care for the dying patient (Efstathiou & Walker, 2014; Fridh et al., 2009; Vanderspank-Wright et al., 2017).

Also similar to many other studies (Liaschenko et al., 2011; Ranse et al., 2012), findings revealed how participants supported the dying patients' families by interacting with, providing information to, and ensuring a comfortable place for them. Recall the example of Melanie, for whom it was important to not be a *"barrier"* to family presence at the bedside of their dying loved ones. Melanie's emphasis and her choice of words, *"barrier"* and *"in the way"* are indicative of how patients and family members are sometimes situated within the social organization of the hospital setting.

To counter such rhetoric, some authors have alternatively suggested that nurses are the ones who should perceive themselves as "guests" in patient and family experiences that take occur in health care settings (McGarry, 2003). In this current study, it can be seen that the participants were stepping back from their usual positioning in the social organization of the hospital setting, and encouraging families to take ownership of the space at the bedside. This

change in positioning suggests that nurses perceived the ICU room to be both the location of where the patient was dying and *living*, and thus, they also acknowledged that the space at the bedside should be shared with the family.

5.4 Practice context: Navigating the "struggles"

In this study, findings revealed that participants experienced many *"struggles"* in the care of dying patients. These struggles were embedded in the participants' practice context and included the transfer of dying patients out of the ICU (*"We needed the bed"*), the heavy patient assignments (*"I want to provide her care… I have no help"*), and the various roles nurses assumed. These struggles highlighted the complex ways in which the context of the ICU in the community hospital influenced participants' moral identity and agency in providing palliative and EOLC to patients and their families. Rodney et al. (2009) similarly described particular factors in nurses' practice context as "currents" (p.303) that constrained or facilitated their ability to take the right or best course of action in the situation involved. In this study, there were three contextual 'realities' that underpinned participants' struggles: limited resources, biomedical priorities, and transitions.

5.4.1 Limited resources.

Extant literature has described limited resources in healthcare in many ways, such as the reduced access to specialized services, lack of equipment and human resources, and fewer educational opportunities for staff (Rechel et al., 2016; Stewart, 2010; Vanderspank-Wright & McMillan, 2016). In this study, limited resources seemed to emerge in the form of finite availability of patient beds in the ICU and inadequate nurse to patient staffing ratios. Furthermore, findings of the study also suggest the community ICU context to be under-resourced, whereby participants held numerous nursing responsibilities inside and outside of the

ICU. Participants' descriptions of these resources (both limited and under-resourced) revealed a perception and narrative of powerlessness, as well as one of possible frustration, that affected their provision of care for dying patients and their families.

In the interviews, participants described experiencing conflicts and tensions with the transfers of dying patients out of the ICU. Recall in Chapter 4 how participants described that they *"had no choice"* but to transfer patients (particularly dying patients) out to the medical floors when all the ICU beds were occupied or *"at capacity"*. Similar instances of transfers of dying patients have also been documented previously (Bloomer, Morphet, O'Connor, Lee, & Griffiths, 2013; Liaschenko et al., 2011). Yet, differing from other studies, these current findings described participants' individual and sometimes collective agency to continue promoting dignity-conserving care for dying patients and their families, which included keeping them in the ICU. This was exemplified with Beth and her colleagues voicing out their concerns to the intensivists and to those in administration, and saying, *"No, you're not getting that bed yet…we're going to keep them* [dying patient] *here."* While Beth and her colleagues' advocacy was at times successful in keeping the dying patients in the unit, the findings revealed that participants' agency was frequently constrained and the transfers of dying patients continued to occur. As such, it can be seen that these transfers were often beyond the immediate control of nurses or first-line management, but rather were attributed to an issue of finite (fixed) bed availability situated in the wider health care context.

In the province of Ontario where this current study was conducted, ICUs are part of a larger and more complex critical care system that is comprised of a number of different level leaders, stakeholders and partners (hospital corporations, emergency medical services, and various committees) (CCSO, 2015). This critical care system not only ensured the day-to-day

delivery of critical care services, but also strategically measured the performance of ICUs, forecasted the demand for critical care services, and allocated resources (CCSO, 2015). As such, in many ways, these processes in the critical care system govern the finite bed availability and also set a precedence to care for critically ill patients in ICUs.

Findings of this study also revealed that participants experienced heavy patient assignments, which was a more demanding workload when caring for dying patients in the unit. Participants found heavy patient assignments problematic, because it was very difficult to meet the needs of the dying patient and the critically ill patients all at the same time. The normalized practice of heavy patient assignments seemed to have occurred in part because staffing ratios were prioritized according to the number of critically ill patients who were receiving mechanical ventilation. This was alluded to by Melanie, when she described the only occasion nurses would care for one dying patient is if they were *"made palliative"* while ventilated (and subsequently extubated), but even then this ratio was *"dependent on the staffing situation"*. This finding related to heavy patient assignments is different from some other ICU contexts, where nurses were able to maintain a one to one ratio with dying patients and families, and to spend the necessary time caring for them (Holms, Milligan, & Kydd, 2014).

Heavy patient assignments also seemed to have resulted from the larger social organization of care in the ICU and in the community hospital context. As mentioned before, some of the hospital administrators' priorities were to ensure performance and quality measures were met accordingly in the ICU (and the community hospital in general).While these priorities are important, they also seem to create a culture in the work environment that is focused on efficiency and cost-effectiveness. Recall in Chapter 3, how Malone (2003) theorized certain changes in hospitals, such as the use of more part-time/ temporary staffing, and the elimination

and redesign of some nursing practices, to be detrimental for the nurse-patient relationship. These hospital changes could constrain the three levels of proximity (physical, narrative, and moral) in the nurse-patient relationship (Malone, 2003). This was exemplified by a situation like Emily's, where she described how she had little time or help to care for the dying patient and the family, because of her heavy patient assignment. In this instance, Emily's time to provide quality care was contested against the numbers of patients, tasks and responsibilities that she had. Furthermore, it could be seen that the heavy patient assignment interfered with Emily's ability to maintain physical proximity with the dying patient, let alone develop other levels of proximity in the nurse-patient relationship. Ultimately, heavy patient assignments had consequences to participants' moral experiences, which was highlighted by Emily who said, *"I just felt so horrible, because this is not how it should be"*. These experiences are indicative of how challenging it is for nurses to provide care in work environments that contradict their values, such as engaging in compassionate and safe care for patients and families.

In the interviews, participants of this study described that they held roles and responsibilities inside and outside of the ICU. This was exemplified with Melanie's story of responding to a code ERT in the ED, while also caring for a critically ill patient in the ICU. Melanie's story (and others alike) demonstrated how participants perceived expanded roles and responsibilities outside of the ICU to be competing priorities in their practice. Recall how Emily described the multiple roles nurses assumed as *"stressful"* because at the end of the day *"someone and something gets set aside"*. Nurses' multiple roles suggest that the community ICU could be under-resourced. Extant literature has described hospitals in small/ non-metropolitan communities to often have fewer and less specialized services to offer patients and families (Rechel et al., 2016). Furthermore, these hospitals often face tremendous challenges with human

resources (Medves, Edge, Bisonette, & Stansfield, 2015; Rechel et al., 2016). For instance, Vanderspank-Wright and McMillan (2016) explored the experiences of nurses providing critical care to patients and families in ICUs north of the 60th parallel in Canada. They described ICU nurses in the northern context to have expanded scope of practice and responsibilities, particularly in being a resource to other nurses and physicians elsewhere in the hospital (Vanderspank-Wright & McMillan, 2016). The expanded scope of practice occurred as a result of the limited available interdisciplinary staff (like Respiratory Therapists) in the northern context, as well as a perception from those outside the unit that the ICU had more resources than other areas of the hospital (Vanderspank-Wright & McMillan, 2016). Likewise, the context of this current study reflected fewer staff and specialized services throughout the community hospital, and a significant reliance on the available skills and experience of nurses in the ICU.

5.4.2. Competing biomedical priorities.

A biomedical philosophy often focuses on "the cure, prevention and management of biological diseases" (p.E640) with the reliance on research evidence (Fuller, 2017). Furthermore, ICUs exist to provide specialized care and life-sustaining treatments to cure or improve patients' critical illness and to prevent further physiological deterioration and death (Adhikari et al., 2010; Truog et al., 2001). In this current study, biomedical philosophy influenced the transfer of dying patients, heavy patient assignments, and multiple roles.

The transfer of dying patients out of the ICU could also have occurred for the reason of providing care to other critically ill patients. Participants alluded to this, when they described transferring out patients to the medical floors, because of the *"acuity"* of patients requiring and awaiting to be treated in the ICU. Recall how Emily described the transfer of dying patients, *"It's an ongoing thing we all know the* [palliative] *patient will be transferred"*. This is

significant as it may reflect a potential perception amongst participants and others healthcare professionals that dying patients do not need the care provided in the ICU any longer.

Furthermore, the findings of participants' experiences with heavy patient assignments and multiple roles seemed to reveal a priority for critically ill patients. This was exemplified in Emily's description of heavy patient assignments, and Catherine's explanation of how she adjusted her priorities in care. Both these situations demonstrate that while dying patients may stay in the ICU, participants' priorities were geared towards carrying out treatments and ensuring that the physiological (i.e. biomedical) needs of the critically ill patients were met. As mentioned before, the findings revealed that participants experienced conflicts because they recognized the importance of both providing life-sustaining treatments and palliative and EOLC. Studies have similarly described how nurses have felt frustrated and unsupported when there was a lack of understanding in the complexity of providing EOLC and a "strong curative culture" (Ranse et al., 2012, p.7) in the unit (Gélinas, Fillion, Robitaille, & Truchon, 2012; Nordgren & Olsson, 2004).

Using an explicit nursing geography theoretical lens, Liaschenko et al. (2011) explored the ways in which nurses worked with dying patients and their families inside and outside the ICU. A relevant finding discussed was how typically the patient's body in the ICU was divided by organs and systems, and looked after by various medical specialities with the purpose of maximizing treatment (Liaschenko et al., 2011). Liaschenko et al. (2011) suggested that the result of this division was the potential loss of a "unified, embodied human being" (p.819). This insight is significant to the current study. Even though there were fewer medical specialities in this ICU context, intensivists and participants practiced and cared for critically ill patients based on the physiological dysfunction of the individual organs and systems. While this approach may be necessary in the implementation of treatment for critically ill patients, it is also deeply rooted

in the way care is organized and delivered in the ICU (i.e the prioritization of patient beds). Under such organization, the needs of patients who are dying are at risk of being overlooked for their needs by health care providers and the wider healthcare system.

5.4.3 Transitions.

In this study, participants experienced the transition from 'cure' to 'comfort' by shifting gears. However, they also experienced other transitions in their practice context, particularly with the organizational changes that included the shift in the model of care of the ICU and the implementation of a hospital-wide EHR. Chick and Meleis (1986) defined transition as a "passage from one phase, condition, or status to another" (p.239) that occurred over a period of time. Schumacher and Meleis (1994) described one of the types of transition to be "situational" (p.120), whereby nurses experienced transition with changes in the practice setting, clinical role, and scope of practice. In this current study, the organizational changes were added challenges to the participants' practice context. Recall in chapter 4 when Emily described how nurses were emotionally overwhelmed, *"aren't themselves"*, and stressed about their responsibilities of caring for critically ill patients and managing the new EHR. Kralik, Visentin and Van Loon (2006) suggested the experience of transition consists of an element of disruption to an individual's reality and a threat to his or her sense of self.

In the current study, participants' role and practice were revealed to evolve as a result of the 'closed unit'. In a recent literature review, Arrowsmith, Lau-Walker, Norman, and Maben (2016) described nurses' experiences with transition in work roles to involve re-shaping of their professional identity, particularly in their attitudes and values. Additionally, nurses in transition to work roles were concerned with gaining skills and confidence in clinical situations (Arrowsmith et al., 2016). As mentioned before, the changes associated with the 'closed' unit led

participants to reflect, and re-evaluate their identity as ICU nurses. While it was clear that the priority appeared to be about saving patients' lives, it is also possible that the nurses were also in a period of having to transition their skill set and knowledge to accommodate a "sicker" patient population in the ICU. Previously published literature exploring shifts in models of care have been generally focused on patient outcomes (mortality rates, length of stay), financial implications, and physicians' perceptions of care (Ghorra, Reinert, Cioffi, Buczko, & Simms, 1999; Katz et al., 2017). However, the findings of this current study bring forth nurses' perspectives and their experiences of organizational transition in a way that, to the researcher's knowledge, has not been previously discussed, particularly within a critical care context.

Study findings also highlighted how participants experienced changes with the EHR in their practice setting, particularly in their workspace and workflow. This was exemplified by Emily's description of nurses working and utilizing the EHR in patients' rooms to access their charts and to administer their medications. Yet, Emily's description was also revealing of the subtle ways the utilization of EHR directed nurses' provision of care, especially as she had noted, *"nurses are on the computer trying to manage their day"*. Based on their Institutional Ethnography (IE) study, Campbell and Rankin (2017) suggested that the use of EHR can lead nurses into objectifying their patients, and focusing on the efficiency of interventions and outcomes, rather than using their own knowledge and judgement to provide care. Similarly Malone (2003) posited that certain spatial structures (work environment) changes, such as "charting by exception" (p.2321), can disrupt the levels of proximity in nurse-patient relationship, threaten nurses' moral engagement with patients and families, and reduce nursing work into a series of tasks. As such, the utilization of the EHR in this current study raises

important questions as to how nursing work is being shaped, particularly as it relates to meeting the holistic needs of dying patients and their families in the ICU.

5.5 Implications for Nursing Practice, Education and Research

Findings of this study elicited important implications for nursing practice, education and research. These implications are not only applicable to this community ICU unit, but also to other similar contexts of intensive care. As such, recommendations based broadly on the findings will be made, and lastly, the limitations of the study will also be discussed.

5.5.1 Key recommendation

An overarching implication from this study is that the provision of EOLC in ICU requires a deliberate change in perceptions and values. The metaphor of switching gears was used to describe how participants shifted the focus of their identity and responsibility from saving lives to caring for dying patients. This shifting of identity indicates that participants were often engaged and responsive to patients and families' circumstances. Yet, at the same time, findings also revealed that participants *struggled* to switch gears, because of some of their own perceptions of caring for dying patients within the context of intensive care. Furthermore, findings of this study highlighted that participants practiced in a context where other priorities, such as the lack of resources, the care of critically ill patients and organizational changes, frequently took precedence. Based on these overall findings, a key recommendation is that a *wider* shift is needed in the local culture of ICUs and hospitals to collectively take up the responsibility for the care of dying patients and their families in all settings. In the following section of nursing practice, specific recommendations will be made for nursing, ICU units, and those in leadership positions in hospitals.

5.5.2 Nursing Practice

Findings of this study revealed that participants sometimes struggled with their responsibility of providing palliative and EOLC in an ICU setting. As previously discussed, there was a perception among some of the participants that it was difficult to be both an *"ICU nurse"* and a *"palliative care nurse"*, however, it is important to note that these are different practice settings requiring specific knowledge and skills. Nurses in general should strive to integrate a palliative approach and the provision of palliative/ EOLC as part of their role in ICU (CACCN, 2017b). One of the ways to approach this integration of role is for nurses to thoughtfully reflect on their own practice, as well as their own beliefs about death and dying. Through reflection, nurses may come to recognize some of the areas where they lack knowledge or competency in providing palliative/ EOLC. Furthermore, as nurses reflect, they may also be more ready to acknowledge their own beliefs and values, and to identify the ways in which they guide their actions, particularly in the care of dying patients and their families.

This current study pointed out that the transition from 'cure' to 'comfort' in ICU is multifaceted, and at times, a challenging process of collaboration with all those involved. Participants described interpersonal conflicts with intensivists during end-of-life decision-making. Some participants perceived their advocacy for patients to be poorly received by intensivists, while on other occasions, they were hesitant to initiate discussions because the patient's prognosis was uncertain. It is clear that there should be various resources available in ICU contexts to support nurses, intensivists, and other interdisciplinary team members with their involvement in end-of-life decision-making. Clinical ethicists and palliative care teams are resources that can provide the staff new perspectives regarding end-of-life situations where there are moral dilemmas or conflicting values (Chow, 2014). As such, nurses, intensivists and other

interdisciplinary team members should be encouraged to consult these resources for assistance in end-of-life decision-making. However, it is also important to consider that these resources may not be available in community hospitals.

Another resource that could be helpful in the ICU is formal debriefing sessions, where nurses, intensivists, and other interdisciplinary team members are able to review and discuss the patient case, and make suggestions for change in the future (Shariff, Olson, Santos Salas, & Cranley, 2017). Formal debriefings could improve communication and also assist in resolving conflicts between staff, particularly in situations of unexpected death or experiences of moral distress (Hamric & Blackhall, 2007; McAndrew & Leske, 20015). Furthermore, ICUs could also implement 'team building activities' that could be helpful in facilitating overall cohesion, collaboration and the development of shared goals and values among the staff (Hamric & Blackhall, 2007; McAndrew & Leske, 2015).

Findings of this study also indicated that there was strong emphasis on the care of critically ill patients among staff in the unit, and furthermore, there was possibly a perception that dying patients no longer need the care provided in the ICU. Yet, this perception might not be valid as there are situations where dying patients need to die in the ICU. For instance, depending on the approach of withdrawing life-sustaining treatments, dying patients might still be mechanically ventilated and require EOLC in the ICU (Cook et al., 2003). Other times, death can be imminent within minutes to hours after the withdrawal of life-sustaining treatments (Rocker et al., 2005). In these situations, there could be little time for nurses to care for the dying patient, and prepare the family for the death of their loved one (Sarti et al., 2015). Furthermore, it would be a disruptive experience for the dying patient and their family to move to other units, and lose precious time and their last moments together (Sarti et al., 2015). As such, it is important that

there is a culture within ICUs that make space for dying patients and their families to spend their last moments together in the unit. This shift in ICU culture might require staff to reflect, appreciate, and raise awareness amongst each other of the benefits and significance in having dying patients and their families stay in the unit (Holms et al., 2014).

Findings revealed that once a decision for palliation was made, participants took an active role in enacting withdrawal or withholding of treatment, and providing palliative and EOLC to patients and families. Yet, study findings also revealed that some of the participants perceived that caring for dying patients was difficult to accept, and at times, stressful, and emotionally draining. It is important to recognize the experience of grief by nurses and other healthcare professionals in the ICU when caring for dying patients and their families, particularly with patient deaths that are perceived to be unexpected (Shariff et al., 2017). Additionally, in community hospital settings, nurses need to be acknowledged for, and supported in, the grief that they may experience over the deaths of patients whom they have come to know over what can be a long period of time, sometimes involving several prior ICU admissions.

ICU managers and charge nurses can play a role to support nurses in their response to patient deaths. They could ensure nurses have some time and space after a patient death to reflect on their experience before taking care of other patients. Furthermore, ICU managers and charge nurses could encourage nurses to develop their individual coping and self-care activities (e.g. journaling, physical activities and art) that might assist with their grieving process (Shariff et al., 2017). Among nurses, informal support from peers has also shown to be helpful in coping with patient deaths (Shorter & Stayt, 2010).

This study also identified several challenges for participants in this community ICU context that made it difficult to provide care to dying patients and their families. Employers have

an obligation to ensure a quality work environment for nurses that promotes safety, respect, and ethical practice (CNA, 2017a). One of the ways those in hospital leadership positions (nursing and other disciplines) can bring change is to improve staffing ratios in ICU, so that nurses are not made to care for other additional patients while withdrawing life-sustaining treatments and providing EOLC (Kirchhoff & Kowalkowski, 2010). This would allow nurses adequate time to prioritize and meet the needs of dying patients and their families (Kirchhoff & Kowalkowski, 2010). Improved staffing would also assist nurses with any added responsibilities, and avoid additional competing demands to their workload (Vanderspank-Wright & McMillan, 2016).

The finite availability of ICU beds in any hospital can negatively influence the quality and safety of patient and family care, as well as the workplace environment (Bagshaw et al., 2017). In the current study, finite availability in ICU beds often led to the transfers of dying patients out of the unit and consequently, experiences of conflict among participants. Yet, Bagshaw et al. (2017) reported a number of possible strategies to manage the finite availability in ICU beds including implementing an ICU bed navigator, developing a policy to temporarily increase ICU capacity during periods of high demand, and creating a standardized patient admission criteria. Those in hospital leadership positions could develop similar strategies to better manage the finite availability of ICU beds, but moreover, they should collaborate with regional and provincial critical care partners and stakeholders to ensure there is adequate allocation of resources and funding prioritized for the ICU.

Lastly, those in hospital leadership positions could help strengthen nurses' autonomy in their practice. Nursing autonomy implies an extent of independence and freedom to act upon responsibilities, and it is associated with knowledge and competence (College of Nurses of Ontario [CNO], 2014). In the current study, some of the participants perceived a loss in their

autonomous practice, especially as the new intensivists became very involved with the care of patients. Yet, it may be that the perception of autonomous practice by the participants needs to be reconsidered with the introduction of the 'closed' unit model. Using grounded theory, Paganini and Bousso (2015) described ICU nurses needing to recognize the spaces in which they can be involved with decision-making and exercising autonomy, particularly in end-of-life situations. In any ICU context, nurses should be encouraged to make use of their involvement in interdisciplinary situations, such as daily rounds and family meetings, to share their own knowledge and judgement in end-of-life decision-making. At the same time, those in hospital leadership positions need to ensure that there are effective organizational processes in place where nurses can be given opportunities to voice their concerns and be involved with decision-making in issues affecting their practice and their care (MacLeod et al., 2008).

5.5.3 Education

In this study, many of the participants described that they had no formal training with palliative/ EOLC, and that they had primarily learned their current practices through peer to peer observation, and encounters with dying patients and families. While observations and first-hand experiences with dying patients are crucial for learning, it is also important for nurses in ICUs to have other ways to develop their knowledge and maintain their competencies in providing palliative and EOLC (Gélinas et al., 2012). A strategy that could be implemented by nurses in ICUs is a journal club. Journal club is a forum where nurses could read journal articles, and dialogue with each other about relevant clinical topics, such as EOLC (Bilodeau, Pepin, & St. Louis, 2012). The implementation of a journal club could allow nurses to take ownership of their own learning, and potentially, make changes to their practice based on research evidence (Gloeckner & Robinson, 2010).

Findings of this study also revealed the experience of a new nurse practicing in the ICU. This participant did not identify herself with being an ICU nurse or a palliative care nurse, but rather a *"new nurse working in ICU"* as she believed that she was still trying to gain the skills and experience to work with critically ill patients. Similarly, Davis (2012) found that novice nurses did not identify with being "an oncology nurse" (p.61) until they gained foundational skills and experience, and felt like they were a part of the interdisciplinary team, all of which occurred over time. In the current study, it could be seen that this participant (new nurse) was experiencing the transition from completing her formal education to beginning nursing practice in an intensive care context. Extant literature has described new graduate nurses' experiences of transition to practice to be stressful, and to include many challenges, such as knowledge and skill acquisition, workload demands, and the encounters of patient deaths (Duchscher, 2008; Thompson, Austin, & Profetto-McGrath, 2010). In particular, Thompson et al. (2010) explored new nurses' experiences of their first patient death in the ICU. They described how these new nurses often felt unprepared and overwhelmed with the responsibility of caring for the dying patient and their family, especially in providing comfort measures and emotional support (Thompson et al., 2010). As such, it is also imperative that new nurses are supported in their experiences of caring for dying patients and families (Vanderspank-Wright, Fothergill-Bourbonnais, Malone-Tucker, & Slivar, 2011). One of the ways to support these new nurses is for educators to include clinical learning of EOLC principles, the use of the standardized palliative care orders, and the process of withdrawal of life-sustaining treatments as part of the orientation to working in the ICU (Kirchhoff & Kowalkski, 2010; Vanderspank-Wright et al., 2011). Additionally, educators or managers of the ICU may also choose to have new nurses

mentored by more experienced nurses, so that they can have gradual learning experiences of caring for dying patients and their families (Vanderspank-Wright et al., 2011).

Study findings revealed that there was a strong emphasis on caring for critically ill patients, and meeting their biomedical needs. While this emphasis is necessary in the ICU, it also created difficulties for participants and intensivists to transition from 'cure' to 'comfort', particularly in initiating end-of-life discussions and having *"family meetings"* with patients and their families. Nurses and intensivists could benefit from educational support in this area. For instance, the unit manager and the educator could bring in guest speakers/or facilitators into the hospital to lead educational workshops with the staff that support and promote the development of communication skills in end-of-life situations (Brooks et al. 2017). Interactive and hands-on workshops focused on improving communication skills have been shown to be helpful for both nurses and physicians, especially in answering questions from family members, participating in family meetings, and discussing end-of-life related topics (such as code status, and advanced care planning) (Krimshtein et al., 2011; Smith, O'Sullivan, Lo & Chen, 2013).

Findings of this study also highlighted the complexity of participants' identities, as well as the contextual 'forces' that often constrained their moral agency. Although participants did not necessarily use the language of ethics to describe their experiences, they recognized that some of the end-of-life situations they faced involved their values, judgment, and ultimately, their actions. There is an ongoing need to foster nurses' development as moral agents in their everyday practices in ICU, including in end-of-life situations (Doane et al., 2004; Rodney et al., 2009). Doane et al. (2004) suggested the sharing of stories to be a helpful tool for nurses to become aware of who they are professionally and personally, and to recognize their ability to practice ethically. Additionally, stories can also bring forth the contextual details (i.e situational,

personal, etc.) that shape nurses' identity and agency (Doane et al., 2004). In ICUs, managers and educators can bring in facilitators or lead workshops, where nurses are guided to understand and work through ethical issues more deeply. For instance, these workshops can address issues that nurses identify as sources of ethical conflict in end-of-life situations, such as discussing patient prognosis, and withdrawing life-sustaining treatments (Ray et al., 2006). Furthermore, the workshops can also be opportunities for reflection for nurses as they share their individual and collective stories of their practice. Ethics education (in the form of workshops as just described) can potentially enhance nurses' capacity to better care for patients and families in the ICU, particularly during challenging end-of-life circumstances.

5.5.4 Research

In the study, participants described the various ways they were involved with the care of dying patients. Yet, at the same, it seemed like participants took an observer role prior to and during family meetings. Nurses' involvement in family meetings is crucial in bringing various perspectives (caregivers, patients and families) together for decision-making (Hamric & Blackhall, 2007; McAndrew & Leske, 2015; McMillen, 2008). Further research needs to be conducted in the community ICU context to explore nurses' involvement with family meetings, particular how they enact their moral agency within those spaces. Such research could potentially generate ways of encouraging nurses to take a more active role in family meetings. Additionally, the current study findings suggest that nurses are part of the process of collaborating with the interdisciplinary team and patients/families, and getting *"everybody on the same page"* for end-of-life decision-making. However, future studies could explore in greater depth the ways in which nurses are morally engaged with the interdisciplinary team and patient/ families, particularly in situations of conflicts or disagreement with end-of-life decision-making.

Study findings examined how participants encountered and transitioned through various organizational changes. Specifically, aspects of participants' experiences with the use of EHR were highlighted in this study. However, future research should examine the extent to which the use of EHR shapes and impacts nursing work broadly and within ICU contexts (Campbell & Rankin, 2017). Furthermore, the current study findings uniquely captured participants' various experiences in the transition from being an 'open' to 'closed' ICU unit in a community hospital. Yet, there are other potential practice changes in the rural and community hospital context, such as the closing and amalgamation of units that could change nurses' roles and responsibilities, as well as the care of patients and families. Future studies could explore nurses' transition through these practice changes, particular with how they influence nurses' identity and agency.

5.6 Limitations

This study sought to explore ICU nurses' moral experiences with EOLC in a community ICU context. While qualitative studies are intended to broaden understanding of experiences, it is necessary to acknowledge that the findings of this study may not reflect the moral experiences of all nurses regarding EOLC in ICU including nurses employed in other "closed" ICUs and/or community hospitals.

The sampling of participants in this study may have impacted the findings. It is possible that the participants sampled were particularly interested and comfortable with discussing EOLC. As such, the findings may not have captured the moral experiences of other nurses in the community ICU, who may have felt uncomfortable with sharing their own stories or perspectives in providing EOLC. Furthermore, certain demographic characteristics of the participants sampled could have also limited the findings of the study. The majority of participants in the study were of Caucasian ethnicity and female. Nurses' moral experiences involve their values and beliefs,

which can be influenced by their families, culture, religion, and own personal experiences (McClendon & Buckner, 2007; Varcoe et al., 2004). The findings of this study may have been presented differently if there were more male participants or those of other ethnicities. As such, future studies could explore ICU nurses' moral experiences among a more diverse sample.

The study design may also have been a limitation. All participants were extended an invitation to participate in both initial and follow interviews, however, only 4 out of the 7 participants were able to partake in the follow-up interviews. As such, the moral experiences of these 4 participants may have been conveyed more strongly throughout the findings of the study. At the same time, the follow-up interviews with participants provided enriching data that would have not otherwise been collected in the initial interviews alone.

5.7 Reflections on conducting follow-up interviews

In reflecting on conducting follow-up interview for this study, it was readily apparent that the data collected from these interviews was essential in the interpretation and construction of the findings. Four of the seven participants took part in these follow-up interviews, which occurred approximately six months after the initial interviews. The primary objective of the follow-up interviews was to explore the findings in greater depth. For instance, in the follow-up interviews, the researcher sought to further probe and examine the complexity of participants' identity as ICU nurses. As such, the researcher asked participants to share their views of what it meant for them to be *"ICU nurses"*, and how that might differ from other identities like that of a *"palliative care nurse"*. Participants' responses brought forth various insights about the circumstances or perceptions that shape who they are, and what they take responsibility for. In particular, the metaphor of "switch[ing] gears" was referred to by a participant during the follow-

up interview, as she discussed her approach with the transition to a palliative focus with patients and families.

Conducting the follow-up interviews also provided an opportunity for participants to reflect, clarify and provide feedback on the findings presented. For example, one of the participants commented that although that the description of EOLC was well-covered, there should be more emphasis on nurses' experiences after the death of the patient. The participant explained, *"I think the aftermath of dying patients* [should be discussed]*…In an ICU setting and as an ICU nurse, I don't expect people to die…you go home and you question: did we do everything that we could?"* Participants' feedback in the follow-up interviews was helpful for the researcher to thoughtfully consider and explore other aspects of nurses' moral experiences with EOLC, which had not been previously sought.

5.8 Conclusion

Findings of the study revealed an overarching theme of *"switching gears"*, which reflected the notion that participants shifted the focus of their identity and their responsibilities from saving lives to caring for dying patients. In particular, the shift in focus involved participants *"making a patient palliative"*, *"providing dignity conserving care"* and *"supporting families"*. Yet, participants encountered many *"struggles"* embedded in their context that made it difficult for them to *"switch gears"*.

The findings of this study enhance our knowledge and understanding of the complexity of nurses' identities, particularly what they take responsibility for the care of dying patients and their families. Furthermore, the findings highlight specific challenges, such as limited resources, biomedical priorities, and transitions, in the community ICU context that impact and shape

nurses' provision of palliative and EOLC. Insights from this study also elicited important implications for nursing practice, education and research.

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Appendix A: Flyer

uOttawa

L'Université canadienne
Canada's university

Interview Research Participants needed!

uOttawa Nursing Research Study Title: "Nurses' moral experiences of end-of-life care in a community hospital intensive care unit"

What is the research study about?

The purpose of this research study is to explore nurses' moral experiences of end-of-life care in a community hospital intensive care unit.

Who is eligible to participate?

Any Registered Nurses currently working in the Hospital.

What do I need to do?

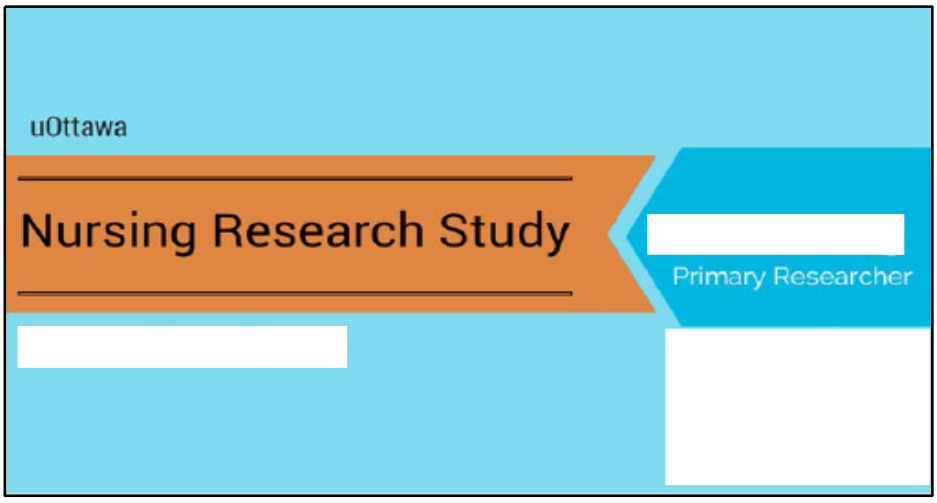
You are invited to participate in one or both interviews (initial and follow up) with the researcher. In the initial interview*, you will be asked to share your own nursing of providing end-of-life care for patients and families. In a follow-up interview, the researcher will discuss the study findings and you will be asked to reflect and provide feedback on the study findings.

*Participants will be selected for initial interview on first come/ first serve basis

Need more information? Interested to participating?

Contact Primary Researcher of the study:

Appendix B: Business Cards



Size of business cards: 3.5 x 2 inches

Appendix C: Website

Home page URL:

uOttawa Nursing Research Study (/)

uOttawa

L'Université canadienne
Canada's university

University of Ottawa
Nursing Palliative Care Research and Education Unit

We are excited to present an upcoming uOttawa nursing research study. This qualitative study explores nurses' moral experiences of end-of-life care in a community intensive care unit.

We are looking for research participants like yourself to participate in our study!

The Study

What is this study about?
What are the benefits of the study?

KNOW MORE (/THE-STUDY.HTML)

The Researchers

Who are the researchers of this study?

KNOW MORE (/THE-RESEARCHERS.HTML)

Participation

What is required to participate?
How do I participate?

KNOW MORE (/THE-RESEARCHERS.HTML)

Appendix C: Website (continued)

"Study" page URL:

The Study

"Exploring nurses' moral experiences of end-of-life care in a community intensive care unit"

We are interested in hearing from nurses about their experiences in providing end-of-life care for patients and families. From these experiences and stories told, we want to discover the values and beliefs nurses' hold when providing end-of-life care. Further, we want to explore how the community intensive care unit environment may influence and shape the way nurses provide end-of-life care.

Why this study?

Currently, what we know about nurses' experiences of end-of-life care come largely from studies conducted in intensive care units of urban and teaching hospitals. Few studies have explored nurses' experiences of end-of-life care in intensive care units of community and rural hospitals. Yet, we believe that issues of death and dying, and end-of-life care are significant in the community and rural intensive care unit setting.

We believe that in conducting this study, we will be adding to the existing research in end-of-life care, and critical care nursing. The findings of this study may be beneficial for improving future end-of-life care for patients and for supporting nurses in providing end-of-life care.

Resources

If you are interested in knowing more about end-of-life care, please see some of the links below:

The Way Forward - An Integrated Palliative Approach to Care: www.hpcintegration.ca/ (http://www.hpcintegration.ca/)

CACCN Position Statement: www.caccn.ca/en/publications/position_statements/providing_end_of_life_care_in_the_icu.html (http://www.caccn.ca/en/publications/position_statements/providing_end_of_life_care_in_the_icu.html)

Appendix C: Website (continued)

"Researchers" page URL:

The Researchers

Meet the Team

Primary Researcher:

Sandra is a graduate student in the Masters of Science in Nursing Program at uOttawa. Her clinical experiences include cardiac and critical care. She has research interests in palliative and EOLC within critical care environments.

Supervisor:

Dr. David K Wright is an assistant professor in the school of nursing, faculty of health sciences, University of Ottawa. His doctoral dissertation was an ethnographic study of hospice care, focusing particularly on end-of-life delirium. His research program examines palliative and end-of-life care from a perspective of relational ethics.

Supervisor:

Dr. Brandi Vanderspank-Wright is an assistant professor at the School of Nursing in the Faculty of Health Sciences at the University of Ottawa. Her doctoral research focuses on the development of Canadian Intensive Care Units and the nature of ICU nurses' work from 1960-2002. Other research interests include end-of-life care in ICUs, technology in ICU and research methodologies including social history and qualitative approaches.

Appendix C: Website (continued)

"Participation" page URL:

Participation

We are looking for participants!

Are you a Registered Nurse?
Do you work at and in the ?
Do you have experience in providing EOLC in ?

If you have answered to all **three** questions, we would like to invite **YOU** to participate in this study!

What do I need to do during participation?

You are invited to participate in one or both of the study interviews:

1. Initial interview (Fall 2016): You will be asked to describe your nursing experiences of providing end-of-life care to patients. You will also be asked to describe some of the barriers and facilitators in your provision of EOLC.

Anticipated length of time for interview: 60 to 90 minutes.*

2. Follow- up interview (Spring 2017): You will be asked to provide feedback to the findings of the study.

Anticipated length of time for interview: 30 minutes*

* interviews will be held outside of work, and at a time and location of your choice

Contact Us

Please contact the Primary Researcher for questions or to participate.

First Last

Email *

Comment *

SUBMIT

EMAIL ADDRESS

TELEPHONE NUMBER

PHYSICAL ADDRESS

Appendix D: Consent form

uOttawa

Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières

University of Ottawa
Faculty of Health Sciences
School of Nursing

Nurses' moral experiences of end-of-life care in a community hospital intensive care unit.

Researchers:

1. Primary Researcher:
Sandra Wong RN, BScN, DTN, CNCC(C), CCN(C)
Masters Science in Nursing student
University of Ottawa, School of Nursing

2. Research/ Thesis supervisor:
Brandi Vanderspank-Wright, RN, MScN, CNCC(C), PhD
Assistant Professor

3. Research/ Thesis supervisor:
David Kenneth Wright, RN, BSc, MScA, PhD
Assistant Professor

Invitation to Participate: I understand that I have been invited to participate in a research study on nurses' moral experiences of end-of- life care in a community hospital intensive care unit. This research is being conducted by Sandra Wong, RN (Primary Researcher) in the context of a Master's thesis and supervised by Drs. Brandi Vanderspank-Wright and David Kenneth Wright.

Purpose of the Study: The purpose of this research study is to understand nurses' moral experiences of end-of-life care in the setting of a community hospital intensive care unit.

Participation:

I _____ will participate in a face to face initial interview with the Primary Researcher. This initial interview will be conducted outside of work hours, and at a location and time of my preference. The initial interview will be approximately 60 to 90 minutes in duration and will be audio-recorded. I will be asked to describe how end of life care is provided in my intensive care unit. I will be asked to share my own nursing experiences where I have provided end of life care for patients and families within the unit.

And/Or

Appendix D: Consent form (continued)

uOttawa

Université d'Ottawa
Faculté des sciences de la santé

École des sciences infirmières

University of Ottawa
Faculty of Health Sciences

School of Nursing

I _____ will participate in a face to face follow up interview with the Primary Researcher. I will be contacted by the Primary Researcher when this occurs. The follow up interview will be conducted outside of work hours, at a location and time of my preference. The follow up interview will be approximately 30 minutes and will be audio-recorded. In this follow up interview, the Primary Researcher will share the findings of the study, and I will be asked to reflect and provide feedback about the findings.

Risks: Sharing personal nursing experiences may evoke difficult emotions and thoughts. I understand that every effort from the Primary Researcher will be made to minimize these risks, including resuming the interview at another time or providing time to rest. I may at any time stop the interview, change the subject or remove any sensitive information from the digital recording and research notes. I understand that I can be referred to an employee assistant program by the Primary Researcher, should I want to speak with a counsellor for more support. However, I understand that the possible risks associated with this study are not greater than risks assumed in everyday life.

Benefits: There is no direct benefit to me as a participant of the study. However, I understand that in participating in this research, I will be sharing relevant information on my nursing experiences in providing end-of-life care. This may add to the existing nursing research in this area and may be beneficial for improving future end of life care for patients.

Confidentiality and anonymity: I understand that all the information I provide will be kept confidential. All identifying information (such as names and contact information) will be removed from the transcripts and my confidentiality will be maintained. It is possible that information of the study will be used in future publication and presentations related to the study. I understand in these circumstances, my confidentiality as a participant will be protected with the use of pseudonyms. I understand that if I choose to be interviewed at the workplace, the primary researcher cannot guarantee my anonymity.

Conservation of data: Any study data collected in electronic form (digital recording, electronic copies of the transcribed notes) will be password protected and files will be encrypted. Any physical form of data (researcher notes) will be kept in a secure location, such as the locked offices of Drs. Brandi Vanderspank-Wright and David Kenneth Wright. Data will be conserved as specified for a minimum of 5 years with the University of Ottawa. If and when data from this study is to be disposed, electronic data will be deleted securely and physical data will be shredded through confidential waste by the University of Ottawa.

Declaration about possible conflict of interest: None to disclose.

Compensation: No compensation will be provided.

Voluntary participation: I am under no obligation to participate and if I choose to participate, I have the right to withdraw at any time and/or to refuse answering questions without suffering any negative consequences. I also understand that if I choose to withdraw from the study, I will also be given the option of withdrawing data.

Acceptance: I, _____, agree to participate in the above research study conducted by Sandra Wong, RN, supervised by Drs.

Appendix D: Consent form (continued)

uOttawa

Université d'Ottawa
Faculté des sciences de la santé

École des sciences infirmières

University of Ottawa
Faculty of Health Sciences

School of Nursing

Brandi Vanderspank-Wright and David Kenneth Wright of the School of Nursing, University of Ottawa.

If I have any questions about the study, I may contact the researchers at the number/email provided herein.

If I have any information requests or complaints about the ethical conduct of the project, I can contact the Protocol Officer for Ethics in Research, University of Ottawa.

There are two copies of the consent form, one of which is mine to keep.

Participant signature: _____

Date: _____

Primary Researcher's signature: _____

Date: _____

My contact information is the following:

Name: _____

Phone Number: _____

Or Alternative Phone Number: _____

Email: _____

Section only for Researchers:

Designated Numeric Code:

Appendix E: Semi-structured interview guide

Demographic questions:

1. Please identify your age range. Are you between the ages of 20 to 30 years old? Between the 30 to 50 years of age? Between 50 to 65 years of age?
2. How many years of nursing experience do you have?
3. How many of those years were in a critical care setting?
4. How long have you worked in this ?
5. In what capacity do you work in ? Are you full time, part time or casual?
6. What is your highest education level achieved in nursing?
7. Have you received additional education or training in critical care nursing?
8. Have you completed the Canadian Nurses Association (CNA) critical care certification and are you currently certified as a CNA critical care nurse?
9. In your nursing career, have you taken educational courses in palliative care?

Questions:

1. Please describe your experiences in caring for dying patients on your unit and provide some examples.
2. Can you please describe how it is you are involved in providing EOLC? Do you provide physical care to the patient? Psychosocial care to the family? What parts of EOLC are you not involved in?
3. Please describe what good EOLC means to you.
4. Are there any barriers to you providing EOLC on your unit? Please elaborate.
5. Are there any facilitators that assist you in providing EOLC on your unit? Please elaborate.
6. Are there EOLC situations where you felt have gone well? Or EOLC situations that could have improved? Please explain.
7. If you were given the opportunity to make changes, how would you like to see EOLC provided to patients on your unit?

Possible Probing Questions:

10. How is it like to practice in a community critical care unit? How does it compare to your other critical care experience?
11. Have you practiced EOLC in any other critical care setting? Please share your experiences. How are these experiences differing or alike from your experiences of providing EOLC in this unit?
12. Is there anything else you would like to add?

Appendix F: Confidentiality Agreement

Confidentiality Agreement For The Research Study: Nurses' moral experiences of end-of-life care in a community hospital intensive care unit.

DATE

It is understood and agreed to that confidential information provided to me over the course of my involvement with this study must be kept confidential. To ensure the protection of such information, and to preserve any confidentiality necessary under any and all applicable laws, it is agreed that

1. confidential information includes but is not limited to identifying information about study participants, documents, charts, recordings, memos, meeting minutes, study findings, or other materials in whatever form or nature, regardless of whether such information is designated as "Confidential Information" at the time of its disclosure.

2. The Recipient agrees not to disclose the confidential information obtained from the discloser to anyone unless required to do so by law.

3. This Agreement states the entire agreement between the parties concerning the disclosure of Confidential Information. Any addition or modification to this Agreement must be made in writing and signed by the parties.

4. The Recipient agrees to inform the Provider of any and all information that will be used for purposes beyond the research project, and obtain permission to utilize this information.

WHEREFORE, the parties acknowledge that they have read and understand this Agreement and voluntarily accept the duties and obligations set forth herein.

Recipient of Confidential Information: [name]

Name (Print or Type): [name]

Signature:

Date:

Discloser of Confidential Information: University of Ottawa

Name (Print or Type):

Signature:

Date: