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**Improving Nursing Provision of Patient Care in High Acuity Medical Units and Fostering  
Their Wellbeing by Providing Education on End-of-Life Care and Finding Joy and  
Meaning in Work:  
A Quality Improvement Project**

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A handwritten signature in cursive script that reads "Mary C. Loughran".

### **Abstract**

Palliative care employs a multidisciplinary approach focusing on the quality of life for patients and their families experiencing the complexity of serious illness (Nelson, 2021). Due to shortages of palliative care specialists and a lack of nurse proficiency in caring for people with serious illnesses, integrating a palliative care approach is an ethical obligation for nursing (Parekh de Campos, 2022). Gaps in palliative care and end-of-life education for new nurses coming to the acute care setting in a large tertiary hospital in Southwestern Pennsylvania were identified.

Evidence-based education was delivered by advanced practice providers trained in this content area. Forty-seven nurses received evidence-based Palliative Care Education, integrating a hybrid model utilizing the End-of-Life-Nursing Education Consortium (ELNEC), organization-specific guidelines, and the Clinical Ethics Residency for Nurses curriculum (Grace, 2022). Nurses were asked to complete pre- and post-knowledge assessments, demonstrating increased confidence in all areas. Qualitative data identified areas of moral distress for nursing. Segmented education for nurses that synergizes an interpersonal-interdisciplinary team approach that integrates wellness and mindfulness techniques for emotional processing of challenging patient care scenarios increases nurse confidence and demonstrates a significant increase for Specialty Palliative Care consults. The results also indicated a need to provide further support in areas of nursing ethics, communication tools, and support for nurse agency and well-being.

*Keywords:* end-of-life care, palliative nursing, existential distress, symptom management, dying in the acute care setting, nursing education for end-of-life or serious illness, nursing theory for end-of-life, nursing ethics, and communication in end-of-life care.

**Improving Nursing Provision of Patient Care on High Acuity Medical Units and Fostering Their Wellbeing by Providing Education on End-of-Life Care and Finding Joy and Meaning in Work: A Quality Improvement Project**

Palliative Care is a philosophy of care for patients living with serious illnesses. The World Health Organization (WHO, 2005) estimates that 56.8 million people may need palliative care, including 25.7 million in their last year of living. The palliative care approach for patient care addresses patients' physical, psychological, social, and spiritual needs and is recognized as a human right to health (WHO, 2005). The International Association for Hospice and Palliative Care developed a consensus-based definition of palliative care (PC) that focuses on relieving serious health-related suffering (Consensus-based Definition of Palliative Care, 2019).

Palliative care employs an interdisciplinary approach focusing on the quality of life for patients and their families experiencing the complexity of serious illness (Nelson, 2021). Due to shortages of palliative care specialists and a lack of nurse proficiency in caring for people with serious illnesses, integrating a palliative care approach with nurses working at the bedside in acute care settings is an ethical obligation for nursing (Parekh de Campos, 2022).

The American Association of Critical Care Nurses (AACN, n.d.) also advocates for nurses to receive education around communication skills to support uncertainty in illness, support families, and elicit patient and family understanding in critical times.

Nurses working on units with high patient mortality are chronically exposed to existential human suffering. Walking alongside patient suffering can bring rewards as nurses provide care. Nurses who find satisfaction in their work are likelier to experience improved optimism and increased energy to engage with patients and their care (Carter, 2019).

The Institutes for Health Improvement (IHI, n.d.) describes four aims for quality improvement in patient care, to provide the highest quality, patient-centered, and low-cost health care. The fourth aim focuses on fostering care for clinicians, and the IHI published a white paper to create a framework for "Joy at Work" in the healthcare setting (Perlo, 2017).

Transforming healthcare from disease-centered to patient-centered satisfies the quadruple aim of improving health, enhancing the patient experience, reducing costs, and improving the nursing work experience of providing care, fostering joy, finding meaning, and experiencing well-being in measurable ways. This QI project will explore the nursing outcomes related to receiving education on caring for patients with serious illnesses and to patients facing end-of-life and explore methods to reestablish joy and meaning in their work in providing this care.

### **Literature Review**

The literature search began using CINAHL, Cochrane Library, EMBASE, HAPI, MEDLINE, Health Source, Google Scholar, and Medscape. The initial search used terms such as end-of-life care, palliative nursing, existential distress, symptom management, dying in an acute care setting, nursing education for end-of-life care or serious illness, nursing theory of the end-of-life, nursing ethics, and communication in end-of-life care. The literature was analyzed using Johns Hopkins Evidence-Based Practice tools (Dang, 2022).

Nursing is front-line care for patients in the acute care setting. Neiman (2020) conducted a qualitative study utilizing interviews of thirty-four nurses to describe nurses' perceptions of basic palliative care. Major themes revealed nurses' experiences of advocacy for patients, helping families navigate serious illness, empowering families, and being present with patients.

Specific areas were identified to strengthen basic palliative care skills, including practice

in palliative care assessments, identifying mental health needs, conflict resolution among families, and recognizing when patients might benefit from hospice care.

A literature review of qualitative descriptive analysis with content analysis design was conducted by interviewing nurses to elicit experiences caring for dying patients. This study by White (2019) looked at the impact on the nurse and how nurses respond to and manage the dying patient. Major areas of impact were enhanced end-of-life care and sources for experiences of patient and nursing distress (White, 2019). Training nurses in palliative care has demonstrated a reduction in hospital utilization by patients living with chronic illness and with high risk for readmissions.

Nurses have ethical responsibilities to focus on human well-being, understood as Nursing Ethics, to achieve "good" in any nurse-patient interaction. Advanced Practice Nursing Palliative Care providers are responsible, by our ethics, to facilitate competency with nurses through education and support (Grace, 2018). Educating nurses requires implementing studied and proven tools to support an atmosphere of inter-professional and interdisciplinary work and learning (Noble, 2018). Research supports developing a nurse-led therapeutic alliance with patients and is associated with better quality of life for people with serious illnesses (Thomas, 2021).

The Institute for Clinical Systems Improvement (2020) conducted literature searches from 2013-2016 to develop guidelines for Palliative Care practices across healthcare settings. The literature was analyzed using the Grading of Recommendations Assessment, Development, and Evaluation methodology. The recommendations support developing hospital primary-palliative education programs for skill development to address symptom management and

improve communication. The guidelines are appropriate for patients who still seek cure for illnesses or life-prolonging treatments.

An integrative review to identify end-of-life learning preferences included twenty-three articles. Five themes were identified (Atreya,2022): (1) Desire to provide palliative care (2) self-actualization needs, (3) relevance to practice (4) sense of responsibility (5) therapeutic bond. After conducting this review, a shift towards a more hands-on and experiential approach to training is recommended. This can be accomplished by incorporating mentorship programs and reflective learning exercises. Learning from mentors enables a place of perceived safety for learners and allows the opportunity to interact with one another (Burgess, 2018).

The United States Healthcare system operates in a biomedical illness model, treating diseases' biological aspects (Farre, 2017). The American Consensus Project for Palliative Care practice guidelines states that spiritual aspects of care congruence with biopsychosocial needs are necessary but not being met in today's health care system. Current Clinical Practice Guidelines for Quality Palliative Care is a comprehensive model for applying Palliative Care across all domains. Domain six of these practice guidelines describes cultural aspects of care (Boddeart, 2022).

A humbling and influential consensus paper, with collaboration from forty-three authors from eight countries, provides recommendations to advance palliative care access globally as a human rights priority (Rosa, et al, 2021). An estimated sixty-one million people of all ages globally experience six billion days of serious health-related suffering (SHS) annually. Suffering can be alleviated by integrating palliative care across all health settings, and benefits contribute to the quality of care (Knaul, 2018).

The Institute for Health Improvement recommends finding joy at work through a positive work environment (IHI, n.d). For nurses working with seriously ill patients and patients facing their own mortality, is the recommendation for finding joy possible? King (2020) describes joy from a eudemonic view, as a virtue arising from a meaningful, well-lived life. This deep sense of joy is a sense of thriving and connects to align with cultivating a life that matters.

### ***Theory, Framework, and Models***

The Theory of Human Caring (Watson, 2008), created and cultivated by Jean Watson, describes authentic presence where the nurse and patient share a moment. This is a moment where a nurse demonstrates caring and compassion and allows for finding meaning and purpose amid illness. Watson describes this moment as the capacity to promote healing with compassion (Pullyblank, 2023). Watson's theory focuses on providing holistic care for the patient, which is integral in the philosophy of palliative care. Watson's theory (Morrow & Watson, 2021) advocates for the current need for nurses to commit to sustaining humanity through human-to-human connections and values.

The Institute for Healthcare Improvement Framework for Safe, Reliable, and Effective Healthcare (Frankel, 2017) serves as a roadmap for this project. The framework focuses on culture and learning. There are nine subdomain components to follow. Patient and family engagement is at the center of this framework. The two key underpinning domains apply to this project, focusing on the culture and the learning system. The concept of psychological safety as an open forum for nurses inspired the application of this framework. This framework aids evidence-based learning to develop, test, implement and integrate changes starting with a small test of change, then broaden to result in better outcomes.



The Model for Improvement (Provost, 2022) is a systematic approach to integrating evidence-based knowledge. The Model for Improvement, utilizing a Plan-Do-Study-Act (PDSA) cycle for testing, begins with three questions: (1) The Aim-What are we trying to accomplish? (2) The Measure-How will we know that a change is an improvement? (3) The change idea-What change can we make that will result in improvement?

Finally, the Actor-Network Theory (ANT) works with a theoretical understanding of everything in the environment as individual "actors." Applying ANT to the hospital setting, people, providers, nurses, patients, computers, intravenous machinery, and others are viewed as individual "actors." All the individual "actors" have agency and power (McBride & Tietze, 2019).

With consideration of nurses and their sense of individual agency and flexibility in the state of change, education for work is not a one-time event; rather, it is a fluid and lifelong process. The workplace is only one site for learning (GOH, 2022). Implementing unit-based nursing education will require feedback from the educators to the nurses about the integration of the Computer Provider Order Entry (CPOE), Comfort Measures Only (CMO), and Respiratory Distress Observation Scale (RDOS) order sets and how the nurses choose the medications from the electronic medical record (EMR) order set to administer to patients. The ability of nurses working on the frontlines and discerning appropriate medication administration for patients at the end of life improves the quality of life for dying patients (Huisman, 2020).

Considering ANT, feedback is used by nursing improvement systems (NPIS) to evaluate nursing performance and ultimately leads to a focus on systemic change (Rapin et al, 2022). The feedback loop evolves and is interdependent on each actor in a social system. The Actor-

Network Theory (ANT) applies seamlessly to nursing education in the context of sociotechnical interactions (Rapin et al, 2022).

### **Description of the Project**

The idea of this QI project began through working as a palliative care nurse practitioner in the inpatient setting in a large academic tertiary care center in Southwestern Pennsylvania. Patient care unit directors contacted the advanced practice providers (APPs) for education for nurses caring for patients at end-of-life or receiving "Comfort Measures Only Care." As a result, nurses verbally expressed a lack of confidence in administering medications ordered for end-of-life.

Therefore, the project manager (PM) initiated a quality improvement project to address the gap in education for nurses caring for patients with serious illnesses, patients at end-of-life, and patients receiving comfort-focused care.

The evidence-based practice question: Does an evidence-based quality improvement project providing evidence-based palliative education for nurses working on two pilot acute care medicine units with high patient mortality and with patients at the end of life improve knowledge, improve confidence, promote holistic care in the delivery care to patients with serious illness and foster meaning and joy for nurses caring for patients with serious illness? The initial work was identified using the mnemonic PICO (Population, Intervention, Comparison and Outcome) from Dang (2018).

**P**-Nurses working in the acute care setting in a large academic center in Southwestern Pennsylvania lack tools and education regarding management of pain, suffering, goals of care, and patient values.

**I-**Provide evidence-based serious illness care, palliative care, and comfort-focused care education and tools to new nurses working in four acute care and critical care patient care units.

**C-**Currently, nurses new to the organization and participating in the current nurse-residency program do not receive palliative-based education. There are no specific interventions to connect nurses with their day-to-day challenges to connect to finding joy and meaning at work.

**O-**A pre and post-knowledge for qualitative measures demonstrate nurses' ability to express confidence and joy in work caring for patients with serious illnesses.

### **Aims and Objectives**

The following aims and objectives were identified to address the existing education and training gap in end-of-life care and finding joy and meaning at work.

**Aim #1:** Identify current nursing confidence and knowledge regarding patient care “Comfort Measures Only” order sets on two pilot acute care medicine units.

#### **Objectives:**

1.1 Administer pre-knowledge assessments to nurses on two pilot acute care medical units.

1.1.1 Administer ELNEC pre-knowledge assessment to identify the current level of knowledge and confidence in caring for patients with serious illnesses at the end of life.

1.1.2 Administer a validated “Meaning and Joy in Work Questionnaire (MJWQ) for nurses.”

1.2 Identify the number of palliative care consults for patients receiving “comfort measures only” care from July 2022-December 2022 utilizing patient data analytics.

**Aim #2:** Implement evidence-based patient-care curriculum utilizing the End-of-Life Nursing Education Consortium Curriculum (ELNEC) and supplemental evidence-based nursing guidelines pertaining to the UPMC “Comfort Measures Only” order set.

**Objectives:**

2.1 Provide education to UPMC staff nurses on three pilot medicine units in person and on zoom during nursing staff meetings.

2.1.1 Provide condensed curriculum using the End-of-Life Nursing Education Curriculum (ELNEC).

2.1.2 Provide education regarding Respiratory Distress Observation Scale (RDOS).

2.1.3 Provide evidence-based care nursing guidelines for continuous opioid infusions for end-of-life patient care.

2.2. During the curriculum implementation introduce personal meaning and purpose concepts from the Institute for Healthcare Improvement (IHI) for Improving Joy at Work.

2.3 Conduct “What Matters” nursing huddles once a month for 2 months during unit staff meeting on pilot units.

2.3.1 Reenforce concepts from Institute for Health Improvement “joy at work.” Initiative.

2.3.2 Reenforce concepts from Centers to Advance Palliative Care (CAPC) toolkit: Emotional PPE.

2.3.3 Provide short activities to allow space for “joy” in work: ink shedding, essential oil simulation, photovoice opportunities, and story share opportunities.

2.3.4 Invite nurses to share experiences of challenges or meaning in caring for patients at end-of-life.

2.4 Administer post-knowledge assessments to nurses on two pilot acute care medical units.

2.4.1 Administer ELNEC post- knowledge assessment to identify changes in level of knowledge and confidence in caring for patients with serious illness at end of life at the conclusion of the presentation.

2.4.2 Administer post-knowledge validated “Meaning and Joy in Work Questionnaire (MJWQ) for nurses.”

**Aim #3:** Evaluate the impact of providing Palliative Medicine education, care and philosophy for nurses working on two pilot acute care patient medicine units.

3.1 Complete a driver diagram to identify areas for process improvement opportunities for care of patients with serious illnesses.

3.2 Conduct post-knowledge validated questionnaire for nurses on the two-pilot acute care medicine units.

3.3 Identify the number of palliative care consults for patients receiving “comfort measures only” patient care and compare to pre-palliative medicine education and support on the two-pilot acute care patient medicine units.

**Aim #4:** Report the results to hospital leadership and committees within six months of implementation.

**Objectives:**

4.1 Present the information to the hospital-based evidence-based practice council.

4.2 Present to quality and safety council.

4.3 Present formal report to Palliative Care Leadership and CNO, UPMC Presbyterian and Montefiore Hospitals.

4.4 Continue work with the UPMC Wolff Center to develop evidence-based congruent clinical guidelines for caring for patients with serious illness and fostering joy in work for the nurses who care for patients for the Nurse Residency Program for UPMC.

4.5 Contribute to education for Palliative Residency/My Nursing Career to include Nursing Ethics and Communication for Nurses working with patients with serious illnesses in the acute care setting.

### **Setting and Population**

The PM presented the QI proposal to the organization's Evidence-Based Practice Council (EBPC) at a large academic hospital setting in Southwestern Pennsylvania. Three pilot units were identified through the EBPC and organizational data analytics for patient care units with high patient mortality and numbers of CMO order sets. The PM contacted the unit directors of the three pilot units and forwarded a follow-up invitation letter for the nursing staff to participate in the QI project.

### **Overview of Methodology**

Through the Quality Improvement Office, the University institutional review board (IRB) and the hospital's IRB approved this study as a Q.I. project as it met the criteria for exempt status. Permission for data analytics use was granted through the Quality Improvement Office. Completing the questionnaires constituted consent to participate in the QI project. Participants were also informed that their participation was voluntary and that they could leave anytime during the project.

*Plan*

The preliminary work for this project began in September 2022, with an initial inquiry and literature review. The formal QI initiative began on January 3, 2023, and was completed on May 1, 2023. The “Study” phase began in January 2023, and the “Act” phase closed on June 5, 2023, which concluded the intervention.

The PM led the initial steps for this project with the Division of General Medicine, Palliative Care. The preliminary community assessment was conducted with a small (10) cohort of nurses. An application was submitted and approved to access the organization’s data analytics. An application was submitted, then approved by the organization’s center for Q.I.

Investigation and data collection to identify current practices were the initial steps for this project. A meeting was held with the hospital’s Evidence-Based Practice Council to identify current education on end-of-life care and if nurses in the acute care setting needed evidence-based palliative education. The PM developed a comprehensive palliative care nursing education lecture as the intervention for this project.

The content of the palliative care lecture comes from a synthesis of evidence-based programs and literature such as End-of-Life Nursing Consortium (ELNEC), current practices of the organization and the Clinical Ethics Residency Education (CERN) program. In addition, information built into the education curriculum includes resources from the Centers to Advance Palliative Care (CAPC), The Hospice and Palliative Nurses Association (HPNA), Nursing Theorists, and current research literature. Permission to incorporate ELNEC curriculum and the validated knowledge assessments was obtained from ELNEC. The permission to incorporate CERN was obtained through direct communication with the authors.

It was decided that six, forty-minute condensed evidence-based practice palliative care education sessions were to be presented to three participating patient care units: (a) the first unit was the Cardiac Care Intensive Care Unit, (b) the second unit was the Neurological-Neurosurgical Intensive Care Unit, and (c) the third unit was the step-down Cardiac/Medicine Unit. The sessions were arranged between unit directors and the PM and were held on different dates and times to accommodate nurses on the units or listening remotely. The education was presented in a PowerPoint format via the TEAMS platform, with one session in the Cardiac/Medicine Unit to be held on the unit.

The PM also obtained information on the number of palliative care consults for patients receiving CMO from November 2022-January 2023, using organization patient data analytics to compare consults to the Palliative Care Team prior to the intervention and after the education provision to nurses. One pilot unit was identified for measurement for consult comparison.

### *Do*

Three patient care units were identified through collaboration with the Evidence-Based Council and data analytics identifying the units with the highest numbers of seriously ill and/or end-of-life patients. Education sessions were arranged with the patient care unit directors at times that aligned with the availability of nursing staff. Each unit was offered two or three online or in-person presentations as an opportunity for nurses to participate. The unit directors offered the education sessions to all nursing staff via email invitation. The opportunity to attend the education sessions was encouraged by the unit directors, and participation was ~~also~~ voluntary.

The education sessions were provided by two Palliative Care trained nurse practitioners. One nurse practitioner previously participated in the specialized three-day train-the-trainer ELNEC course in person with certification for course participation. Education also included



organization-specific information regarding the CMO order set. Information regarding nurses' well-being and self-care was described during the presentation. Application of concepts specifically to nursing ethics in relation to personal meaning and wellbeing were introduced along with self-care activities for nurses.

Participating nurses were administered ELNEC (PCQN) pre-knowledge assessment via QR code at the beginning of the presentation to identify the current knowledge and confidence in caring for patients with serious illnesses and at end-of-life. This assessment asked questions regarding confidence level when caring for patients with serious illness; The five-point Likert scale competence scale assessed competencies and knowledge in eight areas of palliative care: 1) satisfaction with the level of end-of-life care knowledge 2) comfort with initiating a conversation about palliative/hospice care with patients and family members 3) comfort level with pain management 4) comfort level navigating ethical and legal issues surrounding palliative and hospice care 5) comfort level caring for the actively dying patient 6) comfort level helping patients and families with grief and loss (7) comfort level navigating cultural and spiritual issues for patients and families facing end-of-life (8) comfort level managing non-pain symptoms patients can experience at end-of-life. Nurses were given uninterrupted time prior to the start of the education session to complete the pre-knowledge assessment.

Additionally, nurses were allowed to complete the validated Meaning and Joy in Work Questionnaire (MJWQ). The questionnaire is a sixteen-question assessment on a five-point Likert scale; (a) strongly agree (b) disagree (c) neutral (d) agree (e) strongly agree as shown in Table 2. A follow-up email to nursing leadership for the pilot units also included the "Meaning and Joy in Work Questionnaire" and opportunity to complete the assessment. Question seventeen

asked for an open-ended response, “What Matters most to you?” All responses were anonymously provided.

After completing the 40-minute education presentation, nurses were asked to complete the post-knowledge ELNEC (PCQN) survey, which asked identical questions to the pre-knowledge assessment. Completing the assessments was not required for participation in the education presentations. However, the nurses were encouraged to complete them in the time provided.

At the completion of the education presentation, the forum was open to questions from the nurses. Nurses were provided opportunities for open conversations to share challenges and meaningful nurse-patient experiences. Two interdisciplinary team discussion huddles to discuss challenging patient-care experiences were conducted on one pilot unit to reinforce concepts from the IHI Joy at Work Framework. One in-person education opportunity was conducted on one pilot unit. Opportunities for mindfulness were provided utilizing journaling and “ink shedding” experiences involving reflective writing. The participants were invited to journal an experience either at work or outside of work and were guided through reflection on their senses of 1) seeing, 2) feeling, 3) touch 4) taste, and 5) hearing. The participants were able to share their writing voluntarily. Qualitative data were collected from nurses’ impressions, comments, and requests during the session.

### **Data Management Plan**

Data collection for this QI project began on January 3, 2023, and concluded on June 5, 2023. A mixed methods approach was used in collecting qualitative and quantitative data. The qualitative and quantitative assessment tools are both valid and reliable. Participating nurses were administered ELNEC (PCQN) pre-knowledge assessment via QR code at the beginning of

the presentation to identify the current knowledge and confidence in caring for patients with serious illnesses and at end-of-life. Additionally, nurses were allowed to complete the validated Meaning and Joy in Work Questionnaire (MJWQ). The ELNEC survey was administered after the presentation to identify changes in their knowledge and confidence in caring for patients with serious illnesses or at end-of-life.

The data for this project was collected using QR codes integrated into Microsoft Forms. Participants were provided with a unique QR code which they scanned using their smartphones. Upon scanning the QR code, participants were directed to the Microsoft Forms survey, where they responded to the knowledge surveys. A link to the questionnaires was also provided in the chat section of the TEAMs presentation. The anonymous data was analyzed utilizing Microsoft Excel.

### **DNP Project Results/Findings**

#### **Study**

This QI project aimed to determine if segmented unit-based palliative care education provided to nurses increased confidence in caring for patients and families experiencing serious illnesses and/or end-of-life care. Current nursing confidence and knowledge regarding patient care and CMO order sets were satisfied through the pre-knowledge assessment completion of the ELNEC Pre-Knowledge Assessment and MJWQ. Forty-seven nurses completed the pre-knowledge questionnaire, and only seven completed the MJWQ. Forty-five nurses completed these surveys after the integrated curriculum, utilizing ELNEC, CAPC, CERN, and CMO order sets. Additionally, RDOS education was provided simultaneously for evidence-based medication administration for RDOS assessment scores. Education was also provided to contacting medical

providers if symptom management is not satisfied utilizing RDOS and CMO order set medications, dose, and intervals.

The post-knowledge assessment to evaluate the impact of the provision of segmented palliative care education revealed increased nurses' confidence in all areas, except comfort in navigating cultural and spiritual issues patients and families face at end-of-life. Detailed post-knowledge assessment results can be found in Table 1.

Nurses demonstrated increased confidence in end-of-life care knowledge. In the pre-knowledge assessment, 38% agreed and 9% strongly agreed. The post-knowledge assessment demonstrated that 22% agreed and 67% strongly agreed.

In the initiation of conversations about palliative/hospice care with patients and family members, in the pre-knowledge assessment, 30% were neutral, 30% agreed, and 24% strongly agreed. Nurses' confidence in the post-knowledge assessment demonstrated that 18% were neutral, 20% agreed, and 62% strongly agreed.

Nurses' confidence in managing patient pain demonstrated increased confidence in all areas. The pre-knowledge assessment demonstrated that 15% disagreed, 36% were neutral in confidence level, twenty-three or 49% agreed, and zero participants strongly agreed. The post-knowledge assessment demonstrated that only one nurse remained neutral, 47% agreed, and 51% strongly agreed. Ninety-eight percent agreed and strongly agreed at the end of the presentation.

Nurses have confidence in caring for patients who are actively dying in the pre-knowledge assessment; 6% disagree, 17% are neutral, 51% agree, and 26% strongly agree. The post-knowledge assessment demonstrates that one person, or 2% disagreed, 31% agreed, and 62% strongly agreed. Ninety-three percent agreed and strongly agreed in their confidence in caring for patients who were actively dying after the education session.

Nurses demonstrated increased confidence in the area of navigating legal and ethical issues. In the pre-knowledge assessment, 2% strongly disagree, 43% disagree, 28% neutral, 23% agree. In the post-knowledge assessment, zero strongly disagreed and disagreed. There are 56% who remain neutral, 35% agree, and 9% strongly agree—regarding ethical and legal issues. Over 50% remain neutral in confidence in navigating ethical and legal issues. Spiritual care and cultural care were addressed briefly in the education session; however, the shortened sessions did not allow time to expand these areas; therefore, the results show no change from 31% in the pre- and post-educational sessions.

Objectives to reinforce concepts from the IHI “Joy at Work” initiative were introduced. Seven of the forty-seven nurses completed the MJWQ, as shown in Table 2. Unfortunately, follow-up email invitations by the unit directors to their nursing staff did not increase the number of responses.

The open forum questions from the nurses were recognized as moral distress through qualitative data collection, which is found in Table 3 below. According to Grace (2023), the inability of nurses to abide by an unfolding prescribed course for a patient produces feelings of uncertainty, leading to moral distress. With the unexpected surfacing of conversations with nurses indicating moral distress and simultaneously completing coursework in the area of nursing ethics, the PM contacted one of the nurse ethicist scholars via email for permission to incorporate portions of their work. Through this collaboration, three authors graciously extended an invitation to meet via ZOOM to explore ideas around nursing ethics and shared additional research and work in this area.

**Table 3***Open Ended Questions and Comments from Nurses During Open Sessions*

“Can we page you?”
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“How can I get a palliative care consult?”
“How can we call you, my CMO patient was suffering, and I am told, “we don’t want to kill him.””
“I asked for a palliative care consult and was told, “give me 30 more days.”
“We done doing cpr and a coworker didn’t have any emotion. I thought to myself are you ok? I’m not ok.”
“I think we should consult palliative care and nurse hears, “they aren’t ready for that yet.”
“This is so stressful.”
“We try so hard to tell them, but they don’t listen.”
“Patients ask us, and we can’t tell them.”
“I was told, if the nurses are stressed by the patient, maybe they shouldn’t work here.”
“I had no idea what I was doing when my first patient was dying.”

IHI’s “Joy at Work” activities were implemented via interdisciplinary huddles to enable nurses and providers to share challenges and “meaning-making” areas in patient care. One huddle was conducted by the medical director for an intensive care unit, the PM, and the unit clinician with the nurses. A challenging loss of a patient known to the staff was presented for this session. This one-hour session provided an open forum to identify challenges for the co-leaders and nursing staff. Areas of care, compassion, and peaceful passing of their patient were identified as areas of control toward healing moral distress.

A second huddle was held and co-led by the intensive care unit medical director, the PM, and the nurse clinician from the unit, reviewing patient care challenges for patients and families with prolonged hospitalization with ongoing advanced therapies in the setting of serious illness with poor prognosis. The nurses identified challenges in caring for patients with complex care. A psychiatrist from Palliative Care working with this patient also participated in the debriefing. Areas of processing were identified and conducted. Debriefings with supportive leaders help to “making sense” of morally challenging patient care experiences (Kok, 2021).

The huddles that were held were intentional pauses in the workday to “seek joy” and allow individual processing of difficult cases. During the huddles, reflective listening for nurses experiencing challenges with complex clinical situations supports the IHI (n.d) initiative to

strengthen communication skills to support, build a consensus, and guide the interdisciplinary team to consensus decision-making.

An “ink shedding” exercise was conducted during a staff meeting in collaboration with nursing leaders of a pilot unit and was held via TEAMS. Journaling, reflective writing, and “Ink Shedding” as examples of brief periods of mindfulness can instill a sense of self-efficacy and belonging (Fagioli, 2023). This exercise takes place in less than five minutes and serves as a pause to allow meaning-making at work. Unit leaders reported that staff communicated “finding meaning” with this exercise. During subsequent patient rounds on this pilot unit, qualitative data were collected from nurses' positive expressions utilizing journaling as an exercise. Unit leaders plan to incorporate this exercise in future staff huddles.

Providing education, increasing nurse confidence, and implementing techniques to address moral distress demonstrated increased consults to specialty Palliative Care Services. The number of consults was collected for the three months prior to the implementation of the QI project and compared to the three months during project implementation. The number of consults to specialty Palliative Care services increased by 26%, as noted in Table 4.

**Table 4**

*Focus Unit Consults to Palliative Care*

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Month	Year	Number of Palliative Consults
November	2022	48
December	2022	40
January	2023	44
Total		132

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February	2023	47
March	2023	57
April	2023	53
Total		157
Consults to Palliative Care		+26%

Implementing QI frameworks and navigating through the PDSA cycle served to identify deficits in quality end-of-life care. The need for improved end-of-life care is not identified as a nursing problem. However, this project identified gaps in care provision for people with serious illnesses as a systems problem. Nurses working with moral distress require immediate attention and support.

The primary drivers, identified in a driver diagram in Appendix A, outline the presentation to key stakeholders of the organization that include: CNE of the Healthcare System, the CNO of the hospital, the Palliative Care and Medical Ethics, unit directors, Evidence-Based Practice Committee, and the Health System Center for QI.

The secondary drivers, already spearheading new initiatives as a result of this QI project initiative, include: (1) ideas for dissemination of education to integrate primary palliative care concepts for nurses throughout the organization (2) PM participation in an education sub-committee for the Department of Medical Ethics Committee (3) PM participation in a planning committee to develop initiatives for nurse wellbeing (4) formal recommendations to the Healthcare System QI Center for development of education initiatives around CPOE (5) formation of a sub-committee to research and revise the CMO order set for the healthcare organization with evidenced-based medication administration recommendations (6) PM initiated



a focus group of medical providers to identify gaps in care for patients with serious illness risk indicators for readmission risk and high patient mortality.

The change ideas and interventions currently underway as a result of this QI project include: (1) integration of education by content experts (in all specialty areas) for the Nurse Residency program in the hospital and healthcare system (2) a unit leader from one pilot unit is developing a QI project to measure moral distress and identify meaningful interventions with the PM as content expert (3) development of a group, led by the hospital CNO, nursing, and the PM in collaboration with the PM's University faculty, to develop an integrative and holistic nursing program for nurses (4) healthcare system CNO-led initiative for nurse wellbeing focus group in first phase of research evidence-based initiatives (5) the interdisciplinary, CMO focus group, formed at month three of this six-month inaugural QI project is currently in the reporting and recommendation phase of the initiative to include education on the order set to new nurses coming to orientation and to nurses enrolled in the nurse residency program.

### **The Unintended Transformations**

Presenting the QI project to the Evidence-Based Practice Council recommended that trained Advanced Practice Providers provide future Palliative Care Education and Support as content experts working with patients with serious illnesses in the clinical setting.

Recommendations also include further education and support during nurse residency in the area of moral agency, moral distress, moral courage, and moral success for nurses working in high acuity, high patient mortality units.

The QI project idea was presented to the Chief Nursing Executive (CNE) for the Healthcare Enterprise, resulting in an invitation to the PM to collaborate with a small focus group to develop strategies to create areas for well-being for nursing, identify areas for moral

distress, identify areas for gaps in care, and enhance education for nursing across the enterprise. The CNO advocates for education for nurses to return to the bedside. The work and data from this project support the advocacy of leadership to spearhead the improvement.

Presenting the results of the QI project to the Chief Nursing Officer (CNO) for the Organization, with common interests in integrating holistic nursing care at the bedside, stimulated further discussion and formation of an initiative for integrative therapy exploration. The faculty mentor for this QI project collaborated with the University's certified holistic Doctor of Nursing Practice Professor, who will contribute as the content expert. The PM is enrolled in an evidence-based holistic therapy course, Reiki.

The need to further study nursing ethics and incorporate concepts into the education and support for nurses working in the acute care setting surfaced as a priority. Nurses, by nature of our profession, enter the nurse-patient relationship with moral agency, the ability of the nurse to reflect patient autonomy and to take appropriate action in advocacy for patients (Grace, 2018).

The American Nurses Association defines moral distress as the condition of knowing the morally right thing to do. However, institutional, procedural, or social constraints make doing the right thing impossible; it threatens core values and moral integrity (ANA, 2015). Therefore, moral agency is "doing the right thing."

### **Ethical Considerations**

The nurses from three pilot units were invited to participate in the education sessions; participation for the session, the completion of the knowledge assessments, and the completion of the MJWQ were voluntary. Approval for the project was obtained by the IRB for the University and from the organization where the data was collected. The assessments did not contain unique identifiers, and the responses remained anonymous.

**Interpretation**

An unfolding QI project aimed to answer the question: Does an evidence-based quality improvement project providing evidence-based palliative education for nurses working on three pilot acute care critical care units with high patient mortality with patients at the end of life improve knowledge, improve confidence, promote holistic care in the delivery care to patients with serious illness and foster meaning and joy for nurses caring for patients with a serious illness?

Patient care in the acute care setting is complex and requires interdisciplinary, evidence-based approaches to provide education and support for frontline nurses. The process for this QI project identified the need to provide improved end-of-life care as systems problems in the organization, not nursing problems. The American Association of Colleges for Nursing's newest recommendation is to integrate primary palliative care education for nurses caring for patients with serious illnesses supports the importance of ongoing education development for nurses (Parekh de Campos, 2022).

Forty-seven nurses voluntarily participated in education sessions during their workday with support from their leaders. Levels of confidence in caring for patients with serious illnesses or at the end of life increased in all areas. The results support continued practice-based learning for nurses caring for patients with serious illnesses, developed by content experts to identify gaps in knowledge and create a program with established competencies, allows for self-reflection, and incorporates mentoring and peer support (Suitor, 2020).

As technology moves forward, applying ANT emphasizes the importance of all actors in the system, including nurses, providers, and machinery, having equal agency. CPOE requires an interdisciplinary approach to ensure evidence-based orders with appropriate safety guardrails are

implemented. Education for COPE is vital for patient care. Orders embedded within CPOE, as tasks for nursing without education, open deficits for patient care and safety.

The concept of nursing ethics and clinical bioethics unexpectedly became central to this QI project. Clinical bioethics is a set of ethical principles that apply to patients at the bedside (Moen, 2022). The forums conducted after the palliative care educational sessions provided qualitative data from the nurses is recognized as moral distress. The qualitative data suggested barriers to patient advocacy, communication barriers, and gaps in methods to address distress as it occurs. The American Nurses Association defines *moral distress* as the condition of knowing the morally right thing to do (moral agency), but institutional, procedural, or social constraints make doing the right thing impossible; it threatens core values and moral integrity. (ANA, 2015). The American Nurses Association also supports initiatives that support nurses receiving education around practice and assessment of ethical environments across all healthcare work settings, which includes interdisciplinary collaboration with work partners (ANA, 2021). Nurses with moral agency begin by achieving those goals taught in nursing school, form their identity, and center on nurses who set out to care for others (Grace, 2018). Moral distress is a barrier to experiencing “Joy at Work” and outside the work setting: moral, psychological challenges, and quality patient care (Hiler, 2018).

Another interesting outcome was the benefits all providers participating in the QI project received. Journaling, reflective writing, and “Ink Shedding” as examples of brief mindfulness periods can instill a sense of self-efficacy and belonging (Fagioli, 2023). Debriefings with supportive leaders leads to “making sense” of morally challenging patient care experiences (Kok, 2021). Interdisciplinary communication, rounds, and unit huddles increase teamwork and promote collaborative practices leading to quality improvement in healthcare settings (White,

2021). This QI project reflects the integration of interdisciplinary collaboration by demonstrating increased consults to the Palliative Care team from the focus pilot unit.

The Quality Improvement Center is implementing standardized learning for nurses across the Health System. This QI project supports efforts for the CNE of the Health System, who also advocates for segmented bedside education and recognizes the urgency to develop mechanisms to integrate well-being principles for nurses.

Considering ANT, feedback is used by nursing improvement systems (NPIS) to evaluate nursing performance and ultimately leads to a focus on systemic change (Rapin et al., 2022). The feedback loop evolves and is interdependent on each actor in a social system. The Actor-Network Theory (ANT) applies seamlessly to nursing education in the context of sociotechnical interactions (Rapin et al., 2022).

An interdisciplinary focus group, of which the PM is a member, has been organized to develop an evidence-based CMO order set has been formed and will continue to completion. Developing a specialty curriculum for nurses who desire to enhance palliative care training for career development is recommended.

### **Barriers**

The condensed curriculum serves as a segmented introduction to primary palliative nursing education. The timeframe for the education session did not allow for in-depth teaching for cultural-spiritual domains, communication training, and ethical principles. The unexpected underpinnings surfacing from this QI project require dedicated time, research, and mindful application to impact the spread of improvement. Seven of 47 nurses completed the MJWQ. Barriers to completion may have been the organization's system-wide employee engagement survey. Survey fatigue is also a factor.

## **Recommendations and Conclusion**

This QI project demonstrated that condensed, unit-based palliative care education provided to nurses increased their confidence in caring for patients and families experiencing serious illnesses. It was well received by the nurses and nursing leaders that participate

Integrating primary palliative education for new nurses in orientation utilizing this condensed format is recommended. Expanded evidence-based education during the Nurse Residency Program, including enhanced communication techniques, education on legal and ethical issues in caring for patients with complex health problems, and cultural and spiritual care are also recommended.

Coordination with nursing leadership is underway to develop integrative nursing therapies for patients by incorporating the ANA Scopes and Standards of Practice for Holistic Nursing. Collaboration with the CNE of the healthcare system to integrate well-being practices for nurses is proceeding.

Evidence-based education, evidence, and principles are the core of the success of this QI project. Integrating Jean Watson's (2008) Theory of Human Caring to advocate for holistic care and authentic presence for patients and the nurses who care for them is the integral philosophy. Nurses as advocates synergized with the belief that all nursing actions have ethical implications with the ultimate goal of enhancing patient well-being (Grace, 2018, p. 147). Nurses working for the organization demonstrate caring and compassion and find meaning and purpose amid illness. Joy meets suffering in the human connection.

An interdisciplinary focus group, of which the PM is a member, has been organized to develop an evidence-based CMO order set has been formed and will continue to completion.

Developing a specialty curriculum for nurses who desire to enhance palliative care training for career development is recommended.

The rigorous QI process begins with an idea that leads educators to identify gaps, develop evidence-based practices, and process improvements for meaningful changes. Segmenting the initiative to a small change test reflects a transformative learning environment of authenticity, with opportunities for shared meaning-making. The national frameworks and integrative team initiatives can transform healthcare (Dreher & Glasgow, 2017, pp. 212-213).

The interprofessional relationships formed through this process transform nurses in the acute care setting to practice to the fullest extent of their license to create the human-to-human caring experience. Finding joy and meaning was identified. The sustainability of this initiative and the initiatives will require dedicated interdisciplinary teams to understand that improvement is a process and encourage continuous learning and refinement in measurable ways.

Nursing is a vocation, an art, and a science. With permission from the authors, reflecting a unified definition of nursing became a working theme for the PM of this project. Nursing is defined as “A central unifying focus for the discipline: facilitating humanization, meaning, choice, quality of life, and healing in living and dying.” (Wills et al., 2008).

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**Table 1**

*Pre-Knowledge Assessment / Post-Knowledge Assessment Questions 1-4*



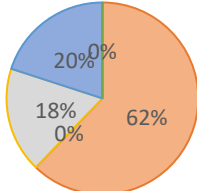
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<p>I am satisfied with my level of end-of-life care knowledge</p>  <table border="1" style="display: none;"> <caption>Pre-assessment: Satisfied with end-of-life care knowledge</caption> <tr><th>Response</th><th>Percentage</th></tr> <tr><td>Strongly Agree</td><td>9%</td></tr> <tr><td>Agree</td><td>38%</td></tr> <tr><td>Neutral</td><td>40%</td></tr> <tr><td>Disagree</td><td>11%</td></tr> <tr><td>Strongly Disagree</td><td>2%</td></tr> </table>	Response	Percentage	Strongly Agree	9%	Agree	38%	Neutral	40%	Disagree	11%	Strongly Disagree	2%		<p>I am satisfied with my level of end-of-life care knowledge</p>  <table border="1" style="display: none;"> <caption>Post-assessment: Satisfied with end-of-life care knowledge</caption> <tr><th>Response</th><th>Percentage</th></tr> <tr><td>Strongly Agree</td><td>67%</td></tr> <tr><td>Agree</td><td>22%</td></tr> <tr><td>Neutral</td><td>9%</td></tr> <tr><td>Disagree</td><td>0%</td></tr> <tr><td>Strongly Disagree</td><td>2%</td></tr> </table>	Response	Percentage	Strongly Agree	67%	Agree	22%	Neutral	9%	Disagree	0%	Strongly Disagree	2%
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Table 1

*Pre-Knowledge Assessment / Post-Knowledge Assessment Questions 5-8*

 <b>PRE</b>	<span style="background-color: #FFD700; padding: 2px;">Strongly Agree</span> <span style="background-color: #6495ED; padding: 2px;">Agree</span> <span style="background-color: #A9A9A9; padding: 2px;">Neutral</span> <span style="background-color: #FF8C00; padding: 2px;">Disagree</span> <span style="background-color: #90EE90; padding: 2px;">Strongly Disagree</span>	<b>POST</b> 																							
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Appendix A

*Driver Diagram, Aim 4 Improving Nursing Provision of Patient Care*

