NEWLY GRADUATED REGISTERED NURSES' PERCEPTIONS ABOUT AND USE

OF PRINCIPLES OF PALLIATIVE CARE IN ACUTE CARE SETTINGS: AN

INTERPRETIVE PHENOMENOLOGY STUDY

by

LATRINA T. GEYER

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Approved:

Lanell M. Bellury, PhD, RN, AOCNS, OCN (Chair)   Date

Helen F. Hodges, PhD, RN (Internal Committee Member)   Date

Rita W. Ferguson, PhD, RN (External Committee Member)   Date

Tammy D. Barbé, PhD, RN, CNE (Associate Dean, Graduate Programs)   Date

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Linda A. Streit, PhD, RN (Dean)   Date

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NEWLY GRADUATED REGISTERED NURSES' PERCEPTIONS ABOUT AND USE
OF PRINCIPLES OF PALLIATIVE CARE IN ACUTE CARE SETTINGS: AN
INTERPRETIVE PHENOMENOLOGY STUDY
Under the direction of LANELL M. BELLURY, PhD, RN, AOCNS, OCN

The terms serious or life-threatening illness now included in current palliative

care literature indicate the broadened scope of palliative care. However, the change in

defining terminology has not consistently translated to a broadened understanding or

advanced clinical practice for many healthcare professionals in acute care settings. The

purpose of this research study was to discover NGRNs' perceptions, meanings, and use

of principles of PC for seriously ill patients in acute care settings. The research question

for this study was: What are NGRNs' lived experiences of providing PC for seriously ill

patients in acute care settings? A conceptual framework adapted from Kolcaba's (2003)

comfort theory and Benner's (1984) competencies of the helping role were developed for

this study. Interpretive phenomenology research design was utilized. A purposive

sample of 12 NGRNs participated in this study. Using Saldaña's coding methods, and

guided by van Manen's (1990) thematic analysis, four themes and six subthemes were

developed: 1) *Trying to Figure Out What the Balance Is*; 2) *Working in the Dark*; 3) *It's

Just Who I Am*; and 4) *The Kairos Effect*. Newly graduated registered nurses' common

and valued experiences demonstrated insight and understanding of comfort

(interventions) and comfort (outcomes) for seriously ill patients in acute care settings, as well as professional formation in nursing practice. The lived experience of providing palliative care for these NGRNs included experiencing a continuum between extreme measures and giving up and the weighty emotionally and ethically taxing nature of caring for seriously ill patients. The NGRNs also applied principles of palliative care daily and found the experience rewarding, validating, and important for professional formation. The innovative framework was useful in understanding the lived experiences of NGRNs and, further research is needed to apply the framework in additional practice settings and nursing populations. Additional research is also indicated to explore whether the findings were influenced by organizational factors including structured transition to practice programs and organizational culture.

CHAPTER 1

INTRODUCTION

Serious or life-threatening illness and complexity of healthcare in the United

States underlie significant challenges, which influence how nursing care is delivered.

Significant challenges in healthcare related to serious or life-threatening illness include

illnesses prolonged by advances in diagnosis, medical treatment, technology, and

specialization. Serious or life-threatening illnesses can range from acute illness

secondary to a sudden traumatic injury or cerebral vascular disorder with significant

functional impairment, to advanced cardiac disease or progressive chronic debilitating

illnesses. Patients are sicker longer. For those who cannot recover, palliative care (PC)

is one adjunct approach or alternative to expected biomedical care.

Palliative care addresses holistic comfort needs and provides appropriate

interventions for patients with serious or life-threatening illness. A palliative approach

encompasses patients' values and preferences, and has as a primary goal improved

quality of life for seriously ill patients and their families (National Consensus Project

[NCP], 2018). Assessing the needs, values, and preferences of seriously ill patients is

paramount to patients' experiences of comfort and quality of life outcome goals (Ferrell,

Smith, Levit, & Balogh, 2014; Kolcaba, 2003; NCP, 2018). Thus, PC is an approach for

understanding the needs of seriously acute and chronically ill patients, interpreting

meanings of comfort and comfort care, improving quality of care delivery and, ultimately, improving patient outcomes for seriously ill patients.

Comfort and quality of life outcomes for seriously ill patients in acute care settings are impacted by PC perceptions, understandings, meanings, and use. Non-palliative care specialists' PC educational preparation and experiential learning in complex patient situations are also important to patients' experiences of comfort and quality of life outcomes in acute care settings. However, a palliative approach to care delivery in acute care settings remains poorly understood by many nurses and other healthcare professionals. Many non-palliative care nurses, providers, and interprofessional healthcare team members in acute care settings lack PC educational preparation and experiential learning. Moreover, even when thought to be understood, PC is predominantly understood only in certain contexts such as oncology care and physical pain and symptom management, or settings such as critical care units, PC units, or hospice.

Newly graduated registered nurses (NGRN) are an integral and rapidly growing segment of the nursing workforce in acute care settings (Auerbach, Buerhaus, & Staiger, 2017; Jones, et al., 2017; Kenny, Reeve, & Hall, 2016). Realities of an aging nursing workforce make the retention of NGRNs one strategic solution to combat the projected shortage resulting from an aging workforce in those settings (Jones et al., 2017; Kenny et al., 2016). This strategy, however, is not without its own set of challenges. Little has been written about the preparation of NGRNs for using PC for seriously ill patients in acute care settings. There is a paucity of research about NGRNs' understanding of

principles of PC, perceptions and experiences of providing PC in acute care settings, and how their experiences affect quality outcomes for seriously ill patients.

Education standards, recommendations, guidelines, and competencies of PC have been linked directly to the essentials of baccalaureate and master's education for nursing programs (American Association of Colleges of Nursing [AACN], 2008; Ferrell, Malloy, Mazanec, & Virani, 2016; Hospice and Palliative Nurses Association [HPNA], 2015; Northam, Hercelinskyj, Grealish, & Mak, 2015). Key principles of PC include pain and symptom assessment and management, cultural and spiritual considerations, quality considerations at end-of-life (EOL), and ethical communication around loss, grief, bereavement, and preparation for and care at time of death (AACN, 2008; Kelly, Thrane, Virani, Malloy, & Ferrell, 2011). According to Kelly et al. (2011), PC nursing education that prepares nurses to provide competent pain and symptom management and consider the whole person will greatly improve the quality of care and quality of life. However, NGRNs may not be prepared. Thus, development of highly competent, ethical, collaborative, and caring NGRNs is essential to models of healthcare delivery for quality patient outcomes for seriously ill patients in acute care settings.

<div align="center">Phenomena of Interest</div>

The focus of this research was on gaining an understanding of NGRNs' perceptions, meanings, understandings, and use of PC for seriously ill patients in acute care settings. Contexts for the study include the intersection of: 1) serious or life-threatening illness; 2) palliative care; 3) acute care organizations; and 4) NGRNs' palliative care academic preparation and professional nursing experiences in acute care

settings. These contexts are ones in which NGRNs may not have a knowledge or foundation, but these contexts are critical in their ability to deliver PC to those who are seriously ill.

Serious or Life-Threatening Illness

Chronic and acute serious or life-threatening illnesses represented seven of the top 10 leading causes of death reported in the U.S. in 2016. Ischemic heart disease, chronic obstructive pulmonary disease, Alzheimer disease and other dementias, and colorectal cancer ranked first, third, fourth, and fifth respectively. Diabetes and ischemic stroke ranked 8th and 10th, which represented an increase in rank from data reported in 1990. Furthermore, many patients with chronic illness report at least one other chronic illness diagnosis (The U.S. Burden of Disease Collaborators, 2018).

Persons who are aged 65 years and older are living longer with serious or life-threatening illnesses, illnesses which would have been imminently terminal in past decades. Progress in science, technology, and pharmacology has increased longevity for people diagnosed with serious or life-threatening illness. Many once fatal diseases have become chronic diseases. For example, data reported from 2015 to 2017 noted an annual increase in the number of newly reported cases of end stage renal disease (ESRD), increase in the percentage of patients living with ESRD, and increase in Medicare spending for patients with ESRD requiring hemodialysis (HD) in excess of $98 billion in 2017. Chronic pain was reported as a chief complaint among patients with ESRD, and their self-reported health-seeking behaviors were linked to exacerbated illness symptoms (Estridge, Morris, Kolcaba, & Winkelman, 2018).

Palliative Care

Palliative care is a comprehensive approach to care delivery for patients of any age with a serious or life-threatening illness. Recommended at the time of diagnosis of serious or life-threatening illness, PC is a primary or adjunct approach to care delivery for patients whose diagnosis, illness trajectory, or prognosis limit possibilities for curative treatments and adversely affect quality of life (NCP, 2013). Palliative care is not synonymous with hospice or end-of-life. Rather, PC is: 1) patient- and family-centered; 2) appropriate for all discussions between healthcare professionals and patients and families; and 3) a foundation for shared, informed decision-making regarding goals of care. Core concepts within the construct of PC are comfort, dignity, and quality of life for seriously ill patients and their families regardless of the acute or chronic nature of serious illness diagnosis or prognosis (NCP, 2018). Although PC is not specific to one age group, health condition, or geographic region (NCP, 2018), the scope, participants, and setting for the current research study focused on acute care settings where nurses care primarily for adult populations.

Acute Care Organizations

Acute care healthcare delivery in the United States is influenced by escalating costs associated with advances in technology, pharmaceuticals, skilled care, and life-sustaining treatments. The Centers for Medicare and Medicaid Services (CMS, 2015) reported the national health expenditure (NHE) grew 5.8 percent to $3.2 trillion in 2015, or $9,990 per person, and accounted for 17.8 percent of the gross domestic product (GDP). Total hospital spending is projected to grow at an average rate of 5.5 percent per

year for 2016-2025, compared to 4.9 percent for 2010-2015. This faster growth partly

reflects anticipated increases in the use and intensity of hospital services by Medicare

beneficiaries over the coming decade. Finally, according to the CMS (2015), given the

Affordable Care Act's (ACA) coverage expansions and premium subsidies together with

population aging, federal, state, and local governments are projected to finance 47

percent of national health spending by 2025 (from 45 percent in 2014).

Factors which impact quality of nursing care and quality of life outcomes for

seriously ill patients in acute care settings are numerous. Quality and patient safety in

most acute care settings are driven by several key mandates. Press Ganey® nursing

(nurse-sensitive) quality indicators set benchmarks by which many acute care settings

measure performance and quality of nursing care. The CMS and U.S. Department of

Health and Human Services (DHHS) Agency for Healthcare Research and Quality

(AHRQ) use evidence-based tools to measure and track quality of care, patient safety,

and clinical performance across inpatient hospital settings.

Quality performance indicators in acute care organizations also include measures

related to recognition and treatment of acute life-threatening illnesses such as heart attack

and stroke. Such quality indicators include mortality data and data related to

complications and errors. Morbidity and mortality statistics related to chronic illness, and

disabilities related to serious or life-threatening illnesses underlie the need for a closer

look at the current state of healthcare delivery in the U.S. (CDC, 2013; The U.S. Burden

of Disease Collaborators, 2018). In addition, 30-day readmission rates for serious

chronic illnesses such as heart failure and chronic obstructive pulmonary disease (COPD)

further emphasize the urgent need for a comprehensive and holistic approach to care across all acute care settings.

Palliative care in acute care organizations has been linked to improved quality outcomes, patient experiences, and finance outcomes for hospitals (Gibbs, Mahon, Truss, & Eyring, 2015; Hermann, Head, Black, & Singleton, 2016; Silvers & Rogers, 2018). The CMS and AHRQ partnered to develop the Hospital Consumer Assessment of Healthcare Providers and Systems (Hospital CAHPS®) survey. The Hospital CAHPS® is a standardized survey used by healthcare organizations to measure patients' self-reported perceptions of patient care experiences during their most recent hospitalization. Palliative care interdisciplinary teams, consultations, advanced care planning, care coordination, and patient- and family-centered communication have been positively correlated with decreased length of stay, decreased hospital readmissions, and increased patient satisfaction in acute care settings (Silvers & Rogers, 2018). In addition, accreditation organizations like the Joint Commission (TJC) have set quality measures and goals for healthcare linked to PC delivery in hospitals.

The scope and significance of PC in acute care settings is becoming more evident with the advent of programs like TJC's PC certification program for hospitals (TJC, 2016, 2017), and the American Academy of Hospice and Palliative Medicine's (AAHPM) partnership with the American Board of Internal Medicine (ABIM) Foundation® Choosing Wisely program. Both programs emphasize the importance of patient preferences in goals and plans of care as well as holistic approaches to assessment and treatment throughout the chronic illness trajectory. The National Coalition for

Hospice and PC is an interdisciplinary network representing medicine, nursing, social

work, chaplaincy and healthcare quality. Due to organizations such as the AAHPM,

HPNA, the Center for Advanced PC (CAPC), and the National PC Research Center, the

science of comfort care is growing in scope and significance for healthcare delivery

across all settings. In fact, these groups promote the position that "PC offers better care

and higher quality of care at a cost the nation can afford" (Ferrell, Smith, Levit, &

Balogh, 2014, p. 398).

Newly Graduated Registered Nurses

> "PC is becoming an essential component of healthcare in America and throughout
> the world making it critical that those entering the health professions understand
> the principles and practices of quality PC across the continuum of healthcare"
> (Hermann et al., 2016, p. 63).

Attending to the physical, psychological, spiritual, sociocultural, and

environmental health needs of patients diagnosed with serious or life-threatening illness

should be priorities of caring professionals across acute care settings. However, NGRNs

who lack PC nursing education and acute care experience as registered nurses may lack

competence, confidence, and clinical reasoning necessary to improve quality of life

outcomes for seriously ill patients in acute care settings (Jones et al., 2017; Kenny et al.,

2016). Learning about PC theoretical knowledge alone may not reflect actual lived

experiences of applying PC knowledge to nursing practice for seriously ill patients in

acute care settings. Also, academic knowledge alone may not be an indication of

NGRNs' understanding of seriously ill patients' needs, nursing care interventions for

complex patient situations, or insights which either impede or enhance patients'

experiences of comfort. Therefore, an exploration of NGRNs' perceptions about PC and comfort and their competencies in the helping role is both relevant and vital nursing research.

Purpose of the Study

The purpose of this qualitative study was to discover NGRNs' perceptions, meanings, and use of principles of palliative care for seriously ill adult patients in acute care settings. Specific aims for this study were to uncover: 1) meanings of palliative care in acute care settings, 2) NGRNs' understanding of principles of palliative care, 3) NGRNs' use of principles of palliative care; and 4) outcomes of a palliative approach.

Research Question

The research question for the study was: What are newly graduated registered nurses' lived experiences of providing palliative care for seriously ill adult patients in acute care settings?

Conceptual Framework

Kolcaba's comfort theory (2003) and Benner's eight competencies of the helping role (1984) guided the conceptualization of this study and formed the framework for phenomenological interviews and reflection. Definitions of key terms are reviewed later in this chapter.

Kolcaba's Comfort Theory

Kolcaba credited several philosophical and theoretical influences in the development of comfort theory. According to Kolcaba (2003), Rankin-Box's (1986) research focused on the lack of any clear definition of comfort, how to interpret

statements about the importance of comfort, how comfort can be achieved in nursing, and the provision of care in an empathetic, caring way (Locations 652-658 of 4589). Kolcaba (2003) also cited the influential work of Arrington & Walborn (1989) who noted in their work "strengthening properties of comfort produced better outcomes" (Location 689-701 of 4589).

Comfort was identified as a crucial concept for nursing by several authors, notably Chinn (1992), Gropper (1992), Kolcaba (1992), and Morse (1992). Kolcaba (2003) credited the work of three mid-range nursing theorists Orlando (1961/1990), Henderson (1978), and Paterson & Zderad (1976/1988) in the conceptualization of comfort theory (Locations 1238, 1364, 1369, 1375 of 4589). Of significant influence in the conceptualization and operationalization of comfort theory, Kolcaba (2003) cited Morse's enthnoscientific analysis of comfort (1983). Morse (1983) made the linguistic distinction between comfort as the process of nurses' work versus comfort as a desired outcome product. Kolcaba's comfort theory (2003) is focused on comfort as an outcome of specific interventions.

Kolcaba (2003) defined comfort as the immediate experience of being strengthened by having needs of relief, ease, and transcendence addressed in four contexts—physical, psychospiritual, sociocultural, and environmental. Relief is defined as the state of having a specific comfort need met (Kolcaba, 2003). Ease is defined as the state of calm or contentment (Kolcaba, 2003). Transcendence is defined as the state in which one can rise above problems or pain; transcendence means that one has risen above difficult work or circumstances (Kolcaba, 2003). The seven major concepts of Kolcaba's

(2003) comfort theory are: 1) contexts of human experiences; 2) comfort needs; 3) comfort care; 4) intervening variables; 5) enhanced comfort; 6) health-seeking behaviors; and 7) institutional integrity.

According to Kolcaba (2003), comfort is much more than simply the absence of pain or other physical discomfort. Moreover, the outcome of enhanced comfort is desirable because "by definition, it strengthens patients to engage in health–seeking behaviors . . . and can also strengthen patients (and families) to make decisions that will facilitate a peaceful death" (Kolcaba, 2003, Location 2492 of 4589). Propositions of comfort theory included nurses and other team members who: 1) identify patients' comfort needs; 2) design interventions to address those needs; 3) consider intervening variables when designing interventions and determining probability of success; and 4) evaluate interventions and care delivery. When nursing interventions are appropriate and delivered in a caring manner, the patient experiences the intentional goal/immediate outcome of enhanced comfort (Boudiab & Kolcaba, 2015; Kolcaba, 2003). However, intervening variables within Kolcaba's (2003) comfort theory are defined as negative or positive factors over which nurses and institutions have little control, but that can affect the direction and success of comfort care plans.

Comfort care is defined by Kolcaba (2003) as nursing interventions which encompass: 1) appropriate and timely intervention to meet the comfort needs of patients; 2) a mode of delivery that projects caring and empathy; and 3) intent to comfort. Comfort care is a positive, humanistic guide for caregiving, discussion, and decision making. All aspects of patient and family comfort, whereby patients and families are

empowered to work through their serious or life-threatening illness toward relief, ease, and/or transcendence are included in comfort care. In summary, according to comfort theory, comfort is the immediate experience of being strengthened (the desired outcome of enhanced comfort) by having the needs for relief, ease, and transcendence addressed in the four contexts of holistic human experience: physical, psychospiritual, sociocultural, and environmental (Kolcaba, 2003).

Benner's Helping Role

In addition to Kolcaba's work to define the processes and outcomes of comfort, concepts of comfort theory are embedded within Benner's helping role of nurses. Benner (1984) identified eight essential competencies in what was termed the *helping role* of nurses. Eight competencies of the helping role included: 1) creating a climate for establishing a commitment to healing; 2) providing comfort measures and preserving personhood in the face of pain and extreme breakdown; 3) presencing (being with the patient); 4) maximizing the patient's participation and control in his or her own recovery; 5) interpreting kinds of pain and selecting appropriate strategies for pain management and control; 6) providing comfort and communication through touch; 7) providing emotional and informational support to patients' families; and 8) guiding a patient through emotional and developmental change. These competencies are congruent with Kolcaba's comfort care (2003).

For Kolcaba (2003), holistic comfort— relief, ease, or transcendence—is the desired patient outcome and immediate result of comfort care. Holistic comfort is achieved when patients' physical, psychospiritual, social, and environmental needs are

addressed. Kolcaba's comfort theory provides the structure for comfort (the desired outcome), and Benner's (1984) competencies of the helping role further explicate the processes (comfort care/nursing interventions) by which holistic comfort is achieved. The eight competencies of the helping role align Kolcaba's theoretical concepts (appropriate and timely interventions, caring and empathy, and intent to comfort) with practical actions to guide and strengthen nursing practice for novice nurses.

The helping role is one of seven domains Benner delineated in 1984 within which nurses increase in proficiency and confidence as they advance through the five stages of skills acquisition (from novice to expert). The helping role of nurses characterizes clinical judgment, clinical reasoning, and ethical care. Clinical reasoning and ethical care are embedded into essential concepts for professional nursing practice (AACN, 2008). According to Benner Kyriakidis, and Stannard (1999), clinical judgment refers to ways nurses come to understand the problems, issues, or concerns of patients, to attend to salient information, and to respond in concerned and involved ways.

Benner et al. (1999) and Benner, Kyriakidis, and Stannard (2011) advanced Benner's (1984) philosophy of nursing practice and skills acquisition. Benner et al. (2011) was consistent with trends and forecasts in healthcare delivery in acute care settings. Increasing complexity of patient situations and rapidly changing acute care environments necessitate nurses caring for patients with serious or life-threatening illness across all acute care settings. Benner and colleagues' (1999, 2011) domains of nursing practice and specific competencies also recognized essential characteristics consist with Kolcaba's comfort theory (2003).

Although Benner et al. (1999, 2011) did not retain the term "helping role" as one of the nine domains of nursing practice, *providing comfort measures for the critically and acutely ill* (Benner et al., 2011) is recognized as an essential domain of nursing practice. Like the helping role, eight competencies were delineated in this domain of providing comfort measures. There are elemental consistencies between Benner (1984) and Benner et al. (1999, 2011). Providing comfort measures, skilled know-how to manage a crisis, caring for patients' families, end-of-life care and decision-making, and communicating and negotiating multiple perspectives are recognized as central to quality of nursing care, ethical healthcare delivery, and formation in professional nursing.

Benner's (1984) domain of the helping role was intentionally selected for this study. The explicit language and concrete performance expectations of clinical expertise associated with the helping role (1984) are most closely aligned with Kolcaba's comfort theory (2003). Furthermore, the helping role strengthens overall conceptualization of this study. Competencies of the helping role are viewed, by this researcher, as being the thread which connects phenomena of interest: serious or life-threatening illness, PC, NGRNs, and acute care settings.

Nurses employ clinical judgment in complex patient care situations, working with interprofessional teams to ensure healthcare quality and safety. Critical components include changes in patient status, uncertainty about the most appropriate course of action, accounting for context, and the nurse's practical experience. Clinical decision-making is rooted in the nurse's theoretical knowledge, ethical perspectives, and interrelationships with patients, caregivers, and the culture in which care is provided. According to Benner

et al. (2010), "learning nursing's focal practices such as being present for patients and bearing witness to their suffering . . . are central to the formation of the nurse, and they are also formative of practice and learning" (p. 192).

The conceptual framework (CF) model (Figure 1) for this study was developed by the researcher. The model is a visual representation of the major concepts of Kolcaba's comfort theory (2003), complemented by Benner's (1984) eight competencies of the helping role, and applied to the researcher's phenomena of interest to address the purpose, aims, and research question for this study. The framework shows interrelated and interdependent connections between seven major concepts of Kolcaba's (2003) comfort theory: 1) contexts of human experiences; 2) comfort needs; 3) comfort care; 4) intervening variables; 5) enhanced comfort; 6) health-seeking behaviors; and 7) institutional integrity.

At the top of the CF model, contexts of human experiences focus on holistic—physical, psychospiritual, sociocultural, and environmental—assessment of patients' comfort needs, which can be applied to the principles of PC: holistic comfort, appropriate interventions, and patient preferences and values. For example, patient preferences and values should be considered in providing appropriate interventions for the physical, psychospiritual, sociocultural, and environmental needs of the patient to promote holistic comfort. The circular arrows between these four contexts represent the interconnected and essential nature of holistic needs. Connecting principles of PC to contexts of human experiences and comfort needs was an important first step in conceptualizing the study.

The next component of the model, in the box titled "Comfort Care: The Helping Role," represents the key nexus between theoretical knowledge, practical application, and understanding principles of PC and comfort. Kolcaba's construct of comfort care (2003), on the left side of the box, includes appropriate and timely interventions, caring and empathy, and intent to comfort. Benner's eight competencies of the helping role (1984) provide key defining attributes of comfort care. This section of the model outlines what comfort care looks like in acute care settings. Kolcaba's concepts of intervening variables (2003) applied to the acute care setting include, PC educational preparation, complexity of patient situations, interprofessional collaboration, and patients' experiences of comfort care. These factors impact 1) outcomes of enhanced comfort, 2) patients' and families' engagement in health-seeking behaviors which promote comfort, and 3) key measures of institutional integrity. For the purpose of this study, key measures of institutional integrity included organizational and professional nursing practice priorities.

The top portion of the CF model (contexts, comfort care, and intervening variables) addresses nursing practices or processes to promote comfort. The bottom portion represents the outcomes of comfort care. The arrows between the outcomes of enhanced comfort, health-seeking behaviors, and institutional integrity represent interdependent relationships, which influence the intentional and desired outcomes of nursing interventions. Health-seeking behaviors are patient- and family-specific actions which influence types of comfort (relief, ease, or transcendence). When nurses are able to assess holistic comfort needs, with patient' and families' input, interventions are more likely to result in relief. Once immediate needs of pain and symptom management are

achieved, patients and families can begin to consider broader goals and plans of care which focus on quality of life. Comfort also includes patients' and families' preferences for dignity and a peaceful death. The extent to which patients participate in their own care, and their preferences are respected, affects enhanced comfort and reflects measures of institutional integrity.

For this study, it was important to consider how each component of the CF model could provide new insights to advance nursing knowledge and nursing practice. Central to these new insights were NGRNs' point of view (perceptions and meanings) and use (understanding and application) of principles of PC for seriously ill adult patients in acute care settings. Newly graduated registered nurses' perceptions and meanings of serious or life-threatening illness and their experiences of caring for seriously ill patients in acute care settings were explored through the connecting principles of PC, comfort contexts and needs, and helping role competencies. The intervening variables are factors over which NGRNs may have little or no control. The outcomes are the intended results of the care NGRNs provide to seriously ill patients in acute care settings.
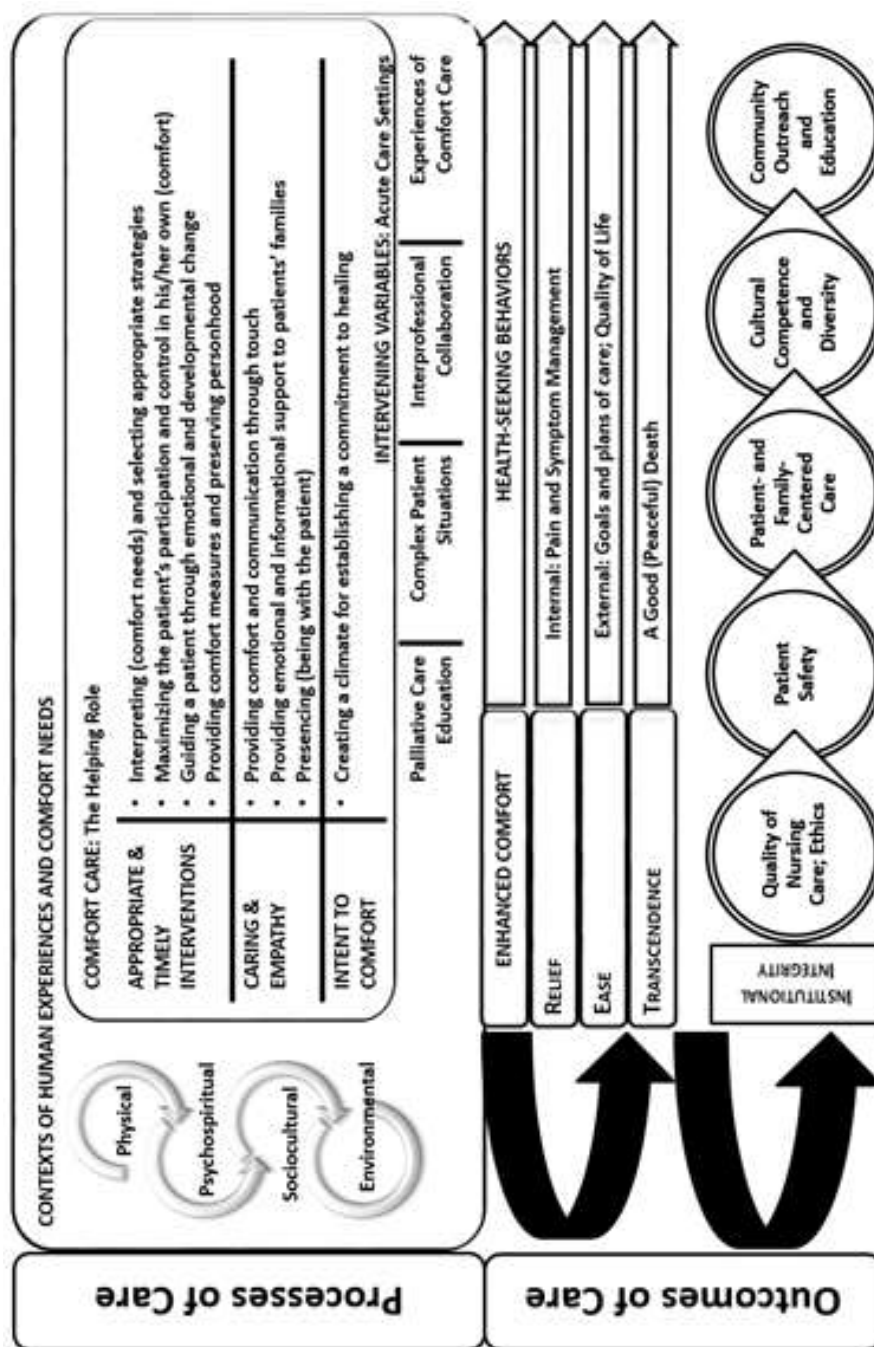
Figure 1. Conceptual Framework for Palliative Care in Acute Care Settings, Adapted from Kolcaba's Comfort Theory (2003) and Benner's Competencies of the Helping Role (1984)

Significance of the Study

In many acute care settings, patient outcomes are inextricably linked to nursing knowledge, nursing interventions, nursing engagement, and nursing leadership. Moreover, expectations of high performing acute care organizations are driven by and largely dependent upon a highly competent, ethical, collaborative, and caring nursing workforce. In addition, as many acute care hospitals move to outcomes-driven, value-based reimbursement institutions or systems, attention must be given to all areas of the health-illness continuum. Quality of life and outcomes for patients with serious or life-threatening illness are greatly impacted by the preparation, experience, and care delivery of healthcare professionals. Newly graduated registered nurses' perceptions, meanings, understanding, and use of principles of PC may provide unique insights of NGRNs' clinical reasoning, clinical judgment, and confidence in caring for seriously ill adult patients in their first year of professional nursing practice.

Exploring NGRNs' experiences would help in identifying factors that may facilitate or impede PC delivery in acute care settings; thereby, findings may provide new insights to improve quality and outcomes of nursing care. With a heavy emphasis on end-of-life care, studies conducted within the past five years do not fully explore or explicate the ways in which the NGRNs' role in comfort care expands beyond the role of facilitating a good death. Thus, a need existed for a more in-depth understanding and interpretation of NGRNs' PC experiences, including specific factors, which may affect nurses' comfort care and enhanced comfort for patients with serious or life-threatening illness in acute care settings. This research study intended to advance the body of nursing

knowledge by addressing two primary gaps in current literature: 1) NGRNs' application and evaluation of PC principles in the care of seriously ill patients and their families in acute care settings; and 2) use of comfort theory and competencies delineated in the helping role as a framework to improve NGRNs' care delivery for seriously ill patients.

<div align="center">Assumptions and Biases</div>

While the researcher for this study had no prior professional or academic educational experiences in PC nursing, several assumptions and biases were drawn from 26 years of professional nursing experience, and clinical observations of nursing education, professional development, and NGRNs' nursing practices for seriously ill patients in acute care settings. Several personal assumptions and biases were identified which may affect this study: 1) NGRNs have varying degrees of pre-licensure PC preparation and clinical experiences which influence their perceptions and meanings of PC; 2) NGRNs' perceptions of comfort will be greater if they have had personal and/or professional experiences to shape their framework and utilization of PC/comfort care nursing principles in practice; 3) complex patient situations in the acute care nurse practice environment present unique challenges for NGRNs to demonstrate competence and gain confidence as they transition to professional nursing practice; 4) NGRNs would demonstrate increased confidence in the helping role as defined by Benner (1984), by utilizing the framework of comfort theory (Kolcaba, 2003) in their practice; and 5) NGRNs will benefit from a PC nursing approach as a framework for holistic assessment, comfort care nursing interventions, development of interprofessional collaborative

relationships; and shared decision-making and communication with seriously ill patients and families.

Further assumptions for the current study were: 1) NGRNs' perceptions about and use of PC to affect enhanced comfort in acute care settings are unexamined areas of practical knowledge; 2) principles of PC and competencies of the helping role are best practice frameworks for nursing care of seriously ill patients in acute care settings; 3) meanings of PC for seriously ill patients in acute care settings, from the NGRNs' point of view, will uncover practical knowledge and unique insights to improve quality of nursing care which can be further studied or extended; 4) nursing practice guided by a palliative approach to care delivery improves structure, processes, and outcomes for seriously ill patients across all acute care settings; and 5) findings from this study could be used to evaluate and influence PC curriculum development and design in baccalaureate nursing programs.

<div align="center">Definition of Terms</div>

Definition of key terms for the study were as follows:

Advanced Beginner

The advanced beginner is one who can demonstrate marginally acceptable performance. This person is one who has coped with enough real situations to note (or to have them pointed out by a mentor) the recurrent meaningful situational components. Advanced beginners need support in the clinical setting. Advanced beginners need help in setting priorities since they operate on general guidelines and are only beginning to perceive recurrent meaningful patters in their clinical practice (Benner, 1984).

Comfort

Comfort is defined as the immediate experience of being strengthened (the desired outcome of enhanced comfort) by having the needs for relief, ease, and transcendence addressed in the four contexts of holistic human experience: physical, psychospiritual, sociocultural, and environmental (Kolcaba, 2003).

Comfort Care

Comfort care focuses on addressing physical (including homeostatic mechanisms as well as sensations), psychospiritual, sociocultural, and environmental comfort needs of patients. Comfort care encompasses appropriate and timely interventions; a mode of delivery that projects caring and empathy; and intent to comfort (Kolcaba, 2003).

Comfort Needs

Comfort needs are defined as physical, psychospiritual, sociocultural, and environmental contexts of human experiences, for which patients desire relief, ease, or transcendence (Kolcaba, 2003).

- The *physical context* in which comfort occurs pertains to bodily sensations, homeostatic mechanisms, immune function, etc. (Kolcaba, 2003). Physical comfort is the most obvious and agreed-upon context of comfort (Location 372 of 4589); the physiological dimension addresses factors that affect the patient's physical status, such as rest and relaxation, treatment of medical conditions, level of nutrition and hydration, and elimination of wastes (Location 385 of 4589).

- The *psychospiritual context* in which comfort occurs pertains to internal awareness of self, including esteem, identity, sexuality, meaning in one's life, and one's understood relationship to a higher order or being (Kolcaba, 2003).

- The *sociocultural context* in which comfort occurs pertains to interpersonal, family, and societal relationships (finances, teaching, healthcare personnel, etc.). Sociocultural contexts also include family traditions, rituals, and religious practices (Kolcaba, 2003).

- The *environmental context* in which comfort occurs pertains to the external background of human experience (temperature, light, sound, odor, color, furniture, landscape, etc.) (Kolcaba, 2003).

Ease

Ease is defined as the state of calm or contentment (Kolcaba, 2003).

Experience

"Experience, as the word is used here, does not refer to the mere passage of time or longevity. Rather it is the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory" (Benner, 1984, p. 36).

Formation

Formation encompasses how a professional is morally and ethically shaped and takes up becoming and being a nurse; how one learns to instantiate the notions of good in actual everyday practice and in the skills of involvement with patients, families, and colleagues (Benner et al., 2011).

Health Seeking Behaviors (HSBs)

Health-seeking behaviors are behaviors in which patients engage consciously or subconsciously which move them toward well-being; HSBs can be internal, external, or a peaceful death (Kolcaba, 2003).

Holism

Holism is defined as the belief that whole persons consist of a mental/spiritual/emotional life that is intimately connected with their physical bodies; persons' bodies comprise their own natural boundaries (Kolcaba, 2003).

Institutional Integrity

Institutional integrity is the quality or state of healthcare organizations being complete, whole, sound, upright, professional, and ethical providers of healthcare (Kolcaba, 2003). For the purpose of this study, institutional integrity included quality of nursing care, ethics, patient safety, patient- and family-centered care, cultural competence and diversity, and community outreach and education.

Intervening Variables

Intervening variables are factors over which nurses or agencies have little control, but which affect the direction and success of "comfort care plans or comfort studies" (Kolcaba, 2003, Location 4359 of 4589). Kolcaba (2003) described intervening variables as "contributors to or detractors from patient comfort" (Location 2680 of 4589). For the purpose of this research, intervening variables included PC education preparation, complexity of patient care situations in the nurse practice environment, patients'

experiences of comfort care nursing practices, and interprofessional healthcare team relationships.

It's Just Who I Am

Developed from the narratives of this study and analytic coding processes, it's just who I am is a theme related to NGRNs' personal values, beliefs, worldview, and personal ethos as central to their palliative care nursing practice. The theme of it's just who I am provide NGRNs' reflections on prior personal experiences of serious illness and comfort care.

Kairos Effect

Developed from the narratives of this study and analytic coding processes, the Kairos effect is a theme related to NGRNs' demonstration of insight, understanding, an "aha moment" which shifted his/her thinking of palliative care from time/space-specific to a holistic approach to care.

Newly Graduated Registered Nurse

New graduate is defined as a nurse who has completed his or her nursing education and is in the first year of employment as a registered professional nurse. New graduates hired to acute care settings are generally advanced beginners who have limited clinical experience and require preceptorship, mentoring, coaching, and safe learning environments to transition into beginning nursing practice (Benner et al., 2009).

Palliative Approach

A palliative approach is defined as integration of PC principles into healthcare settings by professionals who do not specialize in PC (Sawatzky et al., 2016, p. 3).

Palliative Care

According to the *Clinical Practice Guidelines for Quality PC* (National Consensus Project for Quality PC [NCP], 2013), PC is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. PC throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (Ferrell, Temel, Temin, & Smith, 2017; NCP, 2013).

Peaceful Death

Peaceful death is defined as a death in which conflicts are resolved, symptoms are well managed, and acceptance by the patient and family members allows for the patient to "let go" quietly and with dignity (Kolcaba, 2003).

Principles of Palliative Care

For the purposes of this study, the researcher recognized principles of PC in acute care settings include: 1) intentional assessment of seriously ill patients within the context of human experiences, including physical, psychospiritual, sociocultural, and environmental comfort needs; 2) nursing interventions which address the comfort needs of seriously ill patients in acute care settings, including appropriate and timely interventions, caring and empathy, and intent to comfort; and 3) nursing practice inclusive of evidence-based PC guidelines for complex patient situations, interprofessional collaboration, ethical care, and patient autonomy in goals and plans of care (Benner, 2011; Ferrell et al., 2017; Kolcaba, 2003; NCP, 2013).

Relief

Relief is defined as the state of having a specific comfort need met (Kolcaba, 2003).

Serious or Life-Threatening Illness

The term serious or life-threatening illness is assumed to encompass populations of patients at all ages within the broad range of diagnostic categories, living with a persistent or recurring medical condition that adversely affects their daily functioning or will predictably reduce life expectancy (NCP, 2013).

Situated Learning

Situated learning is defined as learning while engaged in actual situation or context; learning to use knowledge while thinking and acting in an ever-changing situation (Benner et al., 2011).

Thinking-in-Action

Thinking-in-action is defined as the patterns and habits of thought and action that are directly tied to responding to patients and families and the demands of a changing situation and for noticing when clinical assumptions and expectations are not met (Benner et al., 2011).

Transcendence

Transcendence is defined as the state in which one can rise above problems or pain; transcendence means that one has risen above difficult work or circumstances (Kolcaba, 2003).

Trying to Figure Out What the Balance Is

Developed from the narratives of this study and analytic coding processes, trying to figure out what the balance is a theme related to NGRNs' moral dilemmas and the corresponding emotional conflict and internal struggle associated with their perceptions of patient suffering from their illness and treatments, decision-making for comfort and quality of life, and their role as nurses.

Working in the Dark

Developed from the narratives of this study and analytic coding processes, working in the dark is a theme related to NGRNs' and patients' and families' expectations and experiences of comfort in the acute care setting.

Summary

This chapter included the phenomena of interest, purpose, aims, and the research question for the study. The conceptual framework for the study represents the complement of Kolcaba's comfort theory (2003) and Benner's helping role (1984). Significances of the study were based on the premise that newly graduated registered nurses, absent years of professional nursing experience and a framework within which to guide their transition to professional nursing practice in acute care settings, may lack the skills needed to care for increasingly complex and seriously ill patients and their families. Personal assumptions and biases of the researcher which may have impacted the study were identified. Finally, key definitions and terms related to the study were provided.

CHAPTER 2

REVIEW OF RELATED LITERATURE

This study explored NGRNs' perceptions about and use of principles of PC in acute care settings. A comprehensive review of related literature was conducted to identify what was already known about the phenomena of interest. The historical, experiential, and philosophical contexts of the study are included in this chapter. In addition, a synthesis of existing and evolving substantive nursing and allied health literature are provided. Gaps in the literature and inferences for this study are also discussed.

Context of the Study

Although in recent years, PC has expanded in scope and significance, PC perceptions, understandings, meanings, and use vary. PC, as a concept and construct, is comprehensive and complex (Dacher, 2014; Meier & Bowman, 2017; National Consensus Project [NCP], 2018). Moreover, PC, even when thought to be understood, may only be understood in certain contexts or situations (Goodwin & Candela, 2013; Oliveira, Fothergill-Bourbonnais, McPherson, & Vanderspank-Wright, 2016; Phillips, Kenny, Esterman, & Smith, 2014). Consequently, PC remains an underused, but value-added care delivery approach in many acute care settings (Gibbs, et al., 2015; Silvers & Rogers, 2018).

Newly graduated registered nurses are recognized as important human resources to future nursing workforce capacity (Laschinger et al., 2016). According to the literature, work environment characteristics have a powerful influence on new graduate nurse transition experiences (Laschinger et al., 2016). The understanding of complex patient situations and the nature of nurse practice environments are factors most closely linked to NGRNs' job satisfaction and retention (Laschinger et al., 2016; Parker, Giles, Lantry, & McMillan, 2014). Clark and Springer (2012) conducted a qualitative study to describe new graduate nurses' lived experiences and job satisfaction during their first year of nursing practice. Participants described caring for seriously ill patients in technologically advanced practice settings. According to this study, higher acuity levels of patients, shortened lengths of stay, and complex technology "placed significant demands on new graduate nurses attempting to master sound clinical decision-making and critical thinking" (Clark & Springer, 2012, p. 3).

The Institute of Medicine (IOM, 2014) in their report on *Dying in America* recognized 1) too little PC knowledge among clinicians caring for seriously ill patients and 2) greater understanding of the role of PC as two of the greatest remaining challenges to delivery of high-quality care for patients with serious and life-threatening illnesses. NGRNs who lack PC nursing preparation may lack competence, confidence, clinical judgment, and clinical reasoning necessary to improve quality of life outcomes for seriously ill patients in acute care settings.

Historical

The word palliative ("Palliative," n.d.) stems from the French word palliatif (14th century) meaning stopgap or stopgap measure ("Palliatif," n.d.). The Latin words palliare, palliat (15th century) referred to a garment cloak, disguise, or cover up ("Palliate," n.d.). The Greek word pallium also referred to a physical garment cloak, or in its literal translation a covering worn by Greek philosophical and religious teachers ("Pallium," n.d.). English translation of the word is palliate (late 19th century). The English translation of the word transformed the tense of the word from a noun to a verb ("Palliate," n.d.). As an action word, and in its current context, palliate means to relieve without curing; mitigate; alleviate; to lessen the severity of a disease or symptom without curing or removing its underlying cause ("Palliate," n.d.).

Over the past two decades, PC has become increasingly recognized in academia and healthcare as a holistic and patient-centered approach to care delivery for patients with *serious or life-threatening illness* (National Consensus Project [NCP], 2013, 2018; The National Palliative Care Research Center, n.d.). Historically considered to be a caring approach for patients with a cancer diagnosis, the concept of PC has now exceeded the realm of cancer care (Bergenholtz, Jarlbaek, & Holge-Hazelton, 2015; Kindl & Good, 2015; Kydd, 2015; Meier & Bowman, 2017). This is most notable in the literature when identifying PC definitions. The terms serious or life-threatening illness (Hospice and Palliative Nurses Association [HPNA], 2015; NCP, 2013; The National Palliative Care Research Center, n.d.) now included in current PC literature indicate the broadened scope of PC. However, the change in defining terminology has not translated to a broadened

understanding or advanced clinical practice for many healthcare professionals since its early conceptualizations.

In the early 20th century, PC focused primarily on terminal illness care at end-of-life (Dobrina, Tenze, & Palese, 2014; Fallon & Smyth, 2008; Murray, 2007). Care of the dying, terminal care, was provided primarily at home and in religious havens known as hospice homes. Only occasionally was terminal care provided in hospitals, and was almost always absent of medical intervention because no cure was possible. The purpose and scope of terminal care were to palliate—relieve without curing, mitigate, alleviate, and lessen the severity of a disease or symptom without curing or removing its underlying cause.

The modern conceptualization of PC is traced to the founding of St. Christopher's Hospice, London (UK), based upon "the realization that care of the dying was suboptimal on hospital wards" (Fallon & Smyth, 2008, p. 1069). In 1967, a group of health and healing practitioners, led by Dame Cicely Saunders, founded St. Christopher's Hospice. Saunders was a nurse, social worker, physician, and volunteer (Meier & Bowman, 2017). Saunders found inspiration for relief of suffering as a volunteer in hospice homes, which were spiritual respite for the terminally ill, disabled, and elderly.

As a professional nurse who held deep religious convictions, Saunders and fellow pioneers believed hospice care for terminally ill patients should encompass "excellent nursing and spiritual care" (Baines, 2011, p. 223). Thus began the development of a "science of comfort care" (Meier & Bowman, 2017, p. 75) for patients with incurable illness. Dignity, comfort, pain management, and symptom management for actively

dying patients were foundational concepts for Saunders and the early pioneers of hospice care. These core elements continue to shape development of best practices for care of patients with serious and life-threatening illness today.

Definitions and models of PC mirror the iterative structures, processes, and outcome goals of PC. The World Health Organization (WHO, 1990) conceptualization of PC included pain management and control of psychological, social, and spiritual symptoms for patients whose cancer was unresponsive to curative treatment (Watts, 2014). Palliative care was defined by WHO (1990) as "active total care" (Watts, 2014) although no further clarification or interpretation was provided for the meanings "active" or "total care." The concepts of PC developed from 2010-2014 were consistent with the IOMs (2010) recommendations for healthcare organizations and healthcare professionals.

Definitions and conceptualizations of PC included several core components. Addition of the words approach, quality, prevention, early identification, and impeccable assessment to the WHO (2013) definition recognized the processes, which improve quality outcomes for patients. The WHO (2013) conceptualization of PC retained components of its 1990 definition; however, like the original definition, this 2013 explanation excluded the environment as a defining attribute of PC. This is a significant omission; yet, many healthcare providers continue to use the WHO 2013 definition for PC education and training.

The concept of PC as articulated by the American Academy of Hospice and Palliative Medicine (AAHPM, 2014) began to address the structure of organizations by defining PC as "both a philosophy of care and an organized, highly structured system for

delivering care" (Watts, 2014, p. 286). Quality of life, concurrent delivery, patient-centered care, autonomy, and shared decision-making across the illness trajectory were essential to the enlightened concept of PC for patients with serious or life-threatening illness regardless of diagnosis or prognosis. Subsequent definitions from the Center to Advance Palliative Care (CAPC), European Association for Palliative Care, and National Council for Palliative Care maintained core elements from both WHO and AAHPM. Unfortunately, these latter concepts of PC also failed to consider the influence of environment in the comfort of patients. This is significant in that the environment is an important existential context of being and meaning-making in lived experiences.

Four models of holistic care for seriously ill patients were identified by Selman et al. (2014) in their exploratory study of cultural contexts in PC. Selman and colleagues discussed the absence of cultural context in Engel's (1978) biopsychosocial model, Saunders' (1967) model of total pain, and Sulmasy's (2002) biopsychosocial-spiritual care model. Each of these models prioritized the needs of the physical body and, with varying emphasis, recognized experiences of suffering in emotional, spiritual, psychological, and social contexts. Murray's transitions model of PC (2007) intended to operationalize PC based upon five contexts of patients' needs in chronic illness: patient characteristics, preferences, readiness, circumstances, and other needs. Murray's model was vague in its description of contexts of human experiences in chronic illness. However, as an operational model for nursing, Murray did link PC interventions such as focus on patient preferences and early integration of PC to measures of quality outcomes.

The Gold Standards Framework (GSF) introduced tools for early identification, assessment, and care planning in primary care settings in the UK (Sawatzky et al., 2016). Another important milestone in the development of PC models was Lynn's (2005) study to understand prognoses and preferred outcomes and risks of treatment (SUPPORT) project. The SUPPORT project identified serious illness trajectories and strategies to improve patient and family-centered care and outcomes through a palliative approach. The GSF and SUPPORT project included principles of PC, but also provided key insights which advanced the palliative approach across healthcare settings. Moreover, continuity of care, outcomes evaluation, and focus on the patient were recognized as essential to quality PC practice.

Models of PC and end of life (EOL) care of greatest influence to current PC/EOL education and training in the United States are the End-of-Life Nursing Education Consortium (ELNEC) undergraduate curriculum and Competencies And Recommendations for Educating undergraduate nursing Students (CARES) competencies (AACN, 2016). In addition, the National Consensus Project (NCP, 2013) *Clinical Practice Guidelines for Quality PC*; and Hospice and Palliative Nurses Association (HPNA, 2015) *Standards for Clinical Education of Hospice and Palliative Nurses* complement ELNEC and CARES, and are also pillars for PC/EOL nursing education and clinical practice. The introductory module of the ELNEC undergraduate curricula includes two elements, 1) philosophy and principles of PC, and 2) the role of the nurse in providing quality PC for patients with serious illness.

These two elements were vital to the development of the NGRNs' PC nursing practice. As a comprehensive model for an interdisciplinary approach to care, ELNEC core content encompasses communication; pain management; symptom management; loss, grief, and bereavement; and final hours of life. This core content builds upon the NCP (2013) guidelines and HPNA (2015) standards. The ELNEC undergraduate curricula also complements Ferrell and colleagues' CARES (2016) and quality and safety education for nurses (QSEN) competencies. The AACN's (1998) *Peaceful Death,* and *Essentials of Baccalaureate Education* (2008) were discussed in the previous chapter. Evidence of their influence and impact toward structured and standardized PC/EOL content in undergraduate nursing education is clear. What is less clear is how traditional conceptualizations of PC possibly inadvertently perpetuate lack of PC understanding and use.

Palliative care is inclusive of diagnoses whose pathology can be characterized as chronic, progressively worsening over time, or terminal (NCP, 2013). Such diagnoses include heart failure, dementia, chronic obstructive pulmonary disease, end stage renal disease, and cancer. Palliative care is also appropriate for life-threatening illnesses such as severe traumas and cerebral vascular disorders "where cure or reversibility is a realistic goal, but the conditions themselves and/or their treatments pose significant burdens and result in poor quality of life" (NCP, 2013, p. 9). Thus, principles of PC are patient-centered, inclusive of a wide range of chronic or acute, serious, or life-threatening illnesses, and intended to orient nursing and interdisciplinary teams toward quality of life outcomes, which respect patient preferences across the illness trajectory.

The goals and plans of PC are context-specific, and may be distinct from end-of-life, hospice, and actively dying approaches (Bergenholtz et al., 2015; Ferrell et al., 2017; O'Shea, Timmons, & Kennelly, 2015; Watts, 2014). For example, goals and plans of care for PC, at end-of-life, and for the actively dying include relief of suffering, comfort care, and support of cultural and spiritual preferences. Whereas goals and plans of PC at other times include curative treatments in conjunction with PC, and focus on longevity, disease management, and interventions which promote optimal quality of life from the time of diagnosis (Kindl & Good, 2015; Murray, 2007; NCP, 2013). As well, both PC and end-of-life care are patient-centered. However, comfort care for physical, psychospiritual, and sociocultural needs throughout a patient's chronic illness trajectory are quite different from, for example, end-of-life conversations with a family and/or caregiver regarding unknown resuscitation wishes for a patient who has suffered a sudden cerebral vascular event and is unresponsive in the intensive care unit (ICU).

Palliative care models and evidence-based practice continue to evolve. Core modules of ELNEC are intentionally aligned with the eight domains identified as part of the NCP quality guidelines (Dacher, 2014). However, PC programs have as many variations in conceptualization, scope, structures, and processes as there are geographic regions (Bergenholtz et al., 2015; Fan, Lin, Hsieh, & Chang, 2017; Hermann et al., 2016; Kydd, 2014; Wiencek & Coyne, 2014). This broadened conceptualization of PC also widens the range of possibilities for nursing knowledge and nursing practice.

Philosophical

Newly graduated registered nurses' transition to practice is most closely associated with the characteristics of the advanced beginner as described by Benner and her colleagues (2009). Advanced beginners in professional nursing practice begin to understand theoretical concepts in the contexts of situational human experiences. As advanced beginners, NGRNs' use of PC is interdependent with their perceptions about situational human experiences. Situational learning concretizes abstract theoretical knowledge through practical application of skills (Benner, 1984; Benner, Sutphen, Leonard, & Day, 2010; Benner, Tanner, & Chesla, 2009; Benner et al., 2011). Interpretive phenomenology seeks to "search out the relationships and meanings that knowledge and context have for each other" (Richards & Morse, 2013, p. 27).

The theoretical and philosophical underpinnings for this study are Kolcaba's comfort theory (2003), Benner's eight competencies of the helping role (1984), and hermeneutic (interpretive) phenomenology. Phenomenology as a philosophy will be discussed in Chapter 3. Interpretive phenomenology as an appropriate methodology for the study will also be detailed in the following chapter. However, a review of relevant philosophical literature is provided next.

Phenomenology as a philosophy is ontological in that it explores the nature of reality (Creswell & Plano Clark, 2011). Phenomenology is also epistemological in that researchers seek multiple perspectives related to the phenomena of interest to gain understand, meaning, and insight. The relationship between the researcher and phenomena of interest distinguish philosophical and methodological approaches to

phenomenological research (Adams & van Manen, 2017; Benner, 1994; Dowling, 2007; Giorgi, 2012; Heidegger, 1975/1982; van Manen, 2017a, 2017b).

> While it is possible to distinguish philosophical phenomenologists and professional practitioner based phenomenologists, the lines between philosophy, the humanities, and the various human sciences are sometimes difficult to draw. (van Manen, 2017b, p. 824)

Phenomenological researchers seek to understand the meaning of human phenomena in the contexts of human existence. Understanding and interpreting life-world experiences are the core of interpretive phenomenology research (Benner, 1994; Heidegger, 1975/1982; van Manen, 2017a, 2017b). In interpretive phenomenology, understanding meanings is achieved through careful exploration of participants' lived experiences such as nurses' experiences of caring for adult patients with heart failure on a general medical unit. Careful exploration requires consciousness and intentionality.

Intentionality brings clarity to the contexts which influence humans' perceptions about and behavior toward phenomena. As participants reflectively share their lived experiences, phenomenological researchers' consider time, space, body, and participants' relationships to other people when interpreting their perceptions (Benner, 1994; Richards & Morse, 2013; van Manen, 2007, 2017b). This allows phenomenological researchers to accurately interpret and uncover true meanings in lived experiences. Based on review of recent and relevant literature, understandings and meanings of PC, from the NGRNs' point of view, have not been explored in this way.

Experiential

Review of literature related to professional formation in nursing focus primarily on nursing students' pre-licensure academic preparation and new graduate nurses' transition to professional nursing practice experiences. According to the literature, work environment characteristics have a powerful influence on new graduate nurse transition experiences (Laschinger et al., 2016). Before exploring NGRNs' perceptions about and use of PC, it was important to understand contexts which shape their lived experiences, i.e., being-in-the-world, in acute care settings. Review of literature was conducted to explore: 1) contexts of acute care nurse practice environments; 2) NGRNs PC education preparation; 3) formation into professional nursing practice; and 4) quality of nursing care.

Contexts of Palliative Care in Acute Care Nurse Practice Environments. The number of seriously ill patients who die in hospitals is increasing and has been well documented in the literature (Bergenholtz et al., 2015; Croxon, Deravin, & Anderson, 2018; Henderson, Rowe, Watson, & Hitchen-Holmes, 2016). Dacher (2014) reported, "non-cancer patients were described as having unpredictable trajectories, which nurses found difficult and therefore sometimes caused lack of symptoms relief, and lack of identification and planning of PC" (p. 199). This echoed what was found in Bergenholtz and colleagues' (2015) study of nurses working in general medical-surgical settings where, "the majority of nurses understood PC as entirely related to care of dying and no actions or initiatives relating to earlier inclusion of PC in the disease process were found"

(p. 198). Dacher (2014) described early integration and implementation of PC in acute care settings as a "foundation of care" (p. 168).

Similarly, Lynn (2005), Murray (2007), and Sawatzky et al. (2016) also considered early integration of PC as a core element of quality PC delivery. McCourt, Power, and Glackin (2013) discussed the "culture of healthcare settings" (p. 513) and organizational structures as did Gibbs et al. (2015). Both studies recommended strengthening organizational structures to address barriers to early integration of PC. Murray (2007) and McCourt et al. (2013) concluded future research should include a research strategy to evaluate application of PC knowledge in practice.

NGRNs' PC Educational Preparation. Preparation and formation of NGRNs encompasses theoretical knowledge, situated learning and acquisition of skills, and embodied practices of a caring profession (Benner, 1984, 2011; Benner et al., 2009; Benner et al., 2010; Spichiger, Wallhagen, & Benner, 2005). Lack of support in developing competent clinical practice, norms of professional nursing practice, and self-efficacy is a factor which relates directly to new graduate discomfort and dissatisfaction in the acute care settings (Henderson et al., 2016; Valdez, 2008). Principles of PC are embedded in the fundamental knowing of all nurses—BSN essentials, ELNEC curricula, CARES competencies, and HPNA guidelines. However, understanding, interpretation, and meanings of PC can differ depending on the perceptual lens of the practitioner. Consequently, use of principles of PC and comfort care, which are considered meaningful to both patients and nurses are not well understood (Alonzo, 2017; Tuti, Dewi, & Imami, 2017).

Formation into Professional Nursing Practice. Newly graduated registered nurses are recognized as an important human resource to future nursing workforce capacity (Laschinger et al., 2016). Newly graduated registered nurses' understanding of complex patient situations and the nature of nurse practice environments are factors most closely linked to job satisfaction and retention (Laschinger et al., 2016; Parker et al., 2014).

> The transition period (the first 12 to 24 months of practice) for new graduate nurses is reported as the most vulnerable time during which they formulate decisions about their intent to commit to the profession and/or their organization. (Parker et al., 2014, p. 151)

Quality of Nursing Care. Understanding the comfort needs of seriously ill patients and tailoring comfort care in acute care settings strengthens quality of nursing care as well as patients' experiences of enhanced comfort (Boudiab & Kolcaba, 2015; Estridge et al, 2018; Goodwin & Candela, 2013; Kolcaba, 2003). Comfort is an existential phenomenon. Kolcaba's comfort theory (2003) defined four types of contexts in which comfort occurs. These contexts—physical, psychospiritual, sociocultural, and environmental—are human experiences which are dependent upon and interdependent with physical body, time, space, and relations with others (Alonzo, 2017; Dobrzykowski, 2017). Building on the work of Kolcaba (2003), both Alonzo (2017) and Dobrzykowski (2017) recognized comfort care as essential to patients' comfort or "feeling comfortable" (Dobrzykowski, 2017). According to Murray (2007), nurses recognize quality as an important aspect of nursing practice. However, quality PC delivery across all acute care settings remains inadequate.

Synthesis of Literature

Research studies included in this synthesis of related literature reflect the broadened scope of PC and end-of-life education and nursing practice. Methodology and research designs include qualitative, quantitative, and mixed methods approaches to advance the science in nursing. Phenomena of interest for this study were found in the nursing, medical, and social sciences literature. Critical appraisal of qualitative evidence, critical appraisal of quantitative evidence, and appraisal of qualitative meta-synthesis (Melnyk & Fineout-Overholt, 2015), as well as van Manen (1990), and Lincoln and Guba's (1985) trustworthiness/rigor criteria were utilized to guide this synthesis of literature.

Comprehensive searches were conducted to identify published evidence related to the phenomena of interest for this study. Preliminary searches in Google and Google Scholar were completed first. Using the keywords PC, novice, nurses, nursing, and dissertations, the search for publications from 2014-2018 yielded 6,500 results. A second search using the keywords "new graduates" to be used interchangeably with "novice nurses," with all previous search parameters being the same, yielded 250 results. The keywords acute care and hospitals were added to this search which narrowed the results to 238.

A search of CINAHL, MEDLINE, OVID, PubMed, and JSTOR databases was conducted to retrieve full text, peer-reviewed research published from 2013-2018. Keywords were PC, novice, nurses, new graduates, acute care, hospitals, and dissertations. Three publications were returned in CINAHL. No results were found in

MEDLINE and JSTOR databases. A search of OVID journals yielded 223 results. A search of PubMed yielded 48 results. Academic librarians were consulted to clarify search terms, and confirm search results by conducting independent searches using the same keywords. Despite using specific keywords relevant to the study, search results were imprecise and in some cases unrelated.

Using the keywords PC and novice nurses, a search of ProQuest dissertations and theses, published between 2013-2018 yielded 106 results. Filtering of these 106 results included a search for titles and abstracts containing the keywords PC and/or end-of-life and novice nurses and/or new graduates. However, of these 106 results, no dissertations were found related to PC and novice and/or new graduate nurses' PC nursing perceptions or experiences in acute care settings within the first 12 months of professional nursing practice.

Kolcaba's analysis of the concept of comfort (1991), taxonomic structure for the concept of comfort (1991), concept of holistic comfort as a nurse-sensitive outcome (1992), theory of holistic comfort (1994), comfort as holistic nursing art (1995a), art of comfort care (1995b), comfort care as an advanced directive (1996), comfort care as a framework for hospice nursing (Vendlinski & Kolcaba, 1997), empirical evidence for the nature of holistic comfort (2000), evolution of the mid-range theory of comfort for outcomes research (2001), comfort theory and practice (2003), and comfort theory, a unifying framework to enhance practice environments (2006) detail Kolcaba and colleague's meticulous study of comfort as a process (nursing interventions) and framework for nursing practice, comfort as a desired patient outcome, and comfort as an

operationalized metric related to quality of nursing care. Kolcaba's body of comfort

knowledge and research span hospice, PC, non-hospice, non-PC, oncology, and non-

oncology settings.

Building on Kolcaba's mid-range theory of comfort, operational definition of

comfort (nursing interventions), and attention to holistic comfort as a patient outcome

(product), framework, and metric of nursing practice, recent studies focused on patients'

comfort experiences in PC (Coelho, Parola, Escobar-Bravo, & Apostolo, 2016; Coelho et

al., 2018; Egger-Rainer, Trinka, Hofler, & Dieplinger, 2017; Krinsky, Murillo, &

Johnson, 2014), spirituality and comfort (Nuraini, Andrijono, Irawaty, Umar, & Gayatri,

2018), comfort and patients' health-seeking behaviors (Estridge et al., 2018), and nurses'

PC practices in PC settings (Durante, Tonini, & Armini, 2014) and non-PC settings

(Boudiab & Kolcaba, 2015). However, no studies were found which applied Kolcaba's

taxonomic structure of comfort, comfort theory, or conceptual framework for comfort to

newly graduated registered nurses' PC understanding, meanings of comfort, or nursing

practice for seriously ill patients across non-hospice or non-PC acute care settings.

Nursing research related to PC/EOL education in baccalaureate nursing programs

(Adesina, DeBellis, & Zannettino, 2014; Henderson et al., 2016; Hermann et al., 2016;

Hold, Blake, & Ward, 2015; Österlind et al., 2016; Pereira & Hernandez-Marrero, 2016;

Ramjan, Costa, Hickman, Kearns, & Phillips, 2010; Watts, 2014); and non-hospice and

non-PC RNs' PC and end-of-life nursing practice (Hou et al., 2013; McCourt et al., 2013;

Santos et al., 2017; Thorn & Uhrenfeldt, 2014; Verschuur, Groot, & van der Sande, 2014)

were prominent in the literature. Several studies explored gaps in the literature related to

principles of PC (Alonzo, 2017; Benner, Kerchner, Corless, & Davies, 2003; Evans & Ume, 2012; Fan et al., 2017; Goldsmith, Ferrell, Wittenberg-Lyles, & Ragan, 2013; Johnston & Smith, 2005; Moir, Roberts, Martz, Perry, & Tivis, 2015; Selman et al., 2014; Taylor, Mamier, Ricci-Allegra, & Foith, 2017; Yadav & Jhamb, 2015). Watts (2014) recognized "there is a dearth of empirical evidence of the effectiveness of education initiatives on professional practice and patient outcomes" (p. 292).

Palliative care and EOL were studied across critical care (Benner, 2001; Krinsky et al., 2014; Puntillo et al., 2001); emergency (McEwan & Silverberg, 2016; Russ et al., 2015); medical-surgical (Bergenholtz et al., 2015; Oliveira et al., 2016); and neurology (Massimo, Evans, & Benner, 2013) nurse practice settings. Studies including obstetric and neonatal (Charles, Yount, & Morgan, 2016; Kilcullen & Ireland, 2017); oncology (Ferrell et al., 2014; Ferrell et al., 2017); and perioperative (Seyedfatemi, Rafii, Rezaei, & Kolcaba, 2014) settings were also found. Puntillo et al. (2001) asserted PC is needed for all serious and life-threatening illnesses, and PC nursing practice should be implemented whether imminent death is expected or not. Russ et al. (2015) found nurses working in emergency departments were well situated to provide care and facilitate access to palliative services. In addition, interprofessional PC/EOL education and collaborative practice (Corcoran, 2016; Masterson, 2014; Northam et al., 2015; Pfaff, Baxter, Jack, & Ploeg, 2014; White, Roczen, Coyne, & Wiencek, 2014; Wittenberg, Ragan, Ferrell, & Virani, 2017), including graduate PC/EOL education in other disciplines (Head et al., 2016) were also addressed in clinical practice settings.

Four qualitative studies (Barrere & Durkin, 2014; Croxon et al., 2018; Goodwin & Candela, 2013; Hendricks-Ferguson et al., 2014) and one qualitative meta-synthesis (Zheng, Lee, & Bloomer, 2016) were related to NGRNs' PC and end-of-life nursing practice. Six studies were included in Zheng and colleagues' (2016) systematic review and meta-synthesis of new graduate nurses' experiences of patient death. Of these six reported studies, only one study (Barrere & Durkin, 2014) was conducted within the past five years and evaluated in further detail. This author found no published studies or unpublished dissertations which explore PC and NGRNs' nursing practice in acute care settings since the AACN's 2016 adoption and widespread implementation of ELNEC curricula and CARES competencies for undergraduate nursing programs in the United States.

The aforementioned qualitative studies provided key insights for the current study. Newly graduated registered nurses' perceptions and experiences of PC in acute care settings included six factors which may influence PC nursing practice: 1) PC education preparation; 2) theoretical knowledge versus practical application; 3) experienced mentors; 4) organizational culture; 5) prior personal and/or professional PC/EOL experience; and 6) interprofessional collaboration (Barrere & Durkin, 2014; Croxon et al., 2018; Goodwin & Candela, 2013; Hendricks-Ferguson et al., 2014).

Lack of preparedness for EOL care despite having received some PC/EOL education in the undergraduate program was consistently reported in findings. Participants' reported undergraduate courses vary in terms of nature and extent of education provided in PC (Croxon et al., 2018). These participants also acknowledged,

even when opportunities for clinical practice were offered through simulation or practicum experiences, they often avoided EOL care. Findings related to PC educational preparation were also reported by Henderson et al. (2016) in their exploratory study of graduating nurses' self-efficacy in PC practice, and by Österlind et al. (2016) in their study of nursing students' perceptions of caring for dying people. Palliative care education was perceived by participants to be "one of the most central tasks in nursing" (Österlind et al., 2016) and important to patient outcomes. Each of these studies recommended future qualitative studies to explore these findings further.

Hendricks-Ferguson et al. (2014) identified the AACN's ELNEC; however, none of the participants in their study had ELNEC in the undergraduate programs. Goodwin and Candela (2013) explored holistic comfort of NGRNs as they transitioned to professional nursing practice in their first year. According to these researchers, "initiating the fundamental tenets of holistic comfort early in the career process may help with the development of the professional nurse" (p. 618).

Palliative care perceptions of NGRNs (Valdez, 2008) and experienced nurses (McEwan & Silverberg, 2016; Russ et al., 2015) working in emergency departments identified limited knowledge and understanding whereby participants "tended to incorrectly associate PC with end-of-life" (Russ et al., p. 294). Croxon et al. (2018) argued "nurses spend more time with people nearing the end of their life than other personnel" (pp. 337-338). This argument is not disputed. However, Croxon and colleagues (2018) proposed two distinct foci, alternating between preparedness "when faced with death and dying" (p. 338) and stated research questions related to "care for

people with life-limiting illnesses" (pp. 38-339). This lack of clarity in conceptualization of the study mirror the chief concerns at the core of lack of PC understanding and lack of PC use identified by Russ et al. (2015). Overwhelmingly, the aim of this study, as was reflected in the reported findings and title of the article, was a focus on NGRNs' nursing practice for patients who are at end-of-life or actively dying.

Cultural competence is recognized as imperative to increased understanding and interpretation of contexts of human needs (Evans & Ume, 2012; Fan et al., 2017; Selman et al., 2014; Taylor et al., 2017; Yadav & Jhamb, 2015). Evans and Ume (2012) found access to PC and EOL care has improved over the last decade, but certain diverse populations remain unserved. Both Johnston and Smith (2005) and Selman et al. (2014) advocated for a greater emphasis on psychosocial aspects of PC to balance the abundance of education directed toward pain and symptom control.

Benner (2001) and Croxon et al. (2018) recognized death, dying, and human illness conditions as individualized, subjective experiences. Similarly, Selman et al. (2014) recognized the importance of culture and spirituality to contexts of human experiences, and are reflected in Kolcaba's (2003) contexts of human experiences and comfort needs, namely "psychospiritual" and "sociocultural" needs. Seyedfatemi et al. (2014) found a direct and significant relationship exists between comfort and hope, and concluded, "Nurses can arrange the environment in a way that allows patients to experience comfort and hope" (p. 219). "Subjective models of patient care recognize that the subjective experience of illness, rather than the physiological descriptions of disease, should take priority" (Selman et al., 2014, p. 82).

Quantitative measures of self-reported knowledge, attitudes, and beliefs do not always provide a full explanation of phenomena (Hou et al., 2014; Moir et al., 2015). Phenomenal insights, through an interpretive research approach, can lay the groundwork for clinical practice. It was reported in Croxon et al. (2018) that "it was not until they were in the workplace, in the actual situation that they were prepared for that participants became aware of what skills they required" (p. 342). Henderson et al. (2016) discussed the "naivety of graduates to the realities of healthcare" (p. 145). Participants in that study confirmed their knowledge of principles of PC, yet they were unable to apply principles of PC in complex patient situations.

Several studies reported by Zheng et al. (2016) found NGRNs' were unable to transfer theoretical knowledge learned in undergraduate programs to professional nursing practice. Actual learning (Barrere & Durkin, 2014), and competencies such as being present, interpersonal caring (Dobrina et al., 2014; Johnston & Smith, 2005), and adaptation of communication strategies to different populations (Sawatzky et al., 2016) occurred only through practical experiences. Benner referred to these types of practical experiences as situated learning in complex situations.

> Experiences with many patients suffering from varied conditions and at various stages in their illness trajectories helps beginners to build a foundation of practical understanding that bolsters prior theoretical training. (Benner et al., 2009, p. 77)

The influence of experienced mentors on PC nursing practice cannot be overstated. This was well documented in several studies, including Croxon et al. (2018) where participants assumed experienced nurses would help guide PC/EOL nursing practice. Barrere and Durkin (2014) recognized not all experienced nurses were

comfortable with PC and, therefore, could not be a resource and guide for PC nursing practice. Henderson and colleagues (2016) concluded "the absence of vicarious role models" (p. 145) in PC nursing practice should be further explored.

Bergenholtz et al. (2015) found most of the participants in their study felt individually competent to provide pain and symptom management; however, PC was perceived to be synonymous with terminal care. This lack of understanding impacted interdisciplinary team involvement and timely PC interventions. Experienced nurses in the studies conducted by McEwan and Silverberg (2016) and Russ et al. (2015) were comfortable with pain and symptom management but found it difficult to articulate interventions which could provide more holistic comfort. These experienced nurses also found it difficult to transition from a curative role to PC which promotes "the facilitation of comfort, dignity, or a good and peaceful death" (Benner et al., 2009, p. 233). It is important to note that NGRNs', who can be classified as advanced beginner, lack the "experientially learned" (Benner et al., 2009, p.233) contexts and situations to guide comfort care toward enhanced comfort for seriously ill patients in acute care settings.

Hou et al. (2013) also found variations in nurses' PC knowledge and understanding, regardless of years of experience or clinical practice setting. Because of these variations in clinical knowledge, understanding, and application of principles of PC, the lack of experienced nurses in PC presents a significant barrier to early integration, implementation, and formation for NGRNs. Finally, and of significant importance to this study, Johnston and Smith (2005) stated, "Future research should be carried out to observe whether expert nurses actually practice in the way they and PC patients say they

should" (p. 708). This author found no evidence where this recommendation for future research was addressed.

A key finding uncovered in Verschuur and colleagues' (2014) study of experienced nurses' PC practices support previously reported themes. Participants in this study were experienced in PC from both hospital and community settings. Yet, experienced nurses demonstrated lack of PC understanding, "reflecting large variation and uncertainty in what is considered to be palliative nursing care" (p. 245). Inferences from this study suggest PC guidelines must be connected to concrete competencies to improve nursing practice. Findings and inferences from this study, as well as the White et al. (2014) study, have significant implications for acute care settings.

Newly graduated registered nurses' nursing practice in emergency settings could be strengthened by drawing upon theoretical knowledge and structuring experiential learning around principles of PC (McEwan & Silverberg, 2016; Valdez, 2008). Valdez (2008) described the period of transition to professional practice as one of "rapid immersion" (p. 435) into dynamic acute care environments where NGRNs feel inadequately prepared. However, ten years after Valdez' study, no additional studies related to NGRNs' understanding or use of PC in emergency or other clinical practice settings were found.

Prior personal and/or professional PC/EOL experiences helped NGRNs understand the complex needs of patients and not feel, as one participant stated, "Way out of my depth" (Croxon et al., 2018 p. 340). Parker et al., (2014) found prior personal and/or professional PC/EOL experiences helped NGRNs to navigate the positive and

negative professional norms and organizational cultures. According to Henderson et al. (2016), "Being able to ascribe meaning to and articulate positive experiences representative of the PC capabilities supports the growth of self-efficacy" (p. 144).

Palliative care and EOL education and collaboration (Corcoran, 2016; Masterson, 2014; Northam et al., 2015; Pfaff et al., 2014; White et al., 2014; Wittenberg et al., 2017), including graduate PC/EOL education in other disciplines (Head et al., 2016) were also addressed in clinical practice settings. White et al. (2014) conducted a pilot study to explore acute and critical care nurses' perceptions of PC competencies. Participants in this study reported variations in understanding of PC core competencies. Participants in the study perceived PC knowledge as a "top competency" (p. 275). However, they did not report its importance or value to all acute care settings. In addition and similar to earlier reported studies, participants in this study perceived both undergraduate PC nursing education and PC continuing education as inadequate.

Several studies reported nurses continue to associate PC with oncology patients (Bergenholtz et al., 2015; Santos et al., 2017; Oliveria et al., 2016) or specific to certain settings such as home or hospice. Oliveira et al. (2016) and Santos et al. (2017) recognized the urgent need for a more in-depth understanding of nurses' perceptions of PC. Bergenholtz and colleagues' (2015) study of organizational cultures and nurses' PC experiences identified a lack of common understanding and nursing practice. According to these researchers, PC "was not easy to grasp" (p. 200). Therefore, a common understanding of PC is required to drive organizational change in nursing practice.

In a recent review of comfort theory (Kolcaba, 2003), palliative/EOL care nursing education, and PC in acute care settings, there is a dearth of literature on NGRNs' perceptions about and use of principles of PC in acute care settings since implementation of ELNEC and CARES into undergraduate BSN curricula. As members of an interdisciplinary team, nurses are well-situated to advance interprofessional collaborative education and PC practice across diverse clinical settings (Hermann et al., 2016; Pfaff et al., 2014). According to Pfaff et al. (2014), future studies should consider a broader definition of interprofessional collaboration that includes collaboration across sectors and settings. Russ et al. (2015) concluded future research was needed to clarify the role of nurses in identifying opportunities for PC.

Benner (2001), Benner et al. (2003), and Croxon et al. (2018) recognize impending death as unique to contexts and patient populations. "Regarding the perception and knowledge of nurses, it is emphasized that the multidimensionality of comfort in PC requires the nurse to know the philosophical references of care and comfort and care of self, so that he can perceive the needs of the other and of itself" (Santos et al., 2017, p. 2292). End-of-life and actively dying represent limited scope in principles of PC. This limited scope and conceptualization was evident in each of the studies exploring the perceptions and experiences of NGRNs. While the aim of these studies were specific to EOL and/or death and dying, what this study seeks to add to the science of nursing is a holistic conceptualization of PC as defined and delineated in Kolcaba's comfort theory (2003) and Benner's (1984/2011) competencies of the helping role.

Palliative care is becoming an essential component of healthcare in America and throughout the world making it critical that those entering the health professions understand the principles and practices of quality PC across the continuum of healthcare. (Hermann et al., 2016, p. 63)

Gaps in the Literature

There was a dearth of substantive literature related to PC and NGRNs in acute care settings. Specifically, gaps in the literature existed related to: 1) NGRNs' perceptions about PC as newly practicing registered nurses; 2) their lived experiences in applying the principles of PC to promote enhanced comfort; and 3) meanings of NGRNs' use of PC which are most meaningful to patients' experiences of enhanced comfort. The singular concept, patient death, within the construct of PC limits the possibilities of what could be uncovered to advance NGRNs' PC nursing practice in acute care settings. Understanding and interpreting context, situation, perception, and meanings of human lived experience is the work of phenomenology.

Enhanced comfort of patients with serious or life-threatening illness in acute care settings is recognized as an outcome goal (Boudiab & Kolcaba, 2015; Gibbs et al., 2015; Goodwin & Candela, 2013; McCourt et al., 2013; Wiencek & Coyne, 2014). However, relief, ease, and transcendence for seriously ill patients, within the contexts of human experiences and complex patient situations, are difficult to understand and interpret. Taken-for-granted perceptions, understandings, and use of PC in acute care settings have not been fully explored. "Nurses' practice experiences and anecdotal evidence provide additional insights into what comprises comfort care" (Krinsky et al., 2014, p. 149). This current study explored NGRNs' understanding of principles of PC, which included

physical, psychospiritual, sociocultural, and environmental contexts of comfort. The interconnected relationship between NGRNs' understanding of principles of PC, contexts of complex patient situations, use of appropriate, caring, intentional comfort care, and perceptions of meaningful care in acute care settings address key gaps found in current literature.

Summary

A review of related literature for the current study was conducted to identify what was already known about the phenomena of interest. The review of related literature was conducted to weigh the author's a priori knowledge of the phenomena of interest against an existing body of evidence, as well as identify gaps in the literature which support the author's rationale for the appropriateness and relevance of the phenomenological analysis. The phenomenon of interest for the study was NGRNs' perceptions about and use of PC in acute care settings. The review of literature identified many gaps in the literature, which were addressed by the study.

CHAPTER 3

METHODOLOGY

This chapter outlines the research methodology and procedures for the study. The

qualitative approach selected was interpretive phenomenology. An overview of

phenomenology as both a philosophy and research methodology is provided. An

explanation of interpretive phenomenology and the rationale for using it are also

discussed. In addition, a description of the setting, sample, and procedures for data

collection, processing, and analysis are included. Finally, the processes for human

subjects protection, confidentiality, and the steps to ensure trustworthiness and rigor are

explained.

Research Method and Design

The purpose of this qualitative study was to discover NGRNs' (NGRN)

perceptions, meanings, and use of principles of PC for seriously ill adult patients in acute

care settings. Interpretive phenomenology was chosen as the most appropriate research

method to address the study purpose and phenomenological research question. This

methodological approach goes beyond description of phenomena to "focus on

interpretations of the discovered world, what is experienced by those studied, and how

their perceptions might be understood" (Richards & Morse, 2013, p. 32). Specifically,

this approach allowed the researcher to understand NGRNs' lived experiences of PC in

acute care settings, and to interpret, from the NGRNs' point of view, what it is like to provide PC for seriously ill patients in acute care settings.

The philosophical perspective of phenomenology, as it is most widely known and referenced today, is credited to Edmund Husserl (1859-1938). Husserl was a German philosopher, mathematician, and student of Franz Brentano (1838-1917). Husserl was recognized as the greatest influencer of 20th century phenomenological thought and *doing phenomenology* (Adams & van Manen, 2017; Dowling, 2007; Giorgi, 2012; Heidegger, 1975/1982; Tuohy, Cooney, Dowling, Murphy, & Sixmith, 2013; van Manen, 2006, 2007, 2017a, 2017b). Brentano was a German philosopher and professor at the University of Vienna. As a professor at the University of Vienna (1874-1895), Brentano and his other renowned student and psychologist, Carl Stumpf (1848-1936), introduced the concepts of consciousness and intentionality as the ontological foundation of phenomenology as science (Heidegger, 1975/1982).

The focus on clarification of the philosophical concepts of consciousness and intentionality marked a significant departure from the prevailing postpositivist and Cartesian worldviews of that time (Benner, 1994; Heidegger, 1975/1982). The concepts of consciousness and intentionality were further developed and expounded upon by Husserl. Husserl's concepts of consciousness and intentionality are the philosophical underpinnings of phenomenology as a "rigorous science" (Giorgi, 2012; Heidegger, 1975/1982; van Manen, 2007, 2017a, 2017b). "Husserl believed that philosophy should become a rigorous science that would restore contact with deeper human concerns . . . the foundation for all philosophy of science" (Richards & Morse, 2013). Additional concepts

of significant importance to Husserl's development of phenomenology were the concepts of *life-world* and *time*, and their relationships to consciousness and intentionality. Consciousness, intentionality, life-world, and time represented the most important aspects of the ontology of science.

Ontology

"Ontology refers to the nature of reality (and what is real) when researchers conduct their inquiries" (Creswell & Plano Clark, 2011, p. 41). The empiricist philosophical worldview of determination (a singular reality), reductionism (aim to reject or fail to reject a hypothesis), empirical observation and measurement (distance, impartiality, objectivity, and instruments), and theory verification (researchers test an a priori theory; explanation and prediction) represented the predominant basis of empiricist philosophical thought and scientific inquiry of Bacon (1561-1626), Galileo (1564-1642), Locke (1632-1704), Berkeley (1685-1753), and Hume (1771-1776). All knowledge stems from human (tangible) experiences, and Bacon's methodological approach to scientific inquiry stemmed from his belief that the purpose of intellectual advancement should be toward practical application for the greater good of all people (Rodgers, 2005). Husserl's explication of consciousness and intentionality was grounded in the ontological, epistemological, and axiological philosophical differentiations of phenomenology from empiricism.

A singular Truth, the separation of body and mind, disregard of spirit, and objectivity—characteristics of the study of phenomena—offered incomplete, disconnected, and disparate views incapable of fully describing, explaining, or

understanding the nature of being (ontology) which is unique to human beings (Benner,

1994; Heidegger, 1975/1982). Benner offered a most succinct rationale for the shift in

philosophical thought from post-positivism to the ontological perspective of

phenomenology relevant to humanistic inquiry and practice:

> It is posited that understanding is more powerful than explanation for prediction in the human sciences because it stands more fully in the human world of self-understandings, meanings, skills, and tradition. Prediction is possible only in limited ways for human beings who are self-interpreting and subject to change by the very interpretations offered by research. Prediction in the human sciences resists the single-factor theories and explanations because human action and world always contain incomplete and multiple levels of meanings. (Benner, 1994, p. xv)

Consciousness means an internal awareness of thoughts, meanings, and

interpretations of lived experiences absent preconceived (a priori) knowledge.

Furthermore, consciousness is an awareness of experiences of things. "Husserl's phrase

for describing the lived presence of the 'now' that lies at the basis of our everyday

existence is primal impressional consciousness" (van Manen, 2017b, p. 821). According

to van Manen, Husserl's description of consciousness and time makes an important

distinction of how we perceive our experiences, in that as we reflect on our experiences

in time (i.e. now), no matter the immediacy of the reflection, it has already become just

now. Our consciousness of now is always a reflective awareness of the past. For

accurate interpretation (i.e. intuiting) of perceptions and lived experiences, van Manen

stressed, "We have to pay attention to how the now gives itself" (van Manen, 2017b, p.

821).

Intentionality means that consciousness is always conscious of something. The external things—extant objects and experiences—regarded in intentionality are based on four unique (existential) individual positions that determine one's authenticity and choices: body, space, time, and human relations (Giorgi, 2012; Heidegger, 1975/1982; Streubert & Carpenter, 2011; van Manen, 2017b). For Husserl, consciousness represented "the medium between people and the world . . . from which understanding of the world and beings relationship to it/in it stem" (Tuohy et al., 2013, p. 18).

Being (ontology), knowing (epistemology), and values (axiology) inherent in human existence represent the philosophical underpinnings of phenomenology. Meanings of human beings are the true nature of individuals' life experiences as they are presented, revealed, or uncovered to consciousness (Heidegger, 1975/1982; van Manen, 2007, 2017a, 2017b). The meanings (being) of being-in-the-world (human existence) are uncovered through humans' self-awareness, understanding, and interpretations. Awareness, understanding, and interpretations of meanings are contextual. Meanings are subjective perceptions, embodied, and interdependent. Meanings are dependent upon and influenced by the relationships between physical (lived) body, physical (lived) space, physical (lived) human relations, and (lived) time. More importantly, embodiment (the expression of being and knowing) is shaped by values. Being, knowing, and values are in constant flux, and this flux drives and is driven by the constantly changing dynamics of life-world experiences.

Being human is a unique way of being-in-the-world (Benner, 1994; Heidegger, 1975/1982). Being, in this philosophical sense, represents multiple realities, perceptions,

understandings, and interpretations of phenomena (Heidegger, 1975/1982; van Manen, 2007, 2017a, 2017b). Phenomenology is ontological. Ontology, in the phenomenological sense, has for its fundamental discipline the analytic of the true meanings and meanings of human existence.

> While Husserl started with the relationship between consciousness and world, as his thought developed, he expanded his analyses to include the body as partaking of consciousness and so more generally, one could say that there is a relationship between embodied subjectivity and world. This is the theme that existentially leaning thinkers such as Heidegger (1962) and Merleau-Ponty (1962) developed in their own ways and so phenomenology became diversified. (Giorgi, 2012, p. 9)

Perception

Perception is the subjective mode of knowing in phenomenology. It is described as an action performed by the ego (Heidegger, 1975/1982). Perception of actual events and existence, as it is lived through, uncovers meaning and meaningfulness in phenomenological studies (van Manen, 2017a, 2017b). Perception is not existence; perception is understanding contexts of the existential (i.e., body, space, time, and human relationships) and the extant. Perceiving is intrinsically a comporting-toward, a relationship to the object, whether that object is extant actually or only in imagination. Only the interpretation of being by way of temporality can make clear why and how this feature of being, earlier a priori, goes together with being (Heidegger, 1975/1982; van Manen, 2017b).

Time and Temporality

Phenomenological research and inquiry is commonly described as turning back zu den Sachen, to "what matters in lived or primal experience." (van Manen, 2017b, p. 811).

In his explanation of temporality, van Manen (2017b) offered this powerful description of the relationship between perception, time, and interpretation of meaningful insights:

> A phenomenological insight may be said to occur in a Kairos moment . . . this instant can be life-altering for the person who encounters Kairos and understands the importance of just this momentary instant. Since ancient biblical times, a Kairos moment has been described as carpe diem, a transformative moment of chance and change, depending on our ability and willingness to recognize this moment and to seize the opportunity that is offered in it. Time is the horizon from which something like being becomes at all intelligible. We interpret being by way of time (tempus). The interpretation is a temporal one. The fundamental subject of research in ontology, as determination of the meaning of being by way of time, is Temporality. (van Manen, 2017b, p. 820)

A vital component for Husserl's phenomenology was the accurate and unbiased description of phenomena as they are lived by participants. This accurate description of everyday life-world experiences, referred to as intuiting, is achieved through what phenomenologists call phenomenological reduction. Phenomenological reduction is a pre-requisite to all phenomenological inquiry. Phenomenological reduction, also called *bracketing*, requires researchers to: 1) identify, through self-reflection, any preconceived notions or ideas about the phenomenon under investigation; 2) suspend all beliefs, assumptions, and biases about the phenomenon under investigation; and 3) separate pure phenomenon from what is already known about a particular phenomenon (Streubert & Carpenter, 2011).

In ontology, being is grasped and comprehended conceptually by way of the phenomenological method. Phenomenology is also a social and humanistic method to study the being of human beings. Consciousness, intentionality, meanings, and phenomenological reduction remain the predominant philosophical underpinnings of

many variants of Husserl's phenomenology. One such method was espoused and further developed by a student of Husserl, Martin Heiddeger. Heidegger's influences on phenomenology are discussed next.

Interpretive (Hermeneutic) Phenomenology—Qualitative Method

Dreyfus noted Martin Heidegger as the most famous philosopher of existential phenomenology. Dreyfus posited the "power of Heideggarian or interpretive phenomenology for areas of study related to lifeworld, meanings, skilled know-how, clinical knowledge, and everyday skillful ethical comportment" (as cited in Benner, 1994, vii). Interpretive phenomenology, fundamentally, is a way of discovering, comprehending, and interpreting existential meanings (being) of subjective human beings' experiences. Major assumptions and propositions of Heidegger's (1975/1982) philosophical perspective, including further conceptual clarifications and explanations provided by van Manen (2006, 2017a, 2017b), are fundamental to this researcher's understanding of hermeneutics in general and the appropriateness of hermeneutic phenomenology for the study.

Dasein

According to Heidegger (1975/1982), phenomenology as philosophy is the science of being—scientific philosophy; critical science; transcendental, and existential science. Phenomenology is the theoretical conceptual interpretation of being, of being's structure, and its possibilities. Being in the phenomenological sense is also referred to as Dasein. Every human being has a way of being (Dasein). Being is essentially different from a being, from beings. Being "is given" only in the specific disclosedness that

characterizes the understanding of being . . . we call the disclosedness of something truth. "Human beings are defined by their self-understandings . . . which in turn sets up the range of possibilities open to them" (Benner, 1994).

Existence and Extant

Heidegger further explicated the relationship between being, existence, and objectivity in phenomenology. According to Heidegger, existence is not the sole determination of the mode of being that belongs to (human) beings. Existence is not a predicate or determination of anything at all. The actuality of a thing, or its existence, is the complement of its possibility. A distinguishing feature between the existent and the extant is found precisely in intentionality, the essential feature of consciousness. Intentionality is the comportmental character or conduct of the Dasein's behavior and the manner of directing oneself toward something. Intentionality is neither objective, extant like an object, nor subjective in the sense of something that occurs within a so-called subject, although it is certainly both. Intentionality is available only after a person has experienced the phenomena. Existence as being-in-the-world is a phenomenological phrase (Richards & Morse, 2013; Tuohy et al., 2013), focusing the phenomenological researchers' attention to the meaningful nature of lived experiences.

Lived Experiences

Phenomenology is concerned with the human beings' everyday experiences that are perceived and understood in the contexts of body, space, time, and human relationships. Understanding and accurately interpreting lived experiences give meaning

and truth. Heidegger (1975/1982) noted experiences are intentional and accordingly belong to the subjective sphere.

> The entire endeavor of phenomenological inquiry, the point of phenomenology as qualitative research method, is to arrive at phenomenal understandings and insights—phenomenal in the sense of impressively unique and in the sense of primordially meaningful. Without meaningful insights, a phenomenological study is of little or no value. (van Manen, 2017b, p. 819)

Dasein, existence, intentionality, and meanings are uncovered through reflective interpretation of existential (including physical, space, time, relational, and material), linguistic, and insight-cultivating experiences. Although reflective methods of epoché, reduction, and intuiting are key in understanding and accurately interpreting concrete lived experiences as experienced pre-reflectively, Heidegger does not require researchers to bracket their own preconceptions or theories during the interpretive process. Like Heidegger, van Manen (1990) did not embrace Husserl's view of bracketing. ''If we simply try to forget or ignore what we already 'know,' we might find that the presupposition persistently creep back into our reflections'' (p. 47). The hermeneutic circle of interpretation is the rigorous (back-and-forth) process of interpretive inquiry and phenomenological analysis. The steps of this circle of interpretation—naïve reading, structural analysis, and interpretation of the whole—will be discussed further in the data analysis section.

Rationale for Research Approach

The nature of being is inseparable from the cultural, social, political, and environmental influences which shape and inform the context and perceptions of all human experiences (Benner, 1994; Tuohy et al., 2013; van Manen, 2017a); therefore, for

a phenomenological inquiry, it is especially imperative to understand the concrete contexts of human experiences (van Manen, 2017a). Nurses are beings in the world. The principal way of being-in-the-world for nurses is human caring in a myriad of contexts and nurse practice settings. As professional caregivers, nurses must be aware of and understand contexts and complexities of patients' suffering to fully engage patients and families in comfort care (Benner, 1994). NGRNs' ways of being in acute care settings are influenced by the increasing complexity of seriously ill patients across all acute care settings and the care delivery model, which guides professional practice. Understanding NGRNs' palliative approaches to caring for seriously ill patients within the holistic contexts of human experiences—their perceptions, meanings, and use of PC in acute care settings—will uncover similarities and differences in nursing practices and ultimately open up new possibilities for PC. Exploring perceptions, meanings, and use of principles of PC for seriously ill patients in acute care settings—through the lived experiences (life-world) of NGRNs'—offers an opportunity to discover unique insights for PC and professional formation.

For this study's purposes, while there are many streams of phenomenology, both philosophical and methodological, stemming from the works of Husserl (Giorgi, 2012; Tuohy et al., 2013; van Manen, 2017b), hermeneutic (interpretive) phenomenology (Heidegger, 1975/1982) was used as the philosophical underpinning for the qualitative nursing research method and design. Heideggerian hermeneutics is an interpretive phenomenological research method of understanding and interpretation of the contextual meaning and relationships of life-world experiences. Interpretive phenomenology is a

complex and evolving process, incorporating contexts and culture. It embraces and encourages interrelationship between researcher and participant (Benner, 1994). As such, interpretive phenomenology is an appropriate way to articulate what caring means in a particular context (Benner et al., 2009; Benner et al., 2011).

In the interpretive phenomenological studies of critical care nursing (Benner et al., 2009) and acute and critical care nursing (Benner et al., 2011) caring was recognized as an essential and defining attribute of nursing practice. Caring was described as "ontological in three ways: 1) caring sets up what matters to a person and what possibilities are available; 2) caring enables persons to focus on the event or the one cared for; and 3) caring sets up the ways in which giving help and receiving help are possible" (p. 306). For nursing, the promise that phenomenology makes to practice rests on questions pertaining to how to act practically and thoughtfully in everyday situations and relations of practice (Adams & van Manen, 2017).

Setting

This study focused on NGRNs employed in a large academic healthcare system in the southeast region of the United States. Four of the system's acute care hospitals were included: a) one 110-bed acute care hospital; b) one 410-bed acute care hospital; c) one 531-bed acute care hospital; and d) one 733-bed acute care hospital. Two of the hospitals were American Nurses Credentialing Center (ANCC) Magnet Recognition Program[®] (Magnet-designated) facilities. All of the acute care hospitals were accredited through the American Association of Colleges of Nursing, Commission on Collegiate Nursing Education (CCNE) Nurse Residency Program. These four hospitals were located in

urban or highly populated suburban areas and provide acute nursing care primarily for adult populations.

Participants

A purposive sample of NGRNs who met inclusion criteria: 1) were graduates of an accredited baccalaureate (BSN) and entry-level masters (MSN) nursing programs within the previous 12 months of enrollment in the study; 2) were licensed registered nurses within the previous 12 months of enrollment in the study; 3) were employed full time (greater than or equal to 36 hours per week); 4) worked in an acute care setting, including medical, surgical, critical care, and emergency settings; 5) had a minimum of six months but less than one year of professional nursing experience in his or her acute care nurse practice setting; and 6) were enrolled in the healthcare system's Nurse Residency Program (NRP). Newly graduated registered nurses working in hospice, oncology, or ambulatory care nurse practice settings were excluded from participation in this study.

Access to participants was influenced by identification and support of key stakeholders/gatekeepers. Influential stakeholders/gatekeepers were consulted to advise and inform the researcher on accessibility to participants, trust and relationship-building with the participants, and competing clinical or research priorities. Key organizational stakeholders included but were not limited to NRP coordinators, chief nursing officers, nursing directors and managers, clinical nurse educators, expert PC clinicians, and nurse researchers. The researcher sought an invitation to attend NRP sessions for the purpose

of observing, engaging, and interacting with NGRNs, as appropriate, prior to introduction and recruitment for the study.

In-person information and study recruitment sessions were conducted by the researcher at scheduled NRP sessions. Recruitment sessions included an overview of the study. The overview provided a brief description of the study, significance, data collection method, data collection timeline, and protection of human subjects. An incentive of $20 was offered for participation in the study. Recruitment materials included printed and electronic versions of the recruitment flyer (Appendix C) and consent form (Appendix D). Information on Institutional Review Board (IRB) approvals, the researcher's credentials and contact information, and incentive for participation details were printed on all recruitment materials.

The recruitment timeline began after IRB approvals and immediately post-presentation to all cohorts of the NRP and extended until a purposive and diverse sample of participants was achieved. The period of open enrollment/recruitment was not intended to extend beyond 30 days post-researcher presentations. However, recruitment of participants would continue until either: 1) the researcher achieved saturation as evidenced by "repetition of discovered information and confirmation of previously collected data" (Streubert & Carpenter, 2011, p. 30); or 2) other sampling techniques were required to increase participation.

Data Gathering

Demographic information was collected from each participant prior to interview data gathering (Appendix E). Demographic questions included name, age, gender,

race/ethnicity, highest nursing education level and year completed, highest non-nursing education level and year completed, place of employment, primary work setting (i.e., nursing unit/department), and previous and current PC or hospice experiences (personal or work-related). Participants were asked to create a pseudonym to be used with all data gathering materials associated with their responses.

Data collection for the study was conducted by semi-structured interviews utilizing an interview guide with open-ended questions and clarifying probes (Appendix F). "Open-ended interviewing allows researchers to follow participants' lead . . . and facilitate expression of the participants' lived experience" (Streubert & Carpenter, 2011, p. 90). One, face-to-face interviews were conducted with each participant at a private meeting room location most convenient to the study participant. Careful selection of interview locations that were comfortable, convenient, and protective of participants' privacy was critically important. Multiple reservations were made at each of the system's acute care hospitals to increase availability (multiple days and times), accessibility (multiple locations), and convenience (privacy and proximity) for study participants.

Two, digital audio recording devices were used for each interview. A second digital recording devise was utilized to ensure no data were lost in case the first recorder malfunctioned during an interview session. While mutual trust and respect and trusting relationships were desirable and essential, the researcher took great care to not project personal views, perceptions, and meanings into the lived experience of the participants. Although the purposive sampling and recruitment techniques chosen for this study were considered appropriate to capture a potentially larger sample, opportunities for face-to-

face recruitment and enrollment according to the RN experience inclusion criteria (greater than six months but less than one year) were limited by the schedule and frequency of Nurse Residency Program (NRP) cohorts and sessions. In most qualitative studies, sample size is determined by data saturation. However, there were no opportunities to recruit additional participants within a reasonable time period beyond the 12 participants. Thus, saturation cannot be assumed.

Colaizzi (1978) noted, "The trustworthiness of the questions put to study participants depends on the extent to which they tap the participants' experiences apart from the participants' theoretical knowledge of the topic" (as cited in Streubert & Carpenter, 2011, p. 93). The following selected questions and probing statements or questions are examples of those used to guide interviews with participants:

In your role as a professional registered nurse,

1. Tell me about a seriously ill patient you have cared for since becoming a registered nurse.

    a. How did you perceive that person as seriously ill?

        i. In your view, what made the patient seriously ill?

    b. How did you assess the needs of this patient?

        i. What were his/her physical needs?

        ii. What were his/her psychological needs?

        iii. What were his/her spiritual needs?

        iv. What were his/her sociocultural needs?

        v. What were his/her environmental needs?

2. What does PC mean to you?

3. What is it like to provide PC for seriously ill patients (in your nurse practice environment)?

   a. What is it like being with a seriously ill patient in the acute care setting?

   b. Share what you perceived to be any disconnect between nursing care and this patient and/or family's desired goals and plans of care?

   c. How do you know when patients experience comfort?

      i. What does comfort look like?

      ii. What does comfort sound like?

      iii. What does comfort feel like?

4. How did you learn about PC?

   a. Baccalaureate nursing education preparation?

   b. Prior personal, professional, or educational PC/end-of-life experiences?

5. When you think about your past education or personal life experiences and your current nursing practice, what experiences, if any, most influence how you currently care for seriously ill patients at work, and why?

Protection of Human Subjects

The principal investigator obtained IRB approvals for this study from Mercer University's IRB (Appendix A) and the selected academic healthcare system IRB (Appendix B). Written informed consent was obtained from participants prior to

enrollment in the study (Appendix D). Informed consent specified participation in the study was voluntary. As part of the informed consent process, NGRNs were advised that participation in the study or refusal to participate would in no way affect their employment status. Further, newly graduated nurses who agreed to participate were informed they had the right to discontinue at any time without consequence. Each participant received a $20 gift card for their participation. Participants were informed that data collection during interview sessions would include written notes and audio recordings.

Ethical considerations for the study were principles of respect for autonomy, beneficence, non-maleficence, and justice. Respect for autonomy is essential for all human research studies. Special attention to verbal, written, and linguistic communication was crucial to ensure ethical conduct in outreach, recruitment, and obtaining informed consent. The researcher was mindful to avoid perceived burden or coercion of the participants. The researcher was also mindful of biases, judgments, beliefs, attitudes, and care practices that may differ significantly from the researcher's own. Finally, the researcher sought participant preferences for meeting locations and times.

Confidentiality

Open and honest communication between researcher and participants is essential in phenomenological inquiry. Uncovering and explicating true meanings of lived experience is the goal of interpretive phenomenological inquiry (Heidegger, 1975/1982). Thus, building trust with participants included ensuring an interview environment where

participants were engaged and felt safe to share their personal stories. This entailed intentional efforts to avoid ambiguity related to the research aims and design. Building and maintaining trust also entailed ongoing protection of participants' privacy and confidentiality.

All written notes, audio records and data transcriptions were coded to protect privacy and kept in securely locked files accessible only by the researcher. A professional transcriptionist was hired to transcribe digital recordings generated from interview sessions. Only the transcriptionist, dissertation committee chair, and researcher had access to the audio recorded files. All documents and files containing personally identifiable information was coded, encrypted, and password protected. In addition, the personal computer used in this study was password protected.

Documents will remain in securely protected file cabinets for three years, as mandated by the IRB at Mercer University, at which time all information, other than de-identified interview transcripts, will be destroyed. Digital audio recordings were destroyed at the conclusion of data analysis. Participants were informed that the narratives and interpretation of themes relating to the study would contain no identifiable information and would be used for scholarly publications and presentations. At no time during this study or in the future would participants' identifying information be shared or published.

Data Processing

Data processing included verbatim transcription of semi-structured open-ended interviews from a digital recording device. All demographic information was recorded

on a demographic form. Each form was labeled with the participant's self-selected pseudonym to ensure confidentiality.

Recorded interviews were transcribed into Microsoft Word by a professional transcriptionist who was required to sign a confidentiality agreement prior to receiving audio files. Data were backed-up to an external hard drive on a weekly basis. To ensure safety and confidentiality of data, the external hard drive and documents will be stored in a locked file cabinet in my home office for three years. The dissertation chair was updated weekly on data processing, provided copies of the transcribed narratives, and given access to digital audio recordings.

Field notes and journaling regarding the study were documented throughout the data collection process. Field notes were recorded during and immediately following each interview session. Personal thoughts concerning data collection and analysis as well as personal reflections of the overall experience were recorded in the journal.

Data Analysis

For the novice researcher, the rigor of qualitative research in general and interpretive phenomenology specifically is arduous. Interpretive phenomenology is subjectively-oriented and thus, the methods employed to carefully uncover pre-reflective truth in data gathering—reading, listening, language, writing, reflexivity, and re-writing—are futile if the researcher does not exercise care to hear, understand, and interpret true meaning and relationships of participants' life-world experiences (van Manen, 1990, 2006).

Doing phenomenology is overlapping and iterative processes of data gathering, data processing, and data analysis. When data collection begins, so, too, does data analysis (Streubert & Carpenter, 2011). Data analysis for this study followed the hermeneutic circle of interpretation with insights from van Manen's (1990) process of writing while reading, reflecting, and re-writing, and existential thematic analysis to uncover meaning in lived space, lived time, lived body, and lived human relation experiences.

The hermeneutic circle of interpretation (Heidegger 1927/1962) involves naïve reading, structural analysis, and interpretation of the whole (writing and re-writing). With naïve reading, the researcher reads each participant's verbatim texts to become familiar with the text and begin to formulate thoughts. Structural analysis is interpretive (selective) reading to identify patterns of meaningful connections. Finally, interpretation of the whole involves reflection on initial readings along with interpretive readings to gain deep, rich, meaningful insights (van Manen, 1990).

> The words we choose to document what we see and hear in the field can never truly be objective; they can only be our interpretation of what we experience . . . and the influence of the researcher's personal values, attitudes, and beliefs from and toward fieldwork is not unavoidable. (Miles, Huberman, & Saldaña, 2014, p. 11)

Bracketing was previously discussed in this chapter as a differentiating concept between Husserl's view of phenomenology and Heidegger's interpretive views. Bracketing is chiefly concerned with the epistemological position of the researcher. Specifically, the researcher's preconceived, a priori beliefs, assumptions, biases, and judgments about the phenomena of interest were considered by early phenomenologists,

such as Husserl, to adversely affect openness (epoché) to what is discovered and disclosed (reduction), description (intuiting), and interpretation. However, bracketing is not required for an interpretive approach.

A priori beliefs, assumptions, biases, and judgments are deeply embedded in the culturally-based being and ways-of being of all human beings (Heidegger, 1975/1982; van Manen, 2007/2017a). Therefore, Heidegger, van Manen, and scholars of hermeneutic phenomenology believe bracketing is an unrealistic and hence unnecessary attempt to separate the researcher from the phenomena of interest or meanings of participants' lived experiences (van Manen, 2017a). Furthermore, "interviewers come with histories and cultural value systems; on many levels, the cultural and social expectations of both individuals—interviewer and interviewee—will affect what is said and what is heard" (Streubert & Carpenter, 2011, p. 35). For this study, the hermeneutic circle of interpretation provided a way of escaping these prior beliefs' potential threat to qualitative validity (true, accurate, meaningful insights).

Data analysis of interpretive phenomenology research sought to preserve uniqueness of each participant's lived experience while permitting understanding of the phenomenon of interest. The intent is not to code the lived experience description, but rather to use the lived experience description as a starting point to ask, "What might this particular lived experience description, passage, phrase, or even word say about the phenomenon of interest?" (Adams & van Manen, 2017, p. 788). Analysis included listening to verbal descriptions, reading, and re-reading of verbatim transcriptions or written responses. Identification of essential relationships among statements, imaginative

variation, and making connections between statements was critical, including how statements or central themes emerged and were connected to one another (Streubert & Carpenter, 2011).

An integration of van Manen's (1990) thematic analysis and coding processes described by Saldaña (2016) were used to guide the identification of themes and subthemes. This practice is commonly noted in qualitative research. van Manen's (1990) thematic analysis process guided the careful examination of the text to discover common themes and subthemes from transcribed narratives. Van Manen (1990) defined a theme as a point, meaning, or focus of an experience. First and second cycle coding methods delineated by Saldaña (2016) were applied throughout data analysis to identify patterns in NGRNs' reflections on caring for acutely ill patients. Narratives were further analyzed through the lens of Kolcaba's comfort theory (2003) and Benner's novice to expert theory (1984), specifically including Benner's eight competencies of the helping role (1984), the conceptual framework for this study.

Analytic Coding

Coding was conducted utilizing first and second cycle coding methods articulated by Saldaña (2016). He described coding as a process of identifying a word or short phase to describe the meaning of the text. Through data analysis, patterns were identified in the narratives. Preliminary jottings were included in my notes and on printed transcripts, providing valuable information and ideas for analytic consideration as I moved through the data analysis phase. Preliminary jottings were followed by first and second cycle coding methods.

For first cycle coding, descriptive, in vivo, emotion, process, and versus methods were used as described by Saldaña (2016). Descriptive coding summarized the words or expressions from the narratives (Saldaña, 2016). In vivo coding was taken from direct language of participants (Saldaña, 2016, p. 295). Emotion coding was utilized during the initial reading of transcripts and field notes, preliminary jottings, and reflective journaling to identify strong emotions and worldviews associated with participants' experiences. Process coding incorporated researcher-generated labels to indicate action (Saldaña, 2016). Versus coding captured the actual and conceptual conflicts within, among, and between participants' perceptions and experiences (Saldaña, 2016). Second cycle coding further organized and condensed codes generated by first cycle coding, using focused coding to identify the most common and significant codes (Saldaña, 2016). It was during second cycle coding that common codes and themes began to emerge from the narratives.

Themes Identification

Findings were derived through multiple readings of the narratives, a review of field notes, and the coding process. Through this systematic approach, four distinctive themes and six subthemes were identified and are described in the next chapter. Once common themes and subthemes were known, another review of the narratives was conducted to highlight personal stories that described and supported the themes. Consideration was given to identifying passages that would provide a vivid interpretation of the lived experiences of NGRNs as they cared for seriously ill patients in acute care settings. Table 1 represents an example of analytic coding and theme identification.

Table 1

Example of Analytic Coding and Themes Identification

Preliminary impressions/jottings
- Doubt/uncertainty; attuned/concerned with/sensitive to suffering; internally conflicted; burden; angst; exhausting; powerless; extreme measures

First cycle codes (descriptive, in vivo, emotion, process, versus)
- (Descriptive) where a daughter of the patient was just wanting to take all the extremes, but like we're all seeing that this patient could be suffering; looking at the big picture just really thinking through why they're here
- (In vivo) "emotionally draining going into that room" (#75)
- (Emotion) Hyperaware of everyone's emotions, and kind of their demeanor; she (this patient) was in distress/very anxious; sad, raw emotion, tearful/crying
- (Process) Paying attention – to nonverbal: (patients') facial expressions, grimacing, eye-rolling, moaning; being with/being there for the patient
- (Versus) knowing my place (communication and relationships with experienced providers) and just following orders (for extreme care) **versus** ethical care, patient advocate, non-judgmental

Second cycle codes (focused)
- Tension/moral distress
- Self-talk
- Role

Theme
- Trying to figure out what the balance is

Subthemes
- Knowing my place
- The care they deserve

Trustworthiness/Rigor

Lincoln & Guba's (1985) trustworthiness criteria provided valuable strategies to establish and critique trustworthiness for the study. Central to Lincoln and Guba's (1985) criteria are the concepts of credibility, transferability, dependability, and confirmability.

Credibility is concerned with truth value, how confident the researcher is with the truth of

the findings based on the research design, informants, and context (Lincoln & Guba,

1985). Dependability and confirmability are concerned with providing enough

information about the data, setting, participants, findings, method, and analytic decisions

so that another researcher reading the study could reach similar conclusions. Both

require a detailed audit trail. Specific strategies to establish trustworthiness in the study

included interview technique, reflexivity, use of field notes and journals, triangulation of

data from multiple data sources, peer examination, and audit trail (Krefting, 1991).

Transferability or applicability of research findings is of importance to the nursing

discipline. Interpretive nursing research with the foci on PC, nursing education, and

formation has significant implications for healthcare practice and profession-based

outcomes across acute care settings. However, as Krefting (1991) noted, "The difficulty

with qualitative research is situational uniqueness" (p. 220). Therefore, only the

consumer of qualitative research can truly determine applicability of findings to other

sites or participants. One transferability strategy suggested by Krefting is consistent with

one of the recruitment techniques discussed in the participant section of this chapter.

According to Krefting, one means of contributing to transferability is the use of

demographic information available on the group being studied, in addition to detailed

audit trails and thick descriptions of participants' experiences.

<p style="text-align:center">Summary</p>

Interpretive (hermeneutic) phenomenology, based on the philosophical

underpinnings of Martin Heidegger, was selected for this study as an appropriate

qualitative research method and design to explicate NGRNs' perceptions, meanings, and use of PC for seriously ill patients in acute care settings. In this chapter, rationale for the study approach was provided. In addition, setting, participants, data collection, protection of human subjects, data processing, and data analysis were also detailed. Finally, trustworthiness and rigor criteria were discussed. Findings of this study follow in Chapter 4.

CHAPTER 4

PRESENTATION OF FINDINGS

In this study, baccalaureate-prepared and entry level masters-prepared NGRNs'
lived experiences of providing PC for seriously ill patients in acute care settings were
explored utilizing face-to-face interviews and an interpretive (hermeneutic)
phenomenology approach. Common themes and subthemes emerged through
interpretation of transcribed narratives from interviews with participants. This chapter
includes an overview of data management and analysis, description of participants and
setting, discussion of findings, and theme development. Findings are described in detail,
including the researcher's understanding and explanation of themes and subthemes.

Data Management

Prior to beginning the data collection phase, a professional transcriptionist was
hired to transcribe interview sessions. A signed confidentiality agreement was obtained
from the transcriptionist to assure participant confidentiality (Appendix G). All written
notes, audio recordings, and data transcriptions were kept in securely locked files
accessible only by the researcher. At no time during the recruitment or data collection
process were participants' identifying information shared. Participants self-selected a
pseudonym for identification purposes prior to data collection. This pseudonym was
used in field notes, transcribed narratives, and all other aspects of the research process.

Demographic data were collected and confirmed prior to interviews. At the conclusion of each of the 12 interviews, recorded audio files were transferred to a personal, password-protected computer and shared with the transcriptionist. Any identifiers were redacted from transcripts to maintain confidentiality. Audio files were only available to the researcher, dissertation committee chair, and the transcriptionist via a password-protected file transfer service to ensure confidentiality of participants. Interviews were transcribed into Microsoft Word. Recorded interviews and transcriptions were reviewed for accuracy and confidentiality. No identifying information was included on the final transcribed narratives.

Data Analysis

Transcribed narratives were electronically submitted to the dissertation committee chair for review and discussion throughout the data analysis phase. Coding and thematic analysis were completed manually with each transcribed narrative. The dissertation chair and I reviewed and analyzed the narratives separately then compared findings to enhance rigor for the study. Methods for data analysis were detailed in the previous chapter.

Findings

The selected setting for this study was a large academic healthcare system in the southeast region of the United States. Four of the hospitals in this setting were located in urban or highly populated suburban areas. Baccalaureate-prepared (BSN) and entry level masters-prepared (MSN) NGRNs from each of the hospitals participate in a 12-month nurse residency program. At the time of initial recruitment, one cohort was just beginning (less than one month experience), the second cohort was at month seven, and

the third cohort was beginning month 10 of the 12-month residency program. Twelve

participants with six to 12 months of professional nursing experience contributed

narrative data. Demographic data are presented in Table 2.

Table 2

Participant Characteristics as a Percentage of the Sample

Characteristic	n	Percentage
Self-identity		
Female	11	92
Male	1	8
Age* (range**)		
20-25 years	4	34
26-30 years	6	50
31-35 years	1	8
36-40 years	1	8
Race/ethnicity		
Caucasian	6	50
African American	2	17
Hispanic-Latino	1	8
Asian	2	17
Other (Mixed)	1	8
Highest nursing degree		
Bachelors (BSN)	11	92
Masters (Entry-level MSN)	1	8
Previous non-nursing degree		
Yes	7	58
No	5	42
Primary work setting		
Medical-Surgical adult	8	67
Critical Care adult	3	25
Emergency Department adult	1	8
Prior hospice or PC***		
Yes	5	42
No	7	58

*Mean age: 27 years

**Age range 22- to 40-years old

***Prior personal, professional (non-nursing) or volunteer hospice or PC experience(s)

Each participant was an entry-level BSN or MSN licensed registered nurse. All study participants were employed full-time, greater than or equal to 36 hours per week, at one of the four acute care hospitals. Length of employment for 11 of the 12 participants was seven months. One participant was in the 11th month of employment. Participant responses for primary work setting included adult care in medical-surgical units, critical care units, and the emergency department.

Five of the 12 participants disclosed they had prior personal experiences or volunteer experiences in a PC or hospice setting. Two participants detailed volunteer experience in a hospice setting. Three of the participants described prior personal experiences of observing the care of at least one seriously ill relative. All personal or volunteer experiences occurred prior to entry into their respective baccalaureate programs.

The average length of interviews was 63 minutes. All participants were asked, and subsequently answered, each question in the interview protocol, including clarifying probes. However, the sequence of questions and probes varied during the interviews according to the researcher's careful observation of NGRNs' cues, such as ease or difficulty with responses or emotions exhibited through facial expressions, long pauses, or tears. Also, moments of deep reflection and elements of stories were allowed to unfold with minimal or no interruption. Participants' responses, which could be appropriately connected to previous statements for follow-up or clarification occurred throughout all interviews.

During interviews, most participants struggled to understand and answer questions related to patients' and families' cultural contexts, even with clarifying probes and multiple attempts at rephrasing the question. The question and probes related to culture often took additional time for participants to thoughtfully reflect upon and respond. This question was modified slightly in each interview according to the participants' responsiveness. No other changes to the protocol were indicated.

Most of the NGRNs described PC academic learning of theoretical knowledge as "a blur." All but one participant described PC education as mostly unremarkable. Most pre-licensure BSN/MSN education was described as having anywhere from one to three lectures, maybe in the health assessment or community health nursing course, possibly in the last year, toward the end of the program, with no specific hospice or PC clinical experience, and no test. Some participants recalled hospice nurses as guest lectures, which they found interesting and meaningful to learning.

One participant recalled a class assignment in which student groups created scenarios and skits to demonstrate a palliative approach. She recalled the experience as positive in that it prepared her to be less afraid of PC discussions with patients and families. Nearly all participants struggled to recall when, where, or what they had gained from their nursing education about PC beyond learning that PC did not mean the patient was imminently dying in the next six months. Interestingly, while nearly all NGRNs could recall learning from their nursing program that PC did not mean the patient was imminently dying in the next six months, their initial contexts for shared stories focused primarily on critically ill patients at end-of-life or imminently dying patients. Only one

participant recalled a structured PC education course separate and distinct from a community health or health assessment course.

Many of the stories shared by NGRNs early in their interviews indicated their perceptions of PC were mainly still associated with end-of-life, do not resuscitate (DNR) code status, or actively dying patients, rather than a comprehensive approach for acute and chronic serious illnesses, prognosis, comfort, and quality of life. Nearly all NGRNs perceived self-limitations in assessing and interpreting patients' and families' comfort needs, particularly those who may be unable to articulate or otherwise communicate their goals for care. The ways of knowing and providing comfort care were clearly of concern to all participants. However, as interviews progressed, contexts of complex patient situations, including physical, psychospiritual, sociocultural, and environmental needs of patients were more thoughtfully considered and expressed by all the NGRNs.

Themes and Subthemes

Through data analysis, four common themes and six subthemes were identified that vividly illustrated NGRNs' experiences of providing PC for seriously ill adult patients in acute care settings. Data analysis revealed the four themes of: "Trying to Figure out What the Balance Is," "Working in the Dark," "It's Just Who I Am," and "The Kairos Effect." Table 3 displays the identified themes and subthemes.

Table 3

Findings: Themes and Subthemes

Theme	Subtheme
Trying to figure out what the balance is	Knowing my place
	The care they deserve
Working in the dark	An unfamiliar place
	Being mindful
It's just who I am	Character
The Kairos effect	Professional formation

Theme 1: Trying to figure out what the balance is. One of the strongest themes to emerge from the narratives focused on NGRNs trying to figure out what the balance is. Trying to figure out what the balance is was defined as NGRNs' moral dilemmas, where they had to balance emotional conflict and internal struggle with their perceptions of patients' suffering from their illness and treatments, decision-making for comfort and quality of life, and their role as nurses. This theme included the subthemes of knowing my place, defined as balancing interprofessional healthcare team members' relationships with nursing autonomy, following orders vs providing comfort oriented nursing care; and the care they deserve, defined as the balance between extreme treatment and comfort and values versus confidence. Participants in this study entered the nursing profession as

advanced beginners (Benner, 1984), often with idealized versions of patient care and

comfort. Trying to figure out what the balance is as related to NGRNs' moral dilemmas

and the corresponding emotional conflict and internal struggle associated with NGRNs'

perceptions of patient suffering from their disease and extreme treatments, decision-

making for comfort and quality of life, and their role as nurses. In recalling her story of

caring for a patient with a chronic and debilitating illness, Emily shared,

> Just looking at him, feeling like I was just looking at a wall…it was a bad feeling
> because I felt like I couldn't help do anything. I felt very limited. I just felt
> helpless to an extent. I wanted to make the difference, but I wasn't sure "how am
> I going to do that?"

In many aspects finding the balance related to tension between following orders

and autonomous nursing practice. Participants focused on the importance and necessity

of following orders. However, the certainty expressed with knowing scope of nursing

practice was often juxtaposed with uncertainty in knowing the right words to say,

advocating for patients, and building confidence. Navigating relationships with patients,

families, providers, nursing peers, and interprofessional colleagues underlie NGRNs'

feelings of tension and moral distress in caring for seriously and chronically ill patients.

Subtheme 1.1: Knowing my place. Participants' responses reflected a heavy

reliance on following orders and completing tasks. Deborah recalled her foundation for

scope of practice stating, "They teach us to be kind of task-based in the beginning, just

kind of follow the orders, and that's what you do." Another participant, Dixie said, "As a

nurse, our primary task is to follow orders, but I also do not undermine our role of being a

patient advocate." However, the reflective emotions associated with "just following

orders" were evident as many participants described feelings of burden, futility,

frustration, angst, and powerlessness when caring for seriously ill patients. Jane recalled

a conversation with her preceptor after her third consecutive shift of caring for one

seriously ill patient,

> Can we please just confront the doctors about what we're doing, and if it's clearly
> not really doing any good for her, like other than keeping her alive, and the
> quality of life is not there, she's miserable and, you know, the doctors don't really
> see the in-between moments. They just see her briefly. They tell her what they're
> going to do, but we're really the nurse, the people that are there every moment
> and we see them.

Another participant, Jill, interpreted PC orders this way, "I was going through my

orders that morning, it said 'stop vital signs'; like stop everything we do as nurses? I was

just like 'this feels, like, really out of control'." Many participants found it difficult to

determine shared decision-making between providers and patients in goals and plans of

care. Because many NGRNs perceived themselves to be unprepared or inexperienced in

PC nursing practice, they relied on the PC experiences of providers, preceptors, and other

team members such as chaplains or social workers. Participants' lack of PC

understanding compounded their frustration with providers who were perceived to avoid

and/or shift ownership when making decisions between curative practices, PC, comfort,

and quality of life. Jane said,

> I just felt terrible in that sense, just as a nurse not being able to provide (comfort).
> I don't know, just, I guess I just, being a nurse now, I guess you kind of become
> hyperaware of everyone's emotions, and kind of their demeanor, and just like I
> could tell she was miserable. And that just, I think, really weighed on me.

NGRNs' decision-making and caring practices were emotionally- and ethically-

laden as they struggled to find the balance between following orders and their

understanding of ethical nursing care (beneficence, non-maleficence, justice, veracity, and autonomy). Subjectivity of what is "good" and "right" and "best" for the patient is difficult for nurses regardless of years of experience—but more so for NGRNs who often see patient care as idealized rather than realistic. Participants described patient assignments with seriously ill patients as "a heavy load," "constant care," "constant attention," "emotionally draining," and "constantly having to find support." Complex patient situations were described as "difficult to process." Participants expressed feelings of confusion, helplessness, and powerlessness. Victoria commented,

> Just seeing some patients, and what they're going through, it's like sometimes you can be treating a patient, but you're doing more harm than good, 'cause like you're medically treating them, but stuff is going wrong. We're good at keeping people alive, but are they comfortable?

Jodi expressed feelings of "raw" emotion as she reflected on what she termed extreme measures having "all these crazy interventions done," versus quality of life. Similarly, in her reflection of communicating with providers, participant Jane shared, "We're doing a lot of things and still not getting anywhere . . . it's hard to see someone (patient) in such a distressed state." The angst expressed in NGRNs' stories of trying to figure out the balance in dynamic clinical situations were also reflected in Deborah's descriptions, "I felt like I was in a position where I didn't really have power, because I was so new. If someone is upset, you want to change their situation . . . we don't go into nursing to hurt people. We go in to help people." The 'balance' uniformly felt by participants, but articulated most succinctly by Ben was comfort. Comfort was understood by participants to be a subjective, individualized experience of patients,

achieved by understanding and then doing everything they could to alleviate their

patients' discomfort, within scope of practice. When participants reflected on their

meanings of comfort and experiences of providing comfort to patients, several NGRNs

similarly stated as Ben did,

> So, comfort, providing a sense of relief to patients--whether that's symptomatic
> relief, whether that's pain relief, whether that's emotional, social relief,
> environmental, economic--I mean, I think that's why interdisciplinary care is just
> so, so important, because it allows us to address the multiple issues that a patient
> may be facing.

In his statement, Ben realized comfort as an intervention based on holistic assessment of

needs and an outcome of an interdisciplinary approach informed by patient and family

goals.

  Subtheme 1.2: The Care They Deserve. Most participants shared common

perceptions of PC delivery, such as listening to patients, being present, and providing

comfort through touch, even though they did not initially articulate those concepts or

aspects of care delivery as nursing and/or principles of PC. As well, participants shared

similarities in their stories of nursing interventions perceived to be most meaningful to

patients' experiences of comfort. The balance between following orders and "knowing

my place" shifted as participants began to more fully reflect upon and understand the

concept of comfort, consider contexts in which comfort is provided, and recall what they

perceived as the care seriously ill patients deserved. They rejected the notion of "just

going through the motions of tasks," and rather embraced the significance of dignity,

respect, and patient autonomy. As best expressed by one participant, "doing more" and

"going deeper" to determine contexts of human experiences and comfort needs was

important to providing meaningful comfort care. Participant Dixie noted the following as

her personal guide to comfort,

> She asks her patients, "What's the biggest problem that we need to tackle to make
> you feel better?" And it is surprising how much it varies, like, sometimes people
> say, 'I just want to see my kids or 'I just want my pain controlled' or 'I just want
> to be able to walk around.' Oftentimes, nurses think everybody just wants
> morphine every two hours, but it's deeper than that.

Several participants spoke of building a good rapport, serving, engaging the

patient, and the importance of presence and transparency in their care of seriously ill

patients. Communicating, explaining, and teaching what is now and what is next for

patients in their illness trajectory were strongly held values and expectations of care.

While many participants expressed more than a bit of trepidation and lack of confidence

in knowing the right words to say, being an advocate of ethical care delivery was what

each NGRN felt patients deserved. The care seriously ill patients deserve also involved

being non-judgmental, negotiating options, and compromising between patients' goals

and nursing care when conflicts and disconnects between the two were perceived.

> By far, transparency, communication, and making them feel comfortable. Just…
> I, I think just, just showing to them that you care. And I think you can do that, not
> necessarily by saying I care about you, but by listening to them, making eye
> contact with them, and being… telling them, you know, what's gonna happen
> today. *Ben*
>
> I feel like the outcome with my patients and our relationship, the nurse to patient
> relationship, is a whole lot better. Because I'm not just in there administering your
> medications. I'm in there talking to you and telling you what's gonna happen
> throughout your day so you're not surprised by anybody coming in your room.
> *Jojo*
> If you want me to sit here and hold your hand in silence, or if you want me to hold
> your hand and talk about it, either way, I think that was important and so, I would
> just touch his arm 'cause his hand was in like little mitts and gloves, but just give

him a little rub and say, "It's alright," you know, like, "We're here to take care of you." "I'm gonna be here with you this time." *Porter*

The theme and subthemes of *trying to figure out what the balance is* uncover the emotions, values, moral dilemmas, and related moral distress of NGRNs' experiences caring for seriously ill patients in acute care settings. Participants' perceptions of serious illness and suffering, contexts of complex situations, and internal dialogue and struggle of following orders and scope of practice in acute care nurse practice settings were described. Participants' interpretations of *the care patients deserve* began to transform during the interviews, as well as their being in nursing and subsequent caring practices as Benner's idea of formation would suggest.

Theme 2: Working in the dark. The second theme of working in the dark identified three overarching concerns, which influenced NGRNs' experiences of caring for seriously ill patients. Working in the dark means nurses do not always know what patients need and want (related to care, comfort and family interactions). This theme is also related to NGRNs, patients, and families' expectations and experiences of comfort in the acute care setting. Working in the dark for patients means being in the dark; being in a foreign, scary, unfamiliar place.

Findings indicate NGRNs seek to understand first, what patients want but are unable to articulate; second, what outcomes are of primary importance to the patient; and lastly, the impact, if any, of positive or negative family interactions on comfort interventions and comfort outcomes. The theme working in the dark represents a continued gradual progression of NGRNs' perceptions and skills from singularly focused

and task-based nursing to the need to make sense of their patient care experiences—what

is really happening here. To know what to do was impeded by the literal and figurative

darkness of the unknowns in serious illness. Findings indicate NGRNs' stories of patient

care initially demonstrated a lack of awareness, inability, or inconsistency in holistic

assessment to identify comfort needs. Participants recognized the need for structure and

scope of practice in nursing care; however, none wanted to rely solely and

unquestioningly on any one discipline or biomedical factor to inform care.

> …just if he could express to me a little bit more what exactly he was feeling about what part of his life, physical, spiritual or home life. I think that would have been a lot easier, so I could just be in there and like comfort him in the ways he actually wanted. *Porter*

Although all participants were able to verbalize some degree of education-based

theoretical knowledge of PC as promoting comfort, their initial stories demonstrated how

theoretical knowledge of PC did not necessarily connect to understanding and application

in practice. Hence, their feelings of working in the dark were compounded. It was not

until participants began to reflect on the whole person situation—patients' physical,

psychological, social, spiritual, cultural, and environmental needs—were they able to find

their way out of the dark. Two subthemes consistently resonated with NGRNs and were

articulated in their stories: 1) serious illness and acute care settings are unfamiliar and

scary places for patients; and 2) mindfulness is an essential way-of-being for a nurse who

promotes comfort.

   Subtheme 2.1: An unfamiliar place. Participants often described seriously ill

patients as those patients who could not do for themselves. Their descriptions often

focused most significantly on the perceived challenges of caring for a patient who could

not articulate his or her needs. Participants' experiential learning in the acute care setting

did not initially account for how, for example, culture may impact individual experiences

of illness or discomfort. However, depending on space and time of their having had

experiences with seriously ill patients, as they were reflected upon, NGRNs'

understanding changed from articulating physical needs and patients' limitations such as

being unable to talk or do things for themselves to broader discussions about mental

health, emotional needs, environmental needs, and spirituality.

> If you're already sick, you're already in a different place, an unfamiliar place. *Emily*

> Being in the hospital is the opposite of comfort for many people . . . being in the hospital setting in general is very foreign to very many people. *Deborah*

> Being with them, and seeing the in-between moments, realizing no one really wants to be alone in the dark in the hospital. *Jane*

> A hospital is a scary place. And if you're alone most of the day by yourself, with nobody to talk to, nobody to express your fears to, that's not comfort at all. It's scary too, a scary place for some people. I think understanding that alone, and putting yourself into a patient's shoes, is one of the most important and vital things that you can do as a nurse. *Jojo*

Subtheme 2.2: Being mindful. Consistent with Kolcaba's (2003) comfort theory

and Benner's competencies of the helping role, participants overwhelmingly described

being mindful as paying attention to the nonverbal cues of pain and suffering and

listening to patients. They aligned being attentive, seeing the patient as a person, and

hearing the holistic needs of patients with intuitively empathetic and impactful caring

measures to promote comfort. Many of the participants shared heartwarming stories of

presence and touch and the impact those had on patients' experiences of comfort.

However, participants often viewed these applications of principles of PC in acute care

settings as something other than nursing. This was illustrated most clearly in the

following participant statements,

> I've realized it's the moments that you're not actively doing like a nursing task. It's like, when you're just in the room, talking, sitting, just presence. Which is like, so crazy. I'll think, 'oh my gosh, I just did this crazy dressing change on you. I just served you so well. I just washed your feet, gave you a bed bath, but what you really want is me to just talk to you.' It kind of shakes you up a little bit. You're like, 'wow, I really don't recognize how important it is, or how much they perceive. *Jill*

> I think touch also is very important comfort for people cause like when you're just going in there and just doing… just shoving the meds in the PEG tube, or the IV line, or whatever it may be and not even acting like they're a real person. I think touch is just so important 'cause like there's so many times patients just hold my hand and I think it really, genuinely means a lot to them. *Porter*

> The hospital setting was not intuitively seen as comfortable or associated with

comfort for seriously ill patients. Creating a climate which promoted comfort required

intentionality. Findings also indicate the impact of presence to the hospital environment.

> Just for like, for the few minutes that I have, they're not focused on the hospital four walls that they're in. It builds a sense of trust and rapport with them and also makes them feel that somebody cares about them, and its, they're not just another sick patient…it makes them feel like, 'I'm all that this nurse cares about.' *Victoria*

Several participants were perceptive to the hospital environment and shared stories of

using natural and room lighting to positively impact patients' comfort. Others shared

stories of using patients' preferred music to promote comfort. Yet others shared stories

of using a patient's artwork to brighten the hospital room.

I feel like the environment is part of the healing process . . . I just like things calm, a certain aura. I think that helps me, when I go into the patient's room, automatically I bring my energy in there because sometimes that's all people have. *Emily*

Being mindful is important; be mindful of not just what's going on with the patient, but also what's going on around the patient. Also, touching the patient, putting hands on the patient, talking to the patient, paying attention and giving patients options. By nature I'm a real attentive person. *Emily*

Several participants in this study also shared powerful stories of what they

perceived as positive (desired, needed, comforting for patient and goals and plans of care)

or negative (perceived as interfering with patient's comfort and/or nursing care) family

interactions.

As much as it's difficult for the patient, whether they're going to die or not, I think it's, for the patients that have accepted it, maybe their family members have not. Or their family members don't know how to feel or don't know what to do in this situation. Even just involving them in the care of the patient sometimes, or just listening to them . . . I mean, I know from experience how hard it is to be a caregiver of someone in the hospital, and just having somebody to be there to understand that I think is important. And, there are those patients that, like, even though they're suffering, and that, or it may even be their last days, they're still concerned about their family. So, I think it kind of helps both the family and the patient to know that both of them are being cared for. *Sarah*

Jill recalled her patient suffering with stage four pancreatic cancer whose chief concerns

were the future well-being of his wife and pre-adolescent children. Jill made this

observation of her patient's interactions with his wife and family:

Playing the host . . . I've seen that a lot in my patients, like, they're just exhausted because they're having to entertain people. He was kind of over it, but his wife definitely needed it. He was having to be the rock for his wife in that moment, but he, you know, was the one who was sick.
Most participants found the presence of family members as positive for patients'

comfort. Involving the family, answering questions, always asking questions, and

keeping families informed were key components, which maximized patients' comfort.

Helping patients and family members understand a palliative approach by interpreting

readiness to receive the information also demonstrated mindfulness. Ben noted,

> I feel like PC or just having that voice in your head will kind of help set realistic goals for that patient. And kind of open up, I mean, not everybody's onboard, even the patient might not be onboard with PC, but I feel like even to the patient, we need to explain like this doesn't mean you're dying, this really does not mean that you're dying…it's just an outlet where we can just kind of explore different options for your quality of care.

The NGRNs commented on the tremendous value some family members could provide,

particularly for those patients who were unable to communicate their needs or goals.

Some NGRNs struggled with understanding the complexities of patients' needs and how

to respond. However, as NGRNs became better at perceptual acuity, they were able to

interpret the contexts and comfort needs of patients and to select appropriate strategies

for enhanced comfort. In Jojo's story, she described her patient's struggle with one of

her sons who wanted her to "keep fighting" while she wanted to die with dignity and at

peace. The son wanted to place his mother in a long-term care facility. Jojo reflected on

how mindfulness changed how she perceived PC and hospice care in nursing school:

> Like, different situations for different folks. And taking that class, you know, or taking those classes, made me more aware of how judgmental I was towards other people because I realized, you know, even though this is what we believe in my religion, there are other people in other situations that just can't do what we do. So, it's not my place to judge anybody for where they choose to put their family members or what they choose, or what people choose to put themselves in sometimes . . . So, it made me way less judgmental.

> The theme and subthemes of *working in the dark* are related to participants'

interpretations of serious illness as an unfamiliar place for patients and families.

Additionally, *working in the dark* described NGRNs' perceptions of the acute care environment and culture (space) as curative places for "extreme measures" versus environments conducive to patients' and families' experiences of comfort. *Being mindful* also related to NGRNs' knowing and choosing when, how, and why to engage family members based on need(s), comfort care, enhanced comfort, and health-seeking behaviors. Patient and family expectations were perceived as positive or negative depending upon the situation and/or environment. Findings indicate enlightened and empowered NGRNs whose insights of comfort needs, comfort care, and PC were continuing to develop with their experiential learning in real practice environments.

Theme 3: It's Just who I am: Character. It's just who I am is related to NGRNs' personal values, beliefs, worldview, and personal ethos as central to their palliative care nursing practice. Newly graduated registered nurses perceived PC and comfort care as inherent to personal identity and character. Participants were not asked directly and did not state if their prior experiences influenced the decision to enter nursing school. However, five participants—Dixie, Jill, Emily, Jane, and Jojo—described their prior experiences of observing the care of patients with serious illnesses as deeply meaningful to their worldview and development as empathetic and attentive NGRNs. *It's just who I am* is related to NGRNs' personal values, beliefs, worldview, and personal ethos as central to their PC nursing practice.

Prior serious illness experiences of family members, cultural backgrounds, spiritual beliefs, and volunteer experience(s) in hospice or PC strongly influenced NGRNs' understanding and application of principles of PC. These findings relate to

Benner's (1984) assertion that an individual's history informs his or her knowledge and

openness to the world. Participants' foundations for and personal fulfillment through

ethos-driven care were clearly reflected in the following responses,

> I think it's mostly foundational for me . . . it's in my character to be empathetic. I think, this is just really who I am, to think about the patient and comfort. *Dixie*
> I think I've always been brought up to be a very empathetic person . . . I try to treat people the way I would want to be treated. That's just the biggest motto I could use for any kind of nursing practice. That's just kind of the way my mom brought me up. *Deborah*

> Being I'm a people person, I like to, you know, have a conversation, fully engage myself, and it's like when you can do that plus caring for someone, it has a sense of fulfillment. *Victoria*

The theme of *it's just who I am* provide NGRNs' reflections on prior personal

experiences of serious illness and comfort care. Prior personal experiences, as well as

NGRNs' character, most strongly influenced how they perceived, understood, and

experienced principles of PC and comfort.

Theme 4: The Kairos effect.

Since ancient biblical times, a Kairos moment has been described as carpe diem, a transformative moment of chance and change, depending on our ability and willingness to recognize this moment and to seize the opportunity that is offered in it (van Manen, 2017b, p. 821).

Merriam-Webster (2019) defines the word Kairos as a time when conditions are

right for the accomplishment of a crucial action, the opportune and decisive moment

(Merriam-Webster's online dictionary, n.d.). In this study, the Kairos effect means

NGRNs' demonstration of insight, understanding, an "aha moment" which shifted his/her

thinking of palliative care from time/space-specific to a holistic approach to care. The

Kairos effect is about insight from NGRNs' behavior in the context of relationships to

things (the acute care nurse practice environment), people (seriously ill patients, families, providers, interprofessional colleagues, and experienced nurses), events (extreme, task-oriented measures versus a palliative approach), and situations (presence, mindfulness, complex learning). Benner et al. (2010) describes a Kairos moment when writing, "Nurses enact their knowledge of the natural and human sciences, technology, and ethics and are able to transform this knowledge into the capacity to perceive and act in a given situation" (p. 178).

As interviews with NGRN participants progressed, nearly all of the NGRNs experienced their version of an "aha moment." The latter portion of many of the NGRNs' stories reflected an increasing ethical disposition toward practice, including respect for patients' and families' autonomy, determination, and desired outcome of comfort. The juxtaposition of self-awareness, reflective practice, cultural and religious values, and professional formation were revealed when a few NGRN participants began reflecting on action during interviews. The convergence of self-awareness, values, and reflection on action attributed significantly to those NGRNs' aha moments. The perceptions, meanings, and use of PC and comfort in acute care settings revealed in these aha moments contributed many phenomenological insights for this study.

As many of the NGRNs reflected on and recalled their experiences with seriously ill patients in great detail, their capacity to perceive their actions as meaningful comfort care in multiple contexts included visible and palpable Kairos moments during the interview. Many of the participants who began their interviews with language and physical posture, which reflected their uncertainty, angst, and powerlessness in

knowledge and skills of nursing practice, completed their interviews with smiles, self-

praise, and greater understanding of their role and ability to use principles of PC to

promote comfort for seriously ill patients. Dixie, who began her interview somberly

reflecting on her experiences with seriously ill patients and the internal conflict she felt

related to "extreme measures" later reflected,

> Whenever they find out they are in PC or need PC, that could be devastating to them or it could not be devastating to them, it could be something that they've been waiting for. *Dixie*

Deborah's seriously ill patients were initially viewed as "kind of a train wreck," and she

felt "emotionally draining going into that room;" their needs were "difficult for me to

process" and "I felt like I was in a position where I didn't really have the power, because

I was so new" later shared,

> I think that they're treated with respect still, just not talking over them . . . and I think that's critical to make sure you're looking at this person (the whole person) as who they are outside of their illness or disease and treat them with that respect. *Deborah*

Sarah, who began her interview sharing stories of feeling completely "overwhelmed" by

her patients' experiences of serious illness and the enormity of trying to understand their

needs, ended her interview with this powerful statement,

> …Just making sure that they're comfortable and that whether their illness is curable or not, that they're okay – physically, mentally, emotionally, spiritually – whatever their needs are that they're being met, in whatever capacity that we can in the hospital setting. *Sarah*

Subtheme 4.1: Professional formation. Benner et al. (2010) stated, "Formation

occurs as students develop knowledge, skilled capacities, and insights into the notions of

the good that are central to nursing practice" (p. 177). In this current study, insightful

Kairos moments contributed to professional formation. The NGRNs' experiences of growing professionally in his or her work environment was supported by a culture of teaching, learning, mentoring, support, and encouragement. Participants felt safe to ask questions at work. They trusted and valued the knowledge, skills, abilities, and attitude of experienced nurses and interprofessional stakeholders.

Professional formation was strongly associated with NGRNs feeling valued and validated in their thought processes and intentionality toward comfort. The knowledge, trust, authority, confidence, and compassion of experienced nurses were comforting, and reassuring for NGRNs. Participants' perceptions of "experienced" when reflecting on preceptors', nursing peers', providers', or interprofessional colleagues' abilities to help them figure out the balance were overwhelmingly influenced by "whatever 'it' is, they've seen it before," and mentors know the right words and interventions to promote comfort.

> I think the biggest thing that just really stands out to me is like, they stay calm, and their calmness, like, transfers to the patient. I actually learn a lot when the doctors make their rounds. Anytime a doctor or provider, pharmacist, social worker, anybody who steps into my patient's room, I'm trying to be in there listening so that when they (patients and families) have questions later I can try to repeat what they said. *Lily*

As reflected in many responses, NGRNs' experiences of caring for acutely ill adult patients changed their perceptions about principles of PC, comfort, and quality of life in acute care settings during Kairos moments. Findings in this study suggest NGRNs' experiences of providing comfort for seriously ill patients in acute care settings contributed to their PC competence, confidence, and patient outcomes. Participants who early in their interview described caring for seriously ill patients as a burden, time-

consuming, and emotionally draining later reflected on those experiences as "good for me."

Many of the participants spoke of not only attending to needs, but trying to anticipate needs to enhance comfort. Emily described her experience of being with a patient, enhanced comfort, and transcendence stating,

> It was really hard watching her struggle as much as she did, and still having a certain determination to live. When she transitioned, the peace. She struggled for so long. And the internal struggle with stuff that she used to be able to do and can't do . . . I just felt like she could finally have some type of peace. So, I think it's just like an awareness of their level of comfort and just making sure we're communicating what PC is and how it makes sense.

Lily described the relief of having a specific comfort need met and contentment with goals and plans of care this way,

> That means we're going to make you comfortable because this is the disease that you have, and you will have it. So we're going try to make the rest of your life, for however long that is, comfortable and in the right direction of where you want go.

Sarah shared her observations of curative approaches versus holistic comfort:

> I think most people would probably just jump to like maybe pain management or something. But, I think quality of life is really important when it comes to PC. Just ensuring that the patient is comfortable, maybe not only physically, but emotionally, mentally and spiritually, if needed.

Kairos moments were evident throughout all NGRN interviews. These final reflections from NGRNs' stories provide insights into NGRNs' care delivery in acute care settings, and the beginning transformation of NGRNs in their understanding and interpreted meanings of comfort and PC. Participants' reflections were evidence that skills, autonomy, and decision-making were deepening as they were beginning to connect

principles of PC with the art and science of professional nursing practice. These Kairos

moments, combined with increasing skills acquisition in complex patient situations

demonstrated evolving professional formation.

Summary

This chapter included an overview of data management and analysis, progression

of findings from early codes to second cycle coding and categorization, and theme

development. A description of study participants and setting was provided. Findings

were described in detail, including the researcher's understanding and explanation of

themes and subthemes. Culminating in the final theme *the Kairos effect*, professional

formation in this study was interpreted in how NGRNs' thinking about serious illness,

comfort and, subsequently, PC, and their thinking about nursing practice (the role of

nursing in care delivery for seriously ill patients) was progressively transforming through

these self-reflective interviews.

CHAPTER 5

DISCUSSION

This chapter provides an overview of the study and discussion of findings.

Similarities and differences between the findings of this study and other relevant studies

are discussed. In addition, discussion on how trustworthiness criteria were demonstrated

throughout the study are detailed. Study strengths and limitations, implications for

practice, and implications for future research, as well researcher reflections are also

provided.

Overview of the Dissertation Study

An interpretive phenomenology, qualitative approach was utilized in this study to

answer the research question, what are NGRNs lived experiences of providing PC for

seriously ill patients in acute care settings? A preliminary review of literature provided

key insights to establish relevance and need for the study. Previous studies reported

nurses continue to associate PC with oncology patients and specific settings such as

home, inpatient PC units, or ambulatory hospice settings (Bergenholtz et al., 2015;

Oliveira et al., 2016; and Santos et al., 2017). Bergenholtz and colleagues' (2015) study

of organizational cultures and nurses' PC experiences identified a lack of common PC

understanding and nursing practice. Despite well-published reports citing the benefits of

multidisciplinary, collaborative PC for patients throughout the illness trajectory and in all

acute care settings (Malloy, Ferrell, Virani, & Mazanec, 2018; NCP, 2018; Noble et al., 2018), recent studies also document the pervasive, and erroneous viewpoint of many providers that PC is incongruous with the acute care setting (Chuang et al., 2017; Kennedy et al., 2019).

Previous studies on PC and new graduate (advanced beginner) registered nurses' care delivery focused solely on end-of-life, patient death, and oncology care (Barrere & Durkin, 2014; Croxon et al., 2018; Goodwin & Candela, 2013; Hendricks-Ferguson et al., 2014). These foci limited the possibilities of what could be uncovered to advance NGRNs' (NGRN) PC understanding and practice, interprofessional PC education and collaboration, and patients' and families' desired outcome of comfort in acute care settings. The current study was conducted to address gaps in the literature related to the broadened conceptualization of PC. By focusing on BSN and entry-level masters-prepared NGRNs' perceptions, meanings, and use of principles of PC for seriously ill patients in acute care settings, new insights on PC and new graduate nurses' professional formation in acute care settings could be gained.

This research successfully addressed the purpose and specific aims of the study, and answered the research question. Through multiple readings of the transcribed narratives and review of field notes, the meaning of the text and insight into what it is like for NGRNs to understand and apply principles of PC for seriously ill patients in acute care settings became clearer. Fifteen questions and subsequent clarifying probes were developed by the researcher to engage participants in self-reflective discussion of their experiences of PC and comfort. This study provided a more in-depth understanding and

interpretation than previous studies of NGRNs' PC understanding, nursing practices associated with PC delivery, and meanings of comfort as nursing interventions and an outcome of nursing care. Findings from this study have the potential to advance the art and science of nursing, design and structure of PC nursing education, quality of nursing practice, and patient outcomes for seriously ill patients throughout the illness trajectory and across acute care settings.

<div align="center">Discussion of Findings</div>

Four distinctive themes and six subthemes revealed similarities and differences in NGRNs' PC understanding and nursing practice, and meanings of comfort as interpreted from their stories of caring for seriously ill patients in complex acute care situations and settings. Themes and subthemes for this study are: 1) trying to figure out what the balance is (knowing my place; the care they deserve); 2) working in the dark (an unfamiliar place; being mindful); 3) it's just who I am (character); and 4) the Kairos effect (professional formation). Kolcaba's (2003) comfort theory and Benner's (1984) novice to expert and competencies of the helping role were applied to the conceptual framework developed for this study. Interpretation and discussion of the findings of this study will be framed in the following contexts: the themes and subthemes, extant relevant literature, research question, conceptual framework, and specific aims.

Trying to Figure Out What the Balance Is

The NGRNs' lived experiences of trying to figure out what the balance is revealed intense emotions and heightened self-awareness as NGRNs' reflectively shared their stories. Participant responses reflected a sense of burden, tension, and angst as they

perceived suffering and the weightiness of ethical decision-making for seriously ill patients. Compounding the sense of burden, tension, and angst were NGRNs' lack of clarity or confidence in their new professional role, including the ability to accurately assess patients' comfort needs, communicate comfort needs with members of the care team, or perform nursing interventions, which promote comfort. Findings emerging from this section reflect NGRNs' beginning transformation from a theoretical and task-oriented base to more skillful advanced beginners.

Meanings of PC in acute care settings were fluidly subjective, and interdependent with intrinsic factors of NGRNs' being and extrinsic influences of organizational culture. Many participants in this study were highly attentive to patients' suffering. Being witness to patients' and families' physical pain and perceived suffering from acute or chronic serious illnesses were vividly described throughout this study. Their experiences were consistent with themes from Gaignard & Hurst's (2019) exploratory study of experienced PC and primary care providers' perceptions of existential suffering in seriously ill patients. In Gaignard & Hurst's study, existential suffering was directly linked to goals, patient autonomy, and patients' quality of life. Similar to this current study, participants' perceptions in the Gaignard & Hurst study identified themes related to patients' "loss of hope for a better future, financial burden, and loss of pleasurable activities" (p. 1).

In a qualitative study of intensive care unit (ICU) nurses caring for terminally ill patients, Leung et al. (2015) identified a primary theme of internal tension. According to their findings, ICU nurses wanted to lessen families' perceived suffering and respect

families' hopes for curative treatments, and therefore determined what information to withhold and when to withhold it based on their perceptions of families' readiness for PC discussions. Participants in this current study also experienced internal tension, angst, moral dilemmas and moral distress in response to patients' suffering. However, unlike the ICU nurses in the Leung et al. study with nurses who had lengthy critical care experience (mean=18 years) and nursing experience (mean=24 years), NGRNs' in this current study had less than one year of professional nursing experience and did not believe they were in a position to discuss PC with patients.

The foremost meaning of PC in this study was the outcome comfort. However, for NGRNs in this study, the processes of providing comfort care to alleviate patients' perceived suffering was overwhelmingly reflected upon as intimate, compassionate caring discordant with the acute care setting. The prevailing perception of the acute care culture was interpreted as a place of extreme measures, reflected in one participant Deborah's perception, "we can intervene, so we must." Furthermore, the acute care setting was often referred to as a scary place, and not intuitively seen as a place of comfort. Georgiadis, Corrigan, & Speed's (2017) study of nurses reported nurses' experiences of moral dilemmas and moral distress in cases of terminally ill patients in acute care settings. Findings from that study were strongly associated with nurses' perceptions of incongruity between personal values and nursing practice and could be similarly attributed to NGRNs' perceptions and experiences in this study.

Stories shared by many of the NGRNs likened PC in acute care settings to a continuum between extreme measures and giving up. Negotiating the space (balance)

between opposites was emotionally draining, frustrating, and exhausting for these NGRNs. Their perceptions of 'cure at all cost'—extreme measures—exacerbated their perceptions of emotional burden and moral distress. As NGRNs' responses reflected empathy, compassion, and respect for hope, similar to the Leung and colleagues' (2015) study and the Gaignard & Hurst (2019) study, NGRNs in this current study struggled with how to reconcile concerns toward quality of life (i.e. "the care they deserve") and scope of practice boundaries (i.e. "knowing my place").

In the context of complex patient situations in acute care settings, NGRNs' stories commonly expressed the exponential weightiness of caring for seriously ill patients. Providing comfort care beyond pain and symptom management in acute care settings, according to several participants, was a thoughtful, albeit unskilled, balance between hope and false hope for complex patients. In their initial stories, participants struggled to grasp interconnectedness of cure and comfort in acute care settings; rather, new graduate nurses' experiences emphasized concepts of cure and comfort as working at cross-purposes and, at times, disconnected from patient-centered, quality of life goals and plans of care. Bergenholtz et al. (2015) study of palliative nursing care in non-PC hospital settings reported similarly that nurses struggled with the seeming incongruence of medical care and PC in hospital settings. Similarities between many participants' perceptions of extreme measures in acute care settings revealed intense sources of NGRNs' internal tension and angst.

Harrison et al. (2017) also explored moral distress among nurses in acute care organizations. Organizational complexity in acute care settings, including structures and

processes such as professional relationships among members of the care team, role

delineation and expectations, communication with patients and families around goals and

plans of care, and ethical care delivery were discussed. Harrison and colleagues' (2017)

stated,

> "Organizationally-mediated ethical tensions may result in moral distress – an
> inability to act in accordance with one's ethical beliefs due to institutional
> constraints" (p. 3).

Similar to nurses in these studies of moral dilemmas and moral distress, NGRNs'

perceptions of patients' and families' suffering, and communications with patients and

providers regarding serious illness were challenging factors, which impeded their

perceived ability to provide comfort. Subsequently, their stories revealed common

experiences of powerlessness, moral dilemmas, and moral distress as they struggled to

know their place in care delivery for complex and seriously ill patients. Knowing their

place included reflecting on organizational culture and understanding what they could or

could not say to seriously ill patients regarding diagnosis, prognosis, or plans of care.

Fantus, Greenberg, Muskat, & Katz (2017) also explored the concepts of moral

dilemma and moral distress in experiences of PC discussions among acute care social

workers, nurses, and providers. Fantus et al. (2017) noted the experiences of moral

distress in hospital-based social workers were intense because social workers do not

practice autonomously, but are "part of a large and often complicated web of

relationships" (p. 2277). Similar to the findings described by Fantus et al. (2017),

Georgiadis et al. (2017), and Harrison et al. (2017), the NGRNs in this current study also

struggled with navigating complicated relationships with providers and other

interprofessional colleagues. The resulting tension and angst experienced by the

NGRNs' mirrored other care providers' moral dilemmas and moral distress. The nature

and complexity of these relationships were implicit in NGRNs' sense of helplessness,

powerlessness, and angst in complex and emotional patient situations with seriously ill

patients.

In the current study, communication between provider and patient was perceived

to be important to patients' and families' understandings of PC and experiences of

comfort. However, most of the participants in this study felt it was not their place to

initiate PC discussion even though they verbalized comfort as the desired outcome.

Chuang et al. (2017) explored physician assistants' experiences of communicating with

terminally ill patients in an acute care organization. Physician Assistants (PA) from that

study reported similarly to NGRNs in this study that most patients and families expect to

receive chronic and terminal illness diagnosis, goals and plans of care, and PC

information from physicians.

Nearly all participants voiced strongly that what patients and families know, how

and when they are communicated with, and who is responsible for seriously ill patients

directly affect comfort, either positively or negatively. However, most NGRN

participants perceived themselves, initially, as powerless, inept, and unprepared to

communicate with providers and advocate for the comfort needs of patients. Findings

reported in Kisorio & Langley's (2016) study of ICU nurses' indicated transparent

communication with providers was essential to patients' and families' comfort in the

ICU. Similar to findings reported in Kisorio & Langley's (2016) study, in the current

study, perceived ambiguous or ambivalent communication about PC by providers often

hindered the possibilities of immediate relief, ease, and transcendence for patients and

families. Many NGRN participants observed providers' reluctance to initiate PC

conversations with patients and families, and they perceived this reluctance as a

significant barrier to PC utilization and patients' comfort. When providers were

perceived by NGRNs to be delayed, disengaged, disingenuous, or otherwise in disregard

of a focus on quality of life, the outcomes of comfort were inevitably threatened and

NGRNs experienced greater distress.

Kentischer, Kleinknecht-Dolf, Spirig, Frei, & Huber. (2018) explored the concept

of complexity in their study of patient situations in acute care hospitals and the

subsequent impact on nurses and nursing care. As reported in Harrison and colleagues'

(2017) study, and similarly by Kentischer et al., complex patient situations—sicker

patients hospitalized during the most vulnerable phases of their illness—are perceived to

be more challenging when exacerbated by organization complexities such as limited time

(shorter length of stay), capital (equipment and supplies), or human resources

(interprofessional collaboration, and teamwork on nursing units). In the current study,

NGRNs' perceptions and observations of complex patient situations in acute care settings

were similarly stated. In the same way Kolcaba (2003) defined intervening variables as

factors over which nurses have little or no control, Kentischer and colleagues' study

reported the theme of "mediating factors," which adversely influence nurses' experiences

with complex patient situations.

The theme and subthemes of trying to figure out what the balance is were also interpreted through the conceptual framework for this study. Trying to figure out what the balance is addressed Kolcaba's (2003) appropriate and timely interventions, caring and empathy, and intent to comfort, and the competencies adapted from the helping role (Benner, 1984), including: 1) interpreting comfort needs and selecting appropriate strategies; 2) maximizing the patient's participation and control in his or her own comfort; 3) guiding a patient through emotional and developmental change; 4) providing comfort measures and preserving personhood; 5) providing comfort and communication through touch; 6) providing emotional and informational support to patients' families; 7) presencing or being with the patient; and 8) creating a climate for establishing a commitment to healing.

Trying to figure out what the balance is also incorporated NGRNs' perceptions related to intervening variables—experiential contexts over which NGRNs had little or no control. For the purpose of this current study, and themes and subthemes of trying to figure out what the balance is, these experiential contexts included complex patient situations, interprofessional communication and collaboration, and patients' experiences of comfort care in acute care settings. Intense awareness of patients' suffering, moral distress, and comfort were primary elements in NGRNs' initial understandings, meanings, and contexts of comfort and PC and created the boundaries between which they had to find the right balance for their practice.

Working in the Dark

  In the current study, the diagnoses and unpredictability of prognosis associated with serious or life-threatening illnesses were analogous to an unfamiliar place for participants as well as patients. Participants, regardless of nurse practice setting, were initially challenged to understand the holistic needs of patients who were unable to speak for themselves or care for themselves. Providing comfort for these patients was likened to working in the dark. When patients were unable to communicate comfort needs, NGRNs relied on family and/or caregivers to provide insights, which were both desired and needed, for comforting patients and informing goals and plans of care. Understanding what was important to patients elevated NGRNs' nursing care from doing for patients, to more meaningful experiences of being with patients, and enhanced comfort.

  Shippee, Shippee, Mobley, Fernstrom, & Britt (2017) utilized a quasi-experimental, longitudinal research design to examine a whole-person model of care on seriously ill patients' experiences. Findings from their study reported that a whole-person model of care had positive effects on these patients. In the current study, several participants expressed seeing the patient as a person. For these participants, this seeing the whole person beyond physical needs, pain, and symptom management advanced their understanding of patients' unique care needs and appropriate measures of comfort. Unlike the current study, Shippee and colleagues' study fell short of explicating defining attributes of whole-person care. Participants' experiences of being empathetic, paying attention, and listening to seriously ill patients provided defining attributes of nursing

process, which are most meaningful to patients' experiences of comfort and quality of life

care. To the extent in which most NGRNs were able to reflect on their assessments of

seriously ill patients—beyond pain and symptom management to care of the whole

person—meanings of enhanced comfort were clarified.

Only a few of the NGRN participants in this study realized the significance of

patients' core beliefs of spirituality or cultural contexts. These few discussed how

patients' core religious and spiritual beliefs were intricately woven into patient autonomy.

They observed how prayer, faith, religious writings, or spiritual connectedness helped

patients transcend psychological despair and "dark places" along the serious illness

trajectory. While not explicitly stated, understanding sociocultural needs possibly added

to what was already perceived by NGRNs as very emotional work.

Haugland, Lassen, and Giske's (2018) study of undergraduate (BSN) nursing

students aimed to provide insights on how experiences in complex patient situations

impacted BSN students' personal values and nursing practices. Their study emphasized

the importance of self-awareness, particularly when others' cultural values differ from

one's own. Most notable from their study, and in contrast to the NGRN participants in

this study, was the inference that self-awareness, caring, and ethical nursing practice

require intentional interest in and respect for cultural similarities and differences. This is

not intended to convey the NGRNs in the current study were not respectful of other

cultures. Making the distinction between Haugland and colleagues' study and the current

study is meant to draw attention to the fact that, without exception, NGRNs had difficulty

articulating how culture may influence patients' experiences of serious illness and

comfort and, without exception, NGRNs were not intentional in their assessment of

sociocultural needs. Assessment of these needs were often incorrectly delegated to other

disciplines, such as social work. This lack of sociocultural understanding appeared to

reflect, simultaneously, NGRNs' acceptance of diversity in patient populations but

cultural incompetence.

Several studies have also linked comfort, culture, and psychosocial needs to

disparities in PC delivery (Evans & Ume, 2012); spiritual competency and care (Balboni

et al., 2017; Evans & Ume, 2012; Taylor et al., 2017), and the value of hope (Alonzo,

2017; Seyedfatemi et al., 2014) when caring for seriously ill patients. Findings from

these studies support what was found with the NGRNs; most healthcare professionals,

inclusive of NGRNs, remain reluctant to assess cultural, spiritual, and psychosocial needs

with patients, and therefore limit the possibilities of what could be learned from

conversations with patients and families to promote comfort.

What was noted in this current study were NGRNs' intentional actions to provide

comfort in their relationships with seriously ill patients. A few participants recognized

the significance of idioms and word choices. Observing, listening, and paying attention

to patients' verbal and nonverbal expressions of anger, bitterness, anxiety, and stress

increased NGRNs' contextual understanding of patients' illness experiences. Some

participants intentionally created a healing environment in the acute care setting through

art, music, lighting, laughter, patients' personal photographs, tone of voice, and presence.

Estores & Frye (2015) in their qualitative study of environmental conditions in the ICU

reported findings of essential oils, acupuncture, and acupressure as part of the healing

environment support the meaningful nursing intervention of touch. Consistencies

between this current study and the research of Estores & Frye (2015) are found in

participants' perceptions of the healing powers of touch. Several NGRNs in the current

study shared stories of holding patients' hands and physically touching patients and

families when appropriate.

Some of the participants in this study were able to recognize how the environment

is part of the healing process, is perceived by patients as meaningful care, and enhances

patients' experiences of comfort. These NGRN participants were perceptive to how the

perceived confinements of being in the hospital affect both psychological state and

physical comfort. Findings from this current study support similar studies that have

reported the positive impact of intentionality of the patient as a whole person on patients'

experiences of comfort, including art (Shella, 2018), acute care environment (Estores &

Frye., 2015; Krinsky et al., 2014), spirituality (Balboni et al., 2017), and touch (Håkanson

& Öhlén, 2015; Harstäde, Blomberg, Benzein, & Östlund, 2017) to preserve personhood,

dignity, and comfort for patients and families in acute care settings. As NGRNs' began

to consider contexts of human needs beyond physical pain and symptom management,

they were better able to recognize and articulate the meanings of comfort and nursing

care interventions in acute care settings.

It's Just Who I Am

Knowledge, understanding, and interpretation of principles of PC varied among

participants, although this variability was independent of the acute care setting.

Participants in this current study who had prior personal or volunteer experiences with

seriously ill patients appeared more comfortable with deep questioning, listening, and engaging with patients and families. Similar to findings from the baccalaureate-prepared nursing students in Haugland and colleagues' study (2018), these NGRNs' current experiences of caring for seriously ill patients were reminiscent of vulnerability, compassion, and learned behaviors of comfort care received in their own lives.

Demographic data from previously reported studies (Aslakson, Curtis, & Nelson 2014; Chuang et al., 2017; Escher et al., 2019; Estores & Frye, 2015; Fantus et al., 2017; Graham et al., 2018; Hetland, McAndrew, Perazzo, & Hickman, 2018; Khandelwal et al, 2017; Leung et al. 2015; Oliveira et al., 2018; White et al., 2014) included participants with more lived experiences, including nursing experience and age. Being empathetic, being attentive, and being mindful were most often attributed by NGRNs' personal values, beliefs, and worldview rather than understanding of principles of PC—*it's just who I am*.

Sterner, Hagiwara, Ramstrand, & Palmér (2019) explored factors, which affect nurses' ability to provide care in acute situations. While Sterner and colleagues' study was not specific to PC or comfort, one theme from their study, personality traits, was of particular interest to this current study. Sterner et al. noted self-confidence and courage as personality traits, which affect care. Many NGRN participants in this study did not express confidence in their nursing assessment, judgments, or practices for seriously ill patients in their acute care settings. However, during the course of interviews, some personality traits or characteristics were noted in a few of the NGRNs' stories. These

NGRNs expressed confidence in their intuition about comfort needs and comfort care chiefly from personal values.

The research question for this current study—what are NGRNs' lived experiences of providing PC for seriously ill patients in acute care settings—was based upon an a priori assumption that participants would have a common educational foundation in and understanding of PC. Similar to participants' understanding of academic knowledge in the Sterner et al. (2019) study, NGRNs reflected some formal educational knowledge of PC from their BSN programs. However, most participants in this current study reported their PC education as mostly unmemorable and unremarkable, a blur. Participants in this current study articulated the meaning of PC as comfort for seriously ill patients. However, the processes, or nursing interventions, which promote comfort, were not always readily apparent or easily understood. Subsequently, many NGRNs' lived experiences reflected dissonance between academic knowledge and PC understanding. Findings from Adesina et al. (2014); Ankers, Barton, & Parry, 2018; and Hold et al. (2015) and also reported academic education (i.e. formal PC nursing education) lags behind nursing practice, thereby inferring, this gap between formal education and current nursing practice contributes to lack of PC understanding and PC use across nurse practice settings. Ankers and colleagues (2018) suggest that due to increasing patient and organizational complexities, it may be impossible for academic education to ever keep pace or fully prepare nursing students for professional nursing practice.

Consistent with characteristics of the advanced beginner (Benner, 1984), knowing what (i.e. understanding patients' holistic comfort needs and contexts in acute care

settings), and knowing how (i.e. applying appropriate comfort care based on unique contexts) were challenging for many NGRNs. Participants' initial responses during interviews were impacted by their limited experiential learning. As advanced beginners, following orders and completing tasks were expected nursing care, although NGRN participants expressed wanting to do more. When most NGRNs began to share their stories of caring for seriously ill patients, they had limited understanding of how nursing interventions such as bathing patients, listening to patients' and families' concerns and goals, or adjusting room lighting or room temperature based on patients' comfort preferences could be consistent with a comprehensive PC approach.

The know-how of experienced nurses' understanding of comfort and use of comfort care in PC settings was explored by Durante et al. (2014). Similar to the current study, findings reported by Durante and colleagues emphasized experienced nurses' initial focus on physical comfort needs and technological aspects of comfort care. In addition, experienced nurses' in their study felt less prepared to address spiritual, cultural, or psychosocial needs; as a result, possibilities for holistic comfort were limited. No recent studies were found which explicitly explored or examined Benner's characteristics of the advanced beginner applied to new graduate or newly licensed registered nurses' understanding or use of principles of PC for seriously ill patients in acute care settings. However, previously reported studies related to formal PC education (Adesina et al. 2014; Ankers et al., 2018; Hold et al. 2015), reflexivity (Haugland et al., 2018), and caring practices of NGRNs with 6-12 months of professional nursing experience (Sterner et al., 2019) support what was found in the current study.

The theme and subthemes of it's just who I am demonstrated philosophical and practical distinctions between NGRNs' perceptions about and lived experiences of providing comfort. Similar to previously reported findings from other studies, interpreting what patients wanted or needed but could not communicate, knowing the right words to say, and perceiving what nursing interventions were most meaningful to patients' experiences of comfort, were seemingly insurmountable challenges with which they had little or no experience. Even when many NGRNs did not know the right words to say, they unwaveringly believed it was the nurse's responsibility to take excellent care of the patient. Nearly all participants recalled doing general nursing care, which included bathing, turning, mouth care, giving medications, and treating the patient as prescribed. However, what was profound and most indicative of competencies of Benner's (1984) helping role and indicative of expressions of PC understanding were NGRNs' descriptions of their role in providing comfort: "listening to my patient and their loved ones," "addressing questions," "treating my patient with respect," "talking to my patient," "explaining," "teaching," "touching my patient; laying hands on them," and "communicating what is now and what is next."

The Kairos Effect

The participants in this study demonstrated extraordinary moral character and foundation for professional formation. Most of them highly valued ethical nursing practices such as promoting quality of life versus extreme measures (beneficence and non-maleficence), communicating truthfully with patients and families about goals and plans of care (veracity), being consistent in care planning and care delivery (fidelity), and

being respectful and non-judgmental of patients' values and care preferences.

Participants spoke of attending to needs, even the smallest ones, and trying to predict the

needs of patients and meet them, even before patients knew what they wanted. These

findings were consistent with those reported by Durante et al. (2014). Guided by

Kolcaba's comfort theory, Durante and colleagues' explored nurses' perceptions of

comfort and types of nursing care for patients admitted to PC settings. Ethical nursing

care and attending to what nurses perceived as the smallest, almost non-skilled nursing

practices were very meaningful to patients' experiences of comfort.

In their study of professional formation, Haugland et al. (2018) explored the

concept of professional formation through nursing students' observations of complex and

vulnerable patient situations. Students' responses were intended to give insight to four

key components of Christian doctrine (values): love, inclusivity, caring, and justice. The

researchers from that study posited these values as fundamental to nursing practice and

professional formation. They emphasized the importance of self-awareness, particularly

when others' cultural values differ from your own. Citing both Benner (the importance

of experiential learning and reflection to professional formation and caring) and van

Manen (the importance of reflection before action, in action, and on action), Haugland

and colleagues' linked reflective practice and greater awareness of values to students'

perceptions of more meaningful caring practices such as compassion and empathy.

As reflection on action increased, most NGRNs began to understand being there

for the patient, being with the patient, holding hands, sitting in silence, attending to the

whole person, anticipating needs, giving the patient options, relying of families when

patients were unresponsive, and seeing the patient "outside of his or her serious illness" as principles of PC and more easily associated these nursing processes with comfort outcomes for patients. Findings from this study indicated NGRNs with less than one year of professional nursing experience applied principles of PC daily, with almost every patient, and in every nurse practice setting. NGRNs' lived experiences of providing PC in acute care settings were most assuredly time-consuming, and emotionally and ethically taxing. However, these PC experiences were also rewarding, validating and, overall, important and affirming for NGRNs' professional formation.

Guided by a hermeneutic phenomenology approach, the lived experiences of newly licensed registered nurses in a transition to practice program were explored by Ankers et al. (2018). The mean age of participants in that study was 34.8 years, considerably higher than the mean age of NGRN participants in the current study. One theme reported in that study was "sink or swim," where Auker and colleagues' participants reported being more compelled to complete tasks than listen to patients, even though they recognized the inherent danger this could pose to patient outcomes. They related this feeling of sink or swim to perceptions of support from experienced nurses and other members of the care team. They recognized the value and importance of experienced (i.e. knowledgeable, approachable, and resourceful) nurses and providers, but only a few of the participants in that study experienced such support.

Participants in the current study were enrolled in a professional transition to practice program (TTP). The relationship of their enrollment in the TTP program and perceptions, meanings, and experiences of PC where not explored in this study.

However, most of the NGRNs spoke of and highly valued the experience of their nurse preceptors. They did not identify the experienced nurses' knowledge, skills, abilities, or attitude toward seriously ill patients with PC or a palliative approach. However, they did observe and similarly articulate what they perceived as nursing actions, which promote comfort. Thus, unlike participants in the Ankers' et al. study, most NGRN participants in this study often spoke of wanting to do more than simply follow tasks or orders, and they felt empowered by their experienced nurses to do so.

The phenomena of interest for this current study and conceptual framework based on Kolcaba's comfort theory and Benner's competencies of the helping role elucidated essences of NGRNs' caring, competence, and confidence, which improved patients' experiences of comfort. Consistent with findings from the literature, lack of PC understanding across non-PC specialists and healthcare disciplines (Carduff, et al., 2018; Monterosso, Ross-Adjie, Rogers, Shearer, & Rogers, 2016) was found in this current study. However, as participants thoughtfully reflected upon experiences of caring for seriously ill patients, use of principles of PC and beginning conceptual clarity began to emerge.

<center>Implications</center>

As acute healthcare delivery shifts to value-based systems, performance on quality measures and clinical outcomes, as well as effective nursing strategies, are essential to achieve safe, high quality, and effective care. Nursing interventions which improve comfort are of increasing significance to the overall patient and family experience of care in acute care settings (Johnston, Gaffney, Pringle, & Buchanan, 2015;

Lind, Wallin, Brytting, Fürst, & Sandberg, 2017; Zalonis & Slota, 2014). Relevance for

this study was posited as a need to explore unexamined areas of PC knowledge,

understanding, and use among bachelors- and entry level masters-prepared NGRNs

caring for seriously ill patients in acute care settings. Findings from this study have

important implications for nursing practice, nursing education, and future nursing

research.

Implications for Nursing Practice

Nursing practice guided by a palliative approach can improve structure, processes,

and outcomes for seriously ill patients across all acute care settings (Black, McGlinchey,

Gambles, Ellershaw, & Mayland, 2018; Hahne, Lundström, Leveälahti, Winnhed, &

Öhlén, 2017). More specifically, findings from this study confirmed findings from

previous studies which indicate nurses can use a palliative approach to transform

patients' experience of enhanced comfort in any nurse practice setting (Ahluwalia et al.,

2018; Altaker, Howie-Esquivel, & Cataldo, 2018; Hahne et al., 2017). Furthermore,

findings from the current study indicate that principles of PC and competencies of the

helping role can be applied regardless of years of experience. The addition of comfort

theory to PC and the helping role may be a plausible operational framework supportive of

autonomous nursing practice and the caring ethos most nurses embrace and help

transform nursing care and the nursing profession. This framework may also strengthen

NGRNs' professional formation and transition into professional nursing practice. This

framework can be used to transform thinking, understanding, and communication of PC

beyond oncology-specific care, end-of-life or imminent death, and settings such as intensive care unit, palliative care unit, or hospice.

Implications for Nursing Education

Prior personal experiences and experiential learning were found to be the greatest influences on NGRNs' understanding and application of comfort. PC experiences, being witness to suffering, and professional formation were more ethos-driven than academically attained. An a priori assumption of this current study was that the American Association of Colleges of Nursing's (AACN) 2016 endorsement of the End-of Life Nursing Education Consortium's (ELNEC) curricula and CARES (competencies and recommendations for educating undergraduate nursing students preparing nurses to care for the seriously ill and their families) would translate into widespread adoption and implementation of PC in nursing programs was not evidenced in findings. All of the participants in this study graduated from baccalaureate or MSN nursing programs in 2017. None of the participants in this study recalled ELNEC or CARES as part of their undergraduate learning. Moreover, if they could recall PC learning at all, recollection was little more than "a blur." This was astounding and troubling. Findings from this study could be used as impetus for the evaluation of baccalaureate nursing programs' curricula for intentional and structured PC content design and delivery. Palliative care content could be a foundational philosophical approach to increase understanding, application, and value to nursing practice, and an independent curricula for nursing programs rather than an add-on to other course content, as was reported by all but one participant in this study.

Implications for Future Nursing Research

Recommendations for future research include: 1) development and testing of a transition to practice (TTP) program based on the framework supported by this study; 2) application and testing of the framework to broader practice populations such as experienced nurses or interprofessional teams, and its effect on nursing (satisfaction, autonomy, quality); and patient outcomes (satisfaction, length of stay, patient education, courtesy and respect, responsiveness, and careful listening); 3) application and testing of the framework to academic and clinical nursing education; and 4) qualitative research which explores whether findings from this study could be replicated or refuted based on organizational factors, including Magnet versus non-Magnet designation, ethical organizational culture, or absence of structured transition to practice programs. Finally, the concepts of burnout, compassion fatigue, psychological burden, spirituality, and coping among healthcare providers were not explicitly explored in this study of NGRNs; however, congruence with these concepts was evident in the themes and subthemes of trying to figure out what the balance is, and further research on these topics is warranted.

The Kisorio & Langley (2016) study, like several recent PC studies which were reviewed following data analysis for the current study, focused on the complex needs of patients in the intensive care unit. Utilizing various methodologies, these studies of experienced, and generally older in years, critical care and emergency nurses and their patients echo perceptions of lack of educational preparedness, PC understanding, and interprofessional collaboration; poor or inadequate patient and family communications; and subsequent moral distress in acute care settings. It would appear from these recent

studies, the discourse on PC has expanded beyond oncology, inpatient PC, and hospice settings. However, PC and comfort have not been equally addressed among medical-surgical and perioperative settings where patient acuity is rapidly increasing. What this current study highlights is that complexities of patient care for acutely, seriously ill patients are no longer unique to critical care settings or PC specialists. The effects of higher acuity on care delivery and comfort outcomes across acute care settings demand greater sensitivity to and preparedness for comfort and quality of life beyond critical care settings—more so for unexperienced care providers.

<div align="center">Trustworthiness</div>

Sources of potential threats to trustworthiness are credibility, dependability, confirmability, and transferability. Lincoln and Guba's (1985) trustworthiness criteria provided valuable strategies to increase trustworthiness for this dissertation research. Specific strategies used to establish credibility included prolonged engagement, purposive sampling, iterative interview technique, reflexivity, use of field notes and journals, triangulation of data from multiple data sources, and peer examination. The researcher met with the dissertation chair for peer debriefing on all transcripts, qualitative coding, and thematic analysis. Dependability was achieved through field notes, design description, and operational details of data gathering. Confirmability was achieved by an audit trail with documentation of theoretical and methodological decisions, including careful documentation of extant literature searches and sources, objectivity (acknowledgments and review of researcher's a priori assumptions and biases), and data triangulation.

Transferability seeks to verify that the lived experiences of participants from a study would be similar to the lived experiences of the phenomena studied in another group of participants similar to the initial study's participants (Lincoln & Guba, 1985; Macnee & McCabe, 2008). It is important to note that in qualitative research, "it is not the researcher's job to provide an index of transferability; it is his or her responsibility to provide an adequate database to allow transferability judgments to be made by others" (Krefting, 1991, p. 221). In this study, strategies used to strengthen transferability included thick descriptions and rich data for interpretation of themes and subthemes. A thick description is defined by Lincoln and Guba (1985) as specifying the smallest components required in order that another person considering the use in an alternative situation could make comparable links. In addition, transferability strategies used in this study were the use of demographic information available for the group being studied and detailed description of recruitment strategies including inclusion and exclusion criteria.

Limitations

Although the purposive sampling and recruitment techniques chosen for this study were considered appropriate to capture a potentially larger sample, opportunities for face-to-face recruitment and enrollment according to the RN experience inclusion criteria (greater than six months but less than one year) were limited by the schedule and frequency of Nurse Residency Program (NRP) cohorts and sessions. In most qualitative studies, sample size is determined by data saturation. However, there were no opportunities to recruit additional participants within a reasonable time period beyond the 12 participants. Thus, saturation cannot be assumed.

Similar to other interpretive phenomenology qualitative studies, the sample size of 12 participants in this study was small. In addition to the aforementioned time limitations, other factors related to NGRNs' willingness to participate are not known. One possible factor may be directly related to NGRNs' lack of PC understanding. The appropriateness of exploring the construct of PC within and across acute care settings may have been beyond most NGRNs' academic or experiential understanding. Many of the NGRNs who are most interested in high acuity, technology, and skills-based learning may have been unable or unwilling to grasp the extent to which principles of PC could be relevant to their approach to care delivery and patient outcomes. These possible factors may have also contributed to the smaller sample size.

Participants for this study were female (n=11), male (n=1), Caucasian (n=6), and Hispanic, Black, or other (n=6). There were no participants from perioperative services. Given the previous limitations related to sample size, it is unknown whether a larger sample size would have resulted in a more diverse (race/ethnicity, gender, and work setting) sample. Also, the demographic data collection did not include questions related to marital status, children, or spirituality as seen in other studies' participant demographic data. Participants' responses to these questions may have provided additional insights from which to interpret NGRNs' lived experiences.

Researcher Reflections

Reflexivity was essential throughout this dissertation process. Self-reflection enabled me to remain humble, remember purpose, and avoid projecting my thoughts, beliefs, attitudes, assumptions, and biases onto participants. Reflexivity allowed

interviews and interview responses to unfold without judgments or undue influences from me. Similarities were noted in most participants' responses of physical and cognitive limitations related to serious and life-threatening illness. Yet, NGRNs' self-reflection and awareness of patients' psychological, spiritual, social, cultural, and environmental needs often required the use of more in-depth, clarifying probes, and repeated rephrasing during participant interviews. Field notes and reflective journaling were therapeutic tools used to channel my opinions and feelings, particularly when participants' responses differed from my personal worldview. Thankfully, differing perspectives and worldviews did not occur often in this study.

George Bernard Shaw is famously quoted as penning the phrase for one of his literary works in 1903, "those who can do, and those who can't teach." I would rather be quoted as emphatically stating, "those who can do and teach." In my mind, this statement is consistent with the philosophical underpinnings of Sir Francis Bacon, as it draws upon both knowledge and action for the greater good. In this statement, I find the conviction, catalyst, and vision necessary to answer the call for radical transformation in nursing practice and nursing education.

I was not a great student in my baccalaureate program. This is my confession. I struggled. This struggle was devastating for my self-esteem and early formation as a professional registered nurse. I knew I had the mind to be a great nurse. However, what I did not know, understand, or have the ability to articulate until many years post baccalaureate program was why I struggled as an undergraduate nursing student and novice nurse. I do and teach because my struggle was not singular. I do and teach

because my struggle was an opportunity to cultivate and clarify purpose and a gift entrusted to me. I view my pedagogical approach to nursing as an opportunity to educate and develop generations of nurses, who may struggle as I did, into intellectually astute and caring professionals.

As I complete this work, I am as excited about the findings as I am about the possibilities of further exploration of PC and new graduate nurses. Findings from this study further increased my interest in NGRN factors, including but not limited to, baccalaureate-nursing education curricula for second-degree accelerated programs versus traditional nursing programs, and organizational culture, including the influence of academic healthcare systems, Magnet designation, and accredited nurse residency programs on ethical caring. Because of this dissertation research, my pedagogy for acute care nurse practice settings is strengthened. I am absolutely grateful for this opportunity to bridge gaps in nursing knowledge and advance the nursing profession.

Nursing pedagogies that begin with the end in mind are those that will care for students, nurses, populations, and the profession. In this I mean, creating intellectually stimulating teaching and learning environments within clinical settings, which demonstrate understanding of the domains of adult learning, as well as the diversity and universality (i.e. ways of being) in nursing. Moreover, I am a firm believer in situated learning as essential to shaping and molding the analytical, creative, and agile minds required for our high-paced, diverse, and complex populations in most acute care settings. This was essential to my formation as a nurse. Advanced beginner nurses must

be given the opportunity to apply their academic knowledge in learning environments that challenge them to consider multiple factors, which affect health.

Conclusion

The purpose of this research study was to discover NGRNs' perceptions, meanings, and use of principles of PC for seriously ill patients in acute care settings. The research question for this study was: What are NGRNs' lived experiences of providing PC for seriously ill patients in acute care settings? The conceptualization of this study required NGRNs to think beyond the contexts of end-of-life, PC setting, and death.

Kolcaba's (2003) comfort theory and Benner's (1984) competencies of the helping role guided the conceptualization of this study and formed the framework for phenomenological questioning and reflection. An interpretive phenomenology methodology was chosen to explore and interpret participants' PC awareness, and their perceptions of being in professional nursing and acute care settings. A purposive sample of 12 bachelors- and masters-prepared registered nurses, with less than one year of professional nursing experience, were recruited and consented to participate in this study. Using Saldaña's coding methods, and guided by van Manen's (1990) thematic analysis, four themes and six subthemes were developed.

This study intended to advance the body of nursing knowledge by addressing two primary gaps in extant literature: 1) NGRNs' application PC principles in the care of seriously ill patients and their families in acute care settings; and 2) use of comfort theory and competencies delineated in the helping role as a framework to improve NGRNs' care delivery for seriously ill patients. Structures and processes within acute care settings

should be in place to augment and advance PC understanding, integration, and quality of life outcomes. Palliative care evidence-based and patient-centered practices, PC performance measures, and accessibility and availability of interdisciplinary PC specialists strengthen the possibilities of enhanced comfort for patients and quality of nursing care.

NGRNs' experiences of providing PC for seriously ill patients in acute care settings are emotionally- and ethically-laden. Participants in this study were perceptively mindful of the weightiness of patients' suffering, autonomy, and comfort. Providing PC—comfort as an intervention—was often perceived as challenging, nondescript, other-than-nursing work. However, knowing patients' implicit and explicit complexities and seeing the patient as a person were intuitively understood as meaningful to patients' experiences of comfort. Common and valued experiences of listening to patients, paying attention, touching, being with, advocating, negotiating options, and navigating relationships demonstrated extraordinary insight and depth of understanding toward professional formation in nursing practice.

Specific aims for this study were to uncover: 1) meanings of PC in acute care settings, 2) NGRNs' understanding of principles of PC, 3) NGRNs' use of principles of PC; and 4) outcomes of a palliative approach. This study is significant in that findings provided new knowledge and phenomenological insights to improve NGRNs' nursing practice, patient outcomes for the acutely ill patients and their families, and overall organizational culture. Based on comprehensive review of literature, this study addressed the need for a more in-depth understanding and interpretation of NGRNs' PC experiences

beyond mere description of end-of-life care and the role of facilitating a good death. This current research uncovered NGRNs' perceptions about seriously ill and complex patient situations; understandings and meanings of comfort and PC; developing professional formation in complex patient situations; and essences of comfort and PC which are most meaningful to patients' experiences of comfort in acute care settings. In addition, findings from this study have the potential to inform design and structure of PC nursing education.

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APPENDICES

APPENDIX A

MERCER UNIVERSITY INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

MERCER UNIVERSITY

Institutional Review Board
For Research Involving Human Subjects

Wednesday, July 18, 2018

Ms. Latrina T Geyer
3001 Mercer University Drive,
Georgia Baptist College of Nursing
Atlanta, GA 30341

RE: Baccalaureate-Prepared Newly Graduated Registered Nurses' Perceptions About and Use of Principles of Palliative Care in Acute Care Settings: An Interpretive Phenomenology Study (H1807169)

Dear Ms. Geyer:

On behalf of Mercer University's Institutional Review Board for Human Subjects Research, your application submitted on 11-Jul-2018 for the above referenced protocol was reviewed in accordance with Federal Regulations 21 CFR 56.110(b) and 45 CFR 46.110(b) (for expedited review) and was approved under category(ies) 06, 07 per 63 FR 60364.

Your application was approved for one year of study on 18-Jul-2018. The protocol expires on 17-Jul-2019. If the study continues beyond one year, it must be re-evaluated by the IRB Committee.

Item(s) Approved:
A new application for qualitative interpretive phenomenology method using face-to-face semi-structured interviews to gain a better understanding of the experiences of nurses who use principles of palliative care for seriously ill patients in acute care settings.

NOTE: You MUST report to the committee when the protocol is initiated. Report to the Committee immediately any changes in the protocol or consent form and ALL accidents, injuries, and serious or unexpected adverse events that occur to your subjects as a result of this study.

We at the IRB and the Office of Research Compliance are dedicated to providing the best service to our research community. As one of our investigators, we value your feedback and ask that you please take a moment to complete our Satisfaction Survey and help us to improve the quality of our service.

It has been a pleasure working with you and we wish you much success with your project! If you need any further assistance, please feel free to contact our office.

Respectfully,

Ava Chambliss-Richardson, Ph.D., CIP, CIM.
Director of Research Compliance
Member
Institutional Review Board

"Mercer University has adopted and agrees to conduct its clinical research studies in accordance with the International Conference on Harmonization's (ICH) Guidelines for Good Clinical Practice."

APPENDIX B

SELECTED SETTING INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

Institutional Review Board

TO: Latrina Geyer MSN
        Principal Investigator
        Unassigned Department

DATE: July 30, 2018

RE: **Expedited Approval**

        Baccalaureate-Prepared Newly Graduated Registered Nurses' Perceptions About and Use
        of Principles of Palliative Care in Acute Care Settings: An Interpretive Phenomenology
        Study by Latrina T. Geyer. A Dissertation Research Study in Partial Fulfillment of the
        Requirements for the Degree Doctor of Philosophy. Georgia Baptist College of Nursing
        of Mercer University. Atlanta, GA. 2018

Thank you for submitting a new application for this protocol. This research is eligible for
expedited review under 45 CFR.46.110 and/or 21 CFR 56.110 because it poses minimal risk and
fits the regulatory category F[7] as set forth in the Federal Register. The ▮▮▮▮ IRB reviewed it
by expedited process on July 30, 2018 and granted approval effective from July 30,
2018 through July 29, 2019. Thereafter, continuation of human subjects research activities
requires the submission of a renewal application, which must be reviewed and approved by the
IRB prior to the expiration date noted above. Please note carefully the following items with
respect to this approval:

- Protocol Document dated 7/19/2018
- Semi-Structured Interview Guide Document
- NGRN Participant Demographic Profile Document
- NGRN Consent Form dated 7/24/2018

Any reportable events (e.g., unanticipated problems involving risk to subjects or others,
noncompliance, breaches of confidentiality, HIPAA violations, protocol deviations) must be
reported to the IRB according to our Policies & Procedures at ▮▮▮▮▮▮▮▮ immediately,
promptly, or periodically. Be sure to check the reporting guidance and contact us if you have
questions. Terms and conditions of sponsors, if any, also apply to reporting.

Before implementing any change to this protocol (including but not limited to sample size,
informed consent, study design, you must submit an amendment request and secure IRB
approval.

In future correspondence about this matter, please refer to the IRB file ID, name of the Principal
Investigator, and study title. Thank you

Research Protocol Analyst
This letter has been digitally signed

APPENDIX C

PARTICIPANT RECRUITMENT FLYER

INVITATION ~Nursing Research Study ~ INVITATION

Baccalaureate-Prepared Newly Graduated Registered Nurses' Perceptions About and Use of Principles of Palliative Care in Acute Care Settings

Purpose:
The purpose of this research study is to carefully explore participants' perceptions, meanings, and use of principles of palliative care for seriously ill patients in acute care settings.

Participants for this study:
- Graduate from a baccalaureate nursing (BSN) program in the past 12 months
- Registered Nurse, licensed (RN) in the past 12 months
- Employed full-time (equal to or greater than 36 hours per week)
- Nurse practice settings: medical, surgical, critical care, perioperative, emergency

Expectations:
- Voluntary participation
- One face-to-face interview with the principal investigator (PI)
  - Approximately 60-90 minutes
  - Private meeting room
  - Location most convenient to the participant
- Written informed consent
- Each participant will receive a $20 gift card for completed interview

This research study has received Institutional Review Board (IRB) approvals from Mercer University IRB and Emory University IRB.

~YOUR PARTICIPATION IS GREATLY APPRECIATED. THANK YOU!~

For questions or TO ENROLL in this study, you can contact Trina Geyer (PI) via email or phone:

Latrina T. Geyer, MSN, RN-BC
Principal Investigator (PI)
PhD in Nursing Student
Georgia Baptist College of Nursing of Mercer University. Atlanta, GA

APPENDIX D

MERCER UNIVERSITY PARTICIPANT INFORMED CONSENT FORM

MERCER UNIVERSITY

Georgia Baptist College of Nursing

Baccalaureate-Prepared Newly Graduated Registered Nurses' Perceptions About and Use of Principles of Palliative Care in Acute Care Settings

Informed Consent

You are being asked to participate in a research study. Before you give your consent to volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigators

Latrina T. Geyer, MSN, RN-BC. Mercer University, Georgia Baptist College of Nursing
3001 Mercer University Drive, Atlanta, GA 30341, 215-783-6697

Helen F. Hodges, PhD, RN. Mercer University, Georgia Baptist College of Nursing
3001 Mercer University Drive, Atlanta, GA 30341, 678-547-6746

Purpose of the Research

This research study is designed to explore bachelors-prepared new graduate registered nurses' (NGRN) perceptions and experiences of palliative care for seriously ill patients in acute care settings.

Findings from this research will be used to gain a deeper understanding of what palliative care is like in acute care settings, and how a palliative approach may be used to improve quality of nursing care and outcomes for seriously ill patients across all acute care settings.

Results from this study will be used in fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing.

Procedures

If you volunteer to participate in this study, you will be asked to meet with the principal investigator (PI) for one face-to-face interview session. During this interview, the PI will ask you questions about your experiences caring for seriously ill patients since becoming a registered nurse. Such experiences may include your assessment of patients' needs, nursing interventions, and patients' experiences of comfort. During the interview, you will also have the opportunity to share your perceptions of palliative care education preparation, prior personal experiences with palliative care (e.g., seriously ill relative or friend), or professional experiences with palliative care (e.g., nurse tech on a palliative care or hospice unit).

Your participation will take approximately 60 to 90 minutes.

Potential Risks or Discomforts

This research study is not intended to cause any physical, psychological, emotional, social, or economic risk. However, open and honest communication is vital to this research study. Throughout the interview, you will be asked to reflect on your experiences with seriously ill patients and provide as much detail as you can. As you think about and talk about your experiences—your perceptions, emotions, thoughts, actions associated with the experiences as you lived through them— you may experience some discomfort. Again, this is not an intended outcome. You can share as much as you feel comfortable during the interview. Please let the PI know immediately if you are feeling any discomforts. You have the right to pause or discontinue your interview at any time without consequence.

Potential Benefits of the Research

New graduate registered nurses are recognized as important human resources to future nursing workforce capacity. According to the literature, work environment factors have a powerful influence on new graduate nurse transition experiences.

Exploring NGRNs' experiences will help in identifying factors that may facilitate or impede palliative care delivery in acute care settings; thereby, findings provide new insights to improve quality and outcomes of nursing care.

Confidentiality and Data Storage

Demographic information will be collected for each participant prior to the interview. Demographic questions include name, age, gender, race/ethnicity, highest nursing education level and year completed, highest non-nursing education level and year completed, primary work setting (i.e., nursing unit/department), length of employment in primary work setting, current employment time (i.e., shift), previous and current palliative care or hospice experiences (personal or work-related). You will be asked to create a pseudonym to be used with all data gathering materials associated with your responses. Each form will be labeled with your self-selected pseudonym to ensure confidentiality.

Interview sessions will include written notes and audio recordings. All written notes, audio records, and data transcriptions will be coded to protect privacy and kept in securely locked files accessible only by the principal investigator. Data will be backed-up on an external hard drive on a weekly basis. To ensure safety and confidentiality of data, the external hard drive and documents will be stored in a locked file cabinet in my home office for three years. In addition, the personal computer to be used in this study will be password protected.

Documents will remain in securely protected file cabinets for three years, as mandated by the IRB at Mercer University. After this time period has concluded, all information other than interview transcripts that contain no identifying information will be destroyed. Digital audio recordings will be destroyed at the conclusion of this dissertation process. Interview transcripts will be kept indefinitely, because these transcripts do not include any identifying information.

Narratives and interpretation of themes relating to the study will contain no identifiable information and will be used for scholarly publications and presentations. At no time during this dissertation process or in the future will participants' identifying information be shared or published.

Participation and Withdrawal

Your participation in this research study is voluntary. As a participant, you may refuse to participate at any time. To withdraw from the study please contact Latrina Geyer, principal investigator.

To withdraw, please send an email to ltgeyer@gmail.com. If you feel comfortable, please share any reasons for your decision to withdraw from this study. You are not required to share any reasons if you wish to withdraw.

Questions about the Research

If you have any questions about the research, please speak with Latrina Geyer, principal investigator. You can contact Latrina at   You can also email Dr. Helen Hodges: Hodges_HF@mercer.edu.

In Case of Injury

It is unlikely that participation in this project will result in harm to subjects. If an injury to a subject does occur, he or she may be seen at a local or regional medical facility. All expenses associated with care will be the responsibility of the participant and his/her insurance.

Mercer IRB
Approval Date 07/18/2018
Protocol
Expiration Date 07/17/2019

Incentives to Participate

After completion of the interview, you will receive a $20 gift card for participating in the study.

Audio or Video Taping

Audio recording will be used as part of data collection. All audio records and data transcriptions will be coded to protect privacy and kept in securely locked files accessible only by the principal investigator. All documents and files will remain in securely protected file cabinets for three years, as mandated by the IRB at Mercer University. Digital audio recordings will be destroyed at the conclusion of this dissertation process.

Reasons for Exclusion from this Study

Newly graduated registered nurses who work in hospice, oncology, or ambulatory care nurse practice settings will be excluded from participating in this study.

This project has been reviewed and approved by Mercer University's IRB. If you believe there is any infringement upon your rights as a research subject, you may contact the IRB Chair at (478) 301-4101.

You have been given the opportunity to ask questions and these have been answered to your satisfaction. Your signature below indicates your voluntary agreement to participate in this research study.

_____
Research Participant Name (Print)

_____
Name of Person Obtaining Consent (Print)

_____
Research Participant Signature

_____
Person Obtaining Consent Signature

_____
Date

_____
Date

Mercer IRB
Approval Date 07/18/2018
Protocol
Expiration Date 07/17/2019

APPENDIX E

PARTICIPANT DEMOGRAPHIC PROFILE

Participant Demographic Profile Self-selected PSEUDONYM: _____

☐ Written informed consent received.		
1. AGE:	**2. GENDER:**	**3. RACE/ETHNICITY:**
What is your current age?	(How do you describe yourself?) ☐ Male ☐ Female ☐ Trans Male/Man ☐ Trans Female/Woman ☐ Gender Queer/Gender Non-Conforming ☐ Different (Gender) Identity (please specify):	(How do you describe yourself?) ☐ White ☐ Black or African American ☐ Hispanic, Latino, or Spanish origin ☐ Asian ☐ American Indian or Alaska Native ☐ Middle Eastern or North Africa ☐ Native Hawaiian or Other Pacific Islander ☐ Other (please specify):
EDUCATION/PROFESSIONAL DEVELOPMENT:		

4. Highest nursing degree completed:
☐ Baccalaureate (BSN)
  o Year graduated:
☐ Masters (MN, MSN)
  o Year graduated:
☐ Doctorate in Nursing Practice (DNP)
  o Year graduated:
		5. Have you earned a degree in a non-nursing discipline?
		☐ Yes (if yes, please specify degree, discipline, and year of graduation):
		  o Associate:
		  o Bachelor:
		  o Master:
		  o Doctorate:
		☐ No

CLINICAL EXPERIENCE:		
6. Which option best describes your current position: ☐ Graduate nurse (RN license pending) ☐ Registered Nurse ☐ Other (please specify):	7. Which option best describes your primary work setting: ☐ Medical/Surgical ☐ Emergency ☐ Critical Care ☐ Perioperative ☐ Other (specify):	8. Years of professional nursing (RN) experience: ☐ Less than one year ☐ Greater than or equal to one year (please specify total number of years):
9. Have you had any work or volunteer experience in a palliative care or hospice setting? ☐ Yes ☐ No If yes, please describe type of experience (work and/or volunteer) and total years of experience:		

APPENDIX F

SEMI-STRUCTURED INTERVIEW GUIDE

I.   Interview Protocol

Date:	Start time:	End time:	Interview Location:
Participant Pseudonym:			
Interview Tools Utilized:			
☐ Digital (Audio) Recorder		☐ Reflexivity Journal	
☐ Field Notes		☐ Other:	

☐ Written/signed informed consent obtained

II.   Informed Consent Review: Do you have any questions for me before we begin?

III. Interview Questions and Clarifying Probes

1. Tell me about a seriously ill patient you have cared for since becoming a registered nurse. (Please describe your experiences in as much detail as possible. Feel free to include your emotions, feelings, thoughts, and interventions as you recall the experiences.)

   a. How did you perceive that person as seriously ill?

      i. In your view, what made the patient seriously ill?

   b. How did you assess the needs of this patient?

      i. What were his/her physical needs?

      ii. What were his/her psychological needs?

      iii. What were his/her spiritual needs?

      iv. What were his/her sociocultural needs?

      v. What were his/her environmental needs?

2. What is it like to provide PC for seriously ill patients? (Please add anything you think would help me to understand what it is like to be a new nurse caring for a seriously ill patient in your nurse practice setting.)

a. What is it like being with a seriously ill patient in the acute care setting?

b. Share what you perceived to be any disconnect between nursing care and this patient's and/or family's desired goals and plans of care?

c. How do you know when patients experience comfort?

    i. What does comfort look like?

    ii. What does comfort sound like?

    iii. What does comfort feel like?

3. Think about this sentence for a moment "culture shapes how people respond to and experience disease"

a. Now tell me how your patients express their illness experiences

    i. Idioms of distress (turn of phrase, jargon, phraseology) to express suffering

    ii. Displays of emotion

    iii. Scores on patient-reported outcome measures (e.g., pain scale)

b. How do you elicit and interpret experiences from patients who may be more "private/private data" based upon their culture and/or spiritual beliefs?

4. What comes to mind when you hear the words "PC"?

a. What does PC mean to you?

5. In the context of caring for patients, what does comfort mean to you?

a. How do you provide comfort?

6. What comes to mind when you think about quality of life?

7. Tell me about your unit/department:

   a. What types of patients (diagnoses) do you care for on your unit?

   b. How do you create a climate for comfort and healing to take place?

8. How would you describe the experienced nurses on your unit?

   a. Who are your experienced nurses?

      i. What was it like to work with them when you are caring for a seriously ill patient?

      ii. What have you noticed, if anything, about how they care for seriously ill patients? (e.g., communication, cultural competence, being present, caring, empathy, listening, touch)

   b. Who are your resources when caring for a seriously ill patient? Who are your "go-to" people and why?

      i. What personnel at your hospital have you used as a resource for communicating about PC?

      ii. Who are the people you see/hear communicating with patients about advanced care planning or goals and plans of care?

         1. What are those conversations like?

         2. What it is like being in those moments?

9. What literature (evidence-based practice/guidelines) has been available to you as an institutional resource for communicating about PC?

10. How did you learn about PC?

        a. Baccalaureate nursing education preparation?

        b. What "clinical" experiences did you have to apply what you learned?

            i. How often?

            ii. What were those experiences like?

            iii. How do those undergraduate student experiences compare/contrast with your PC experiences since becoming a professional registered nurse?

        c. Prior personal or professional PC/end-of-life experiences?

11. When you think about your past education, personal life, or professional experiences and your current nursing practice, what experiences, if any, most influence how you currently care for seriously ill patients at work, and why?

12. What do you perceive as your role in PC delivery?

13. What nursing interventions do you perceive as most meaningful to patients' experiences of comfort, and why?

14. What is your perception of the use of principles of PC for seriously ill patients in your (nurse practice) area?

        a. How are principles of PC being applied in your work environment?

15. Please share anything else you would like to add to your overall perceptions about and/or use of PC in acute care settings.

IV.   Field Notes/Follow Up

APPENDIX G

TRANSCRIPTIONIST CONFIDENTIALITY AGREEMENT

CONFIDENTIALITY AND DOCUMENT RELEASE FORM

I, ████████████████████████, agree to transcribe the submitted audiotapes verbatim and will not include any identifying names of persons or places. If the participant verbalizes a name, I will input three letters for people and three numbers for places. I will maintain confidentiality and no verbal or written communication will be shared with outside parties. I also agree to release all transcribed documents and the original audiotapes to Latrina T. Geyer, principal investigator, upon completion.

████████████████

Transcriptionist Name (Printed)

6/19/18

Date

████████████████████████████████

Transcriptionist Signature