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**The Effect of Providing End of Life Care on the
Mental Health of Critical Care Nurses**

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A masters project completed in partial fulfillment of the
requirements for the degree of Masters Science—Nursing, Family Nurse
Practitioner at the Valley Foundation School of Nursing, San José State
University

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The Effect of Providing End of Life Care on the Mental Health of Critical Care Nurses

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Family Nurse Practitioner Program

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Abstract

Critical care nurses are providing care to acutely ill patients now more than ever and may experience moral or emotional distress due to providing end of life care to their patients. The purpose of this literature review is to determine the mental health effects of a critical care nurse providing palliative end of life care. A literature search using PubMed and CINAHL was conducted and fourteen published articles between 2012-2023 were included in this review. Several interventions were identified which may be useful in decreasing burnout and moral distress in critical care nurses. Overall, nurses experienced the most negative mental health impacts from providing what they perceived to be futile care and felt less distress when they felt empowerment. Critical care nurses also reported benefits to having received some end-of-life education.

Keywords: Critical Care, Critical Care Nursing, Intensive Care Units, palliative care, end of life care, moral distress, burnout, and resilience

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Background and Significance

Each year, 700,000 people in the United States spend the last days of their life in a hospital (Shmerling, 2018). Hospitals are at capacity with patients who are more acutely ill than ever, and with this increase in sick patients comes the sobering reality nurses are caring for more patients who are at the end of their life (Wolf et al., 2019). Nurses who work in critical care areas are particularly impacted by the growing population of hospitalized patients with end-of-life care needs. In fact, one of every five deaths in the United States will occur in a critical care bed of a hospital (Cook & Rocker, 2014). At times, ICU nurses may be required to provide interventions that cause patients to suffer from pain and indignity or prolong their inevitable death (Su et al., 2018). Moral and emotional distress can be created when they feel they are providing futile care or care which is contrary to what the patient might wish if they could choose for themselves (Mercadante et al., 2018).

Psychological distress tends to be higher among nurses when they are unable to provide care that aligns with their ethical standards (Jameton, 2017). The World Health Organization defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (*Mental health: Strengthening our response* 2018). The consequences of poor mental health can be seen in suicide rates among nurses. In a retrospective study looking at data over a ten-year period, Davis et al. found after synthesizing data that included nurses, physicians, and the general population, the suicide risk was significantly higher for nurses (Davis et al., 2021). In another systematic review and meta-analysis, there was evidence of an overall decline in the mental health of nurses around the

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world. The study found poor mental health was manifested in terms of anxiety, stress, depression, PTSD, and insomnia from nurses all over the world (Varghese et al., 2021). Urgent attention is needed to address this growing problem.

An intervention that may avert the negative mental health impacts on nurses providing end of life care is the introduction of palliative care. Sixty years ago, Dame Cicely Saunders introduced the notion a patient's pain was a sum of their physical, emotional, social, and spiritual dimensions, giving birth to the development of a specialty later to be recognized as palliative care (Wood, 2021). Many others continued to build upon Saunders' work, and in 1990, The World Health Organization officially recognized palliative care as a specialty (Nejm). The fundamental purpose of palliative care medicine is to provide care for patients with a life-limiting illness while relieving their suffering and improving their quality of life (Wood, 2021). While medical care is focused on a medical diagnosis, palliative care is centered on providing care holistically, focusing on a patient's whole self. It prioritizes pain management and the minimization of suffering, as well as care allowing for respect of a person's dignity at the end of their life. Patients and their loved ones stand to benefit greatly when palliative care is introduced early and throughout the course of their illness.

Palliative care and nursing care share core values emphasizing providing patient care in a holistic way, assessing, and treating their physical, emotional, and spiritual health (Hagan et al., 2018). Because of the shared values of palliative care and nursing, it may prove to benefit the mental health of the nurse when a patient who is at the end of their life is also receiving palliative care. This paper will systematically review existing literature to determine the mental health effects of providing end of life care on a critical care nurse.

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Methods

Study Purpose & Design

The purpose of this structured narrative review is to synthesize the existing literature regarding critical care nurses' experiences while providing end of life care and identify the impact on their mental health.

Search Strategy

A literature search was conducted using CINAHL and PubMed databases. On PubMed ("Critical Care"[Mesh]) or "Critical Care Nursing"[Mesh]) or "Intensive Care Units"[Mesh] and (palliative care or end of life care) and (moral distress or burnout or resilience) were searched and yielded 226 results. A filter was used to screen for studies published between 2012-2023, resulting in the elimination of fifty-five articles and leaving one-hundred seventy-one remaining articles. Six articles published in non-English languages were eliminated. The titles of the remaining articles were reviewed and one-hundred thirty-six were eliminated as they were not relevant to the literature review. The remaining twenty-nine abstracts were reviewed and eighteen were eliminated based on the inclusion/exclusion criteria of this literature review, leaving eleven studies from this database search. CINAHL Complete was searched using the terms Critical Care or Critical Care Nursing or Intensive Care Unit, palliative care or end of life, moral distress or burnout or resilience and one-hundred fifty-one articles were identified. A filter was applied for articles published between 2012-2023, resulting in one-hundred twenty-five papers. The one-hundred twenty-five titles were reviewed, six articles were excluded because they were published in a non-English language and another seventy-nine articles were excluded due to irrelevance to subject matter. The remaining forty abstracts were reviewed, seven literature reviews, two doctoral dissertations, and two journal article commentaries were

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eliminated. Twenty of the articles were eliminated for not meeting the inclusion/exclusion criteria of this literature review, leaving nine suitable articles remaining from this search. Once duplicates from the twenty remaining articles were accounted for, there were twelve studies remaining. Prior research yielded an additional two studies meeting inclusion criteria and were included in this review. See Figure 1 for the Prisma flow diagram of the search strategy.

Inclusion & Exclusion Criteria

Articles were included in the review if they were published from 2012-2023, included critical care nurses in the United States in the study sample, and reported on nurses' experiences of providing palliative care in the ICU setting. Commentaries, doctoral dissertations, and literature reviews were excluded. Both qualitative and quantitative studies were included.

Data Extraction and Analysis

Each study was reviewed, and details were extracted on study purpose and design, setting, population, sample size, and quality. Narrative synthesis was used to describe results organized by theme.

Quality Appraisal

To appraise the level of evidence, the Hierarchy of Evidence for Intervention Studies was used (Fineout-Overholt et al., 2010). The study designs of all fifteen papers were examined to determine the level of evidence of each study.

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Results

Population & Setting

After applying inclusion and exclusion criteria to the search results, a total of fourteen studies remained for analysis in this review. To be included in this review, the population had to include critical care nurses who provide end of life care. Three studies incorporated additional disciplines in their samples, including ICU physicians, pharmacists, therapists, and patient care technicians (PCT). Six studies specifically mention the setting was an academic institution, while others did not include hospital information. In terms of specialty populations, one paper's research was specific to pediatric ICU nurses, one study was specific to neonatal ICU nurses, one specific to oncology ICU, and the remaining eleven studies' populations were various adult critical care settings including neuro, medical, cardiac, and surgical. The breakdown of education revealed most nurses surveyed in each study were bachelors prepared nurses. Ninety percent or more of the participants in each study were female and Caucasian. Over half of the studies reported the years of experience of the nurses, and the data ranged widely from study to study from one year of experience to thirty years. The same number of studies also described the ages of the nurses included in the study with the median age ranging from 29-47.

Study Design, Sample Size, and Quality

Three out of the fourteen studies were qualitative studies, with a fourth study containing both qualitative and quantitative components. The remaining ten studies were quantitative by design, including a study with an intervention with a randomized control group and another study with an intervention with a nonrandomized control group. The sample size of the qualitative studies ranged from 13 to 36. The sample size of the quantitative studies ranged from

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n-38 to n-473 with the average sample size of 160. Three of the qualitative studies used an open-ended phenomenological approach allowing the participant to lead the interview with sharing information at their leisure as they answered a single research question, while only one of the qualitative studies used a guided and structured interview approach to gather experiences from the participants. A quarter of the qualitative studies utilized a survey, which allowed the participants to leave open-ended answers about their grief experiences. The quantitative studies all utilized a survey format to gather their data. Many survey tools and assessment scales were used. The Maslach Burnout Inventory (MBI) and the moral distress scale were the most widely used tools as they were utilized in a total of six of the fourteen studies. A Likert scale was used as a tool in different capacities in many of the surveys. Other survey tools included The Perceptions and Ability to Care for the Dying tool (PPACD) and the Professional Quality of life (ProQOL R-IV), Psychological Empowerment Instrument (PEI), Moral Distress Thermometer (MDT), Patient Health Questionnaire 8 (PHQ-8), Generalized Anxiety Disorder 7-item scale (GAD-7), perceived stress scale, Psychological Empowerment Index, Hospital Ethical Climate Survey scales, meaning scale, State Hope Scale, and the Depression, Anxiety and Stress Scale (DASS-21). In terms of levels of evidence, eleven of the fifteen studies were categorized as level VI evidence, one study was level II, one study was level III, and one study was level IV.

Burnout and Providing End of Life Care

Four quantitative studies were included in this review that examined burnout in the context of end-of-life care. According to the hierarchy of evidence, which ranks the strength of evidence based on study design and methodology, the level of evidence varied among the studies. Two of the studies were level VI evidence, which is considered the lowest level of evidence because it is considered to have a high risk of bias and therefore the conclusions should

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be cautiously interpreted (Fineout-Overholt et al., 2010). One study was found to be level III evidence, which is considered moderate quality evidence, and the other study was found to be level II evidence, which is considered high-quality evidence with a low risk of bias. Three interventions were studied: a mindfulness-based intervention (MBI), a sacred pause observed after the death of a patient, and participation of the nurse in a death cafe debriefing.

In a study conducted by Rushton et al. (2015), factors involved in burnout, moral distress, and resilience were explored. Notably, nurses with three to ten years of experience had the highest average scores of emotional exhaustion and depersonalization. Though resilience did not change with years of nursing experience, moral distress increased, and hope decreased over time. Their results revealed a moderate negative correlation between both emotional exhaustion and depersonalization with personal accomplishment. A moderate correlation was also noted between burnout and moral distress and burnout and stress. Their data showed that hope and resilience were negatively correlated with emotional exhaustion and depersonalization was positively correlated with personal accomplishment (Rushton et al, 2015). While this study did not examine a specific intervention, the results of the study showed moral distress was a predictor of burnout, and moral distress was significantly higher for nurses working in critical care areas (Rushton et al., 2015).

Urso et al. (2022) developed a mindfulness-based intervention that included an eight-week personalized yoga therapy to reduce stress and burnout among critical care staff. Participants were surveyed prior to the MBI and after using the Depression, Anxiety, and Stress Scale (DASS-21) and the Maslach Burnout Inventory-Human Services Survey for Medical Personnel (MBI_HSS (MP)). Forty-five staff were included in the final analysis, eighty-four percent of whom were nurses and the remaining sixteen percent were PCTs. There were no

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statistically significant changes in stress and burnout before and after the intervention. However, similar to the study examining a “sacred pause,” open-ended feedback from participants suggested they did perceive improved health, less stress, and decreased sense of burnout.

Kapoor et al. (2018) examined the impact of a similar but less labor-intensive intervention to reduce burnout and moral distress, by implementing a “sacred pause” after a patient death. During the defined study period, seventy-eight deaths occurred in the ICU. The sacred pause ritual was observed in seventy of those seventy-eight deaths. The study found slightly more than half of the participants expressed that the implantation of the ritual could lead to a reduction in burnout among ICU nurses, while a larger majority of nurses felt the sacred pause practice achieve a sense of closure and cope with emotions such as disappointment, grief, distress, and failure after the death of their patient in the ICU. The majority agreed the practice improved their professional satisfaction, and fifty-nine percent felt like the sacred pause should be practiced in all ICUs (Kappoor et al., 2018). This ritual was so successful, the hospital incorporated it into a compassionate care initiative aimed to increase positive experiences despite challenging situations staff encountered (Kapoor et al., 2018).

Bateman et al (2020) study is the only randomized control study in this review. For the study, they examined whether participating in a Death Café would decrease the burnout experienced by ICU nurses, physicians, pharmacists, and therapists. The participants of the study arm attended biweekly debriefing sessions facilitated by a psychotherapist for three months. The participants in the control arm did not attend these sessions. The debriefings were intended to be informal in nature where the participants and therapist discuss death, dying, loss, grief, and illness. In doing so, participants were allowed to reflect on events causing distress and allow for collaboration and community among peers outside of the work environment (Bateman et al.,

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2020). A similar study of Death Cafés conducted a few years back using a student population (Nelson et al., 2018) reported positive experiences showing that Death Cafés could be a useful intervention in mitigating burnout critical care nurses experience in providing end of life care.

Empowerment

Three quantitative studies were included in this review to examine the relationship between empowerment and moral distress among critical care nurses providing end of life care. All three of these studies were found to be level VI evidence, which is considered the lowest level of evidence because of the lack of rigorous methodology and control in these study designs. While the information from these studies does not typically guide clinical practice, it can still provide valuable insight (Fineout-Overholt et al., 2010).

Seeking to describe the relationship between moral distress, psychological empowerment, and demographics in ICU nurses providing end of life, Browning (2013) surveyed two-hundred seventy-seven critical care nurses using two unique survey instruments. In this study, the degree of perceived moral distress was high among critical care nurses, but the frequency in which the nurses experienced moral distress was low. The frequency of moral distress decreased the more the nurses were able to participate in end-of-life care conferences. Empowerment scores were high and increased with age, years of nursing experience, collaboration in end-of-life conferences, and with end-of-life education. Overall, the study's data emphasized the more empowered nurses perceived themselves, the less often they experienced moral distress (Browning 2013).

A similar inverse relationship between empowerment and moral distress was described in a separate study, however, their methodology involved an intervention where the nurses daily

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administered a palliative care screening tool to the physician caring for the patient. Study data showed after the intervention, perception of workplace empowerment increased significantly. Also noted were significant negative correlations between the frequency and intensity of moral distress and one's sense of workplace empowerment. This study reported no relationship between moral distress and demographic factors (Condon et al., 2021).

In contrast to the other studies showing an inverse relationship between empowerment and moral distress, one study reported nurses who had access to a palliative care team reported higher levels of moral distress (Altaker et al., 2018). In the ICU setting, palliative care is accessed via a consult and nurses are typically not allowed to initiate the consult. Although palliative care services exist, if there is not a consensus among nurses and physicians when those services are used, one could understand why just the existence of those resources would not lessen moral distress. Additionally, in this study more than twenty percent of the nurses reported they did not fully understand what palliative care was and so perhaps the palliative services were not properly being utilized (Altaker et al., 2018).

Perception of Ability or Responsibility in Caring for the Dying Patient

Two quantitative studies were included in this review to describe the critical care nurses' perception of their ability to provide end of life care. Additionally, one qualitative study was included to investigate the responsibility nurses perceive when caring for dying patients. These three studies were found to have level VI evidence, indicating again a less rigorous study in terms of design and methodology.

Todaro-Franceshci (2013) investigated if ICU nurses felt that their nursing education had provided them with adequate training to care for dying patients and their families. The objective

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of her research was to identify a correlation between the critical care nurses' perception of their preparedness to provide end of life care and their ability to do so, as well as their professional quality of life (PQOL) (2013). The data indicates there is a relationship between critical care nurse perceptions of preparedness and ability to care for the dying and their PQOL. There were overall higher compassion satisfaction scores, lower compassion fatigue scores, and lower burnout scores for those who perceive themselves more prepared and better able to provide end of life care.

Wolf et al. (2019) took a similar approach as they examined critical care nurses' perceived knowledge of palliative care, their recent experiences of moral distress, and relationships between those variables. The study analyzed data from one hundred sixty-seven completed questionnaires and found less than forty percent of the nurses reported feeling highly competent in palliative care. Their data revealed a positive correlation between years of nursing experience and perceived competence. Neary forty percent reported they received no palliative care education in the previous two years. Interestingly, no correlation existed between their overall competence in the domains of palliative care and their level of moral distress. However, when individual domains of palliative care were compared to moral distress, an inverse correlation between perceived competence in self-care and moral distress existed. Only six percent of respondents reported palliative care was always used when indicated. When palliative care was not utilized at patients' end of life, their data shows nurses experienced higher levels of moral distress. Sixty seven percent of their participants listed unclear goals of care as the overwhelming source of their moral distress. Prolonging dying, lack of consensus regarding treatment plan, inadequate staffing, or experience, and providing false hope to patients or families were also reported by about fifty percent of the participants (Wolf et al., 2019).

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In addition to perception of ability due to preparedness, the theme of responsibility was also identified. The qualitative research done by Dr. Stephanie Lewis (2017) explored the experiences neonatal ICU nurses have while caring for dying infants and their families. The feeling of responsibility was the most common response included in their written narratives where the nurses shared their stories of providing end-of-life care. The nurses expressed they felt a deep responsibility to advocate for their patients and felt a strong personal commitment to providing the best care possible to their patients. One nurse described a time where “One of our staff held the infant at all times until she passed away which was over 24 hours.” (Lewis, 2017). These experiences point to nurses going over and above their job expectations because of the personal responsibility they felt for their patients, especially at the end of life. Subthemes of responsibility were identified including commitment to deliver quality end of life care, disbelief, inadequacy, and advocacy.

Emotional and Moral Distress in Providing End of Life Care

This review included three studies that focused on factors contributing to different types of distress experienced while providing end of life care. Two of the studies used qualitative methodology to gather data, while the third study examined the impact of an intervention nurse’s distress. The two qualitative studies were classified as level VI evidence, which is the lowest level of evidence, while the intervention study was found to have level IV evidence, suggesting a moderate level of rigor but also a reasonable risk of bias.

These studies show that both emotional and moral distress can be experienced when providing end of life care. Lief et al. (2018) sought out to describe patient and family factors associated with nurses’ distress in the ICU. For their study, one hundred nurses were interviewed about their patients’ psychological and physical symptoms, their reactions to those patient

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experiences, and perceived factors contributing to their emotional distress. Analysis of their data showed patients overall quality of death and suffering contributed significantly to the nurse experiencing emotional distress. Nurses reported loss of patient's dignity also contributed to them experiencing emotional distress. Forty percent of the nurses surveyed reported significant emotional distress when families were fearful of the patient dying or when they displayed unrealistic expectations of the patient's survival (Lief et al., 2018).

Similarly, Groves et al. (2022) explored the degree of emotional distress displayed as grief that pediatric critical care nurses experience after the death of a patient in the pediatric ICU. They surveyed one hundred and four participants and collected demographic data as well as responses to open-ended qualitative questions about their experiences with the death of their patients. One of the main themes the analysis provided was a continuum of grief responses ranging from minimal emotional responses like, "I have dealt with these experiences in a healthy manner and not suffered from grief or distress" to persistent emotional responses like "It is rare for me to have a night where I do not have some sort of dream about work, almost always distressing" (Groves et al., 2022). Emotional prompting was seen to either increase or decrease emotional responses. Some responses identified an increase in grief such as this participant's response, "The level of grief and distress I feel following a patient's death depends on the relationship I have with the patient and/or their family. It is all about connection for me." (Groves et al., 2022). Some participants shared how their grief was lessened when the patient passed and described "When the patient has been suffering for a while, such as a cancer patient or chronic patient, I somehow feel more at ease with their death." (Groves et al., 2022). Participants' coping mechanisms for dealing with grief were identified as another theme in the open-ended survey. These included strategies such as compartmentalizing their emotions,

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seeking support from their network, feeling validated by their work, and maintaining resilience through an optimistic outlook.

In contrast to the methodologies of the previous two studies, Piscitello et al. (2022) investigated an intervention designed to address nurses' moral distress. The study involved forty-eight medical ICU nurses who completed pre-and post-intervention surveys to assess their moral distress levels before and after an intervention that included triggered palliative care consults and scheduled family meetings in the ICU. The researchers compared patient outcomes in the intervention medical intensive care unit to those of a control group, but they found no statistically significant difference in the nurses' moral distress levels after the intervention.

Discussion

The studies included in this review described the mental health impact of critical care nurses providing palliative end of life care. It has been established in existing literature that critical care nurses report high levels of burnout (Epp, 2012; Rushton et al., 2015). According to one recent study, nurses who experienced higher rates of moral distress and burnout were more likely to quit their current position (Witton et al., 2022). However, research has shown that mindfulness-based interventions can be helpful in mitigating the burnout and stress in general that nurses commonly experience (Sarazine et al., 202).

Burnout was a significant theme presented in many studies included in this review. From this literature review it is evident that burnout has also been linked to poor health outcomes, increased turnover of nurses, and decreased patient satisfaction (Rushton et al. 2015). Burnout remains a problem for critical care nurses and so it is crucial to study interventions which may be useful in preventing or at the very least, decreasing the burnout nurses are experiencing. Although the quantitative study in this review that examined a mindfulness-based intervention

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was unable to support their study hypothesis that a mindfulness intervention could mitigate burnout, the participants did report positive findings of an improvement in their professional efficacy (Urso et al., 2022). The population of this study was unique in that their initial score of burnout, depression, stress, and anxiety were low at baseline which is contrary to what most literature describes of critical care nurses and may have influenced the findings. Knowing that moral distress can be a predictor of burnout in critical care nurses, and having proven interventions to decrease burnout, it may be possible to mitigate the negative mental health impacts felt from providing end of life care.

While some organizations may lack the resources to implement resource-intensive interventions like mindfulness training, our review found that even brief interventions, like Kapoor et al.'s (2018) "sacred pause" can improve the well-being of ICU nurses. The "sacred pause" is a feasible intervention that can be performed by anyone, in any place, at any time, and without the need for education. The intervention involves taking a brief pause to reflect and refocus, and it takes only a few minutes to complete, making it attractive to encourage implementation. Implementing the "sacred pause" intervention could lead to benefits such as reduced burnout and increased job satisfaction among ICU nurses.

A second theme that emerged from this review was empowerment. Empowerment refers to an individual's sense of confidence in their capacity to exercise control and command (Gottlieb et al., 2021). One study reviewed reported that participants felt more empowered after the daily administration of the palliative care screening tool (Condon et al., 2022). The screening tool provided a formal way for nurses to indicate which patients needed palliative care consultations, enabling them to actively participate in the process. This led to a decreased occurrence of moral distress among the ICU nurses. This is a way in which the nurses felt

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empowered and overall were able to decrease the occurrence of moral distress. The sense of empowerment the nurses felt goes back to the way they perceive their access to support, information, resources, and opportunities for learning and development. This finding shows that nurses' perceptions of empowerment can be a useful tool in mitigating the negative health impacts of critical care nurses providing end of life care. Browning's research in large part supported the same findings, they did not report less intense episodes of moral distress when they felt more empowered, they only reported moral distress less frequently (Browning, 2013). This highlights future opportunities for researching methods that can not only decrease the frequency of moral distress, but the intensity as well. There is still work to be done to understand the role of empowerment and how it relates to palliative care.

Another significant theme identified in the literature was the nurse's perception of their ability and or their responsibility in providing quality palliative end of life care. Witnessing a person die can be a distressing event in and of itself. Interestingly, across the board, this is not mentioned as a source of stress, burnout, anxiety. Over and over, nurses mention providing care they feel is futile contributes to their moral distress. Critical care nurses feel a responsibility to provide high level care especially in the ICU when the emphasis of patient care is on curing, even when nurses feel the care is futile and should be focused on caring and comforting. Nurses can feel trapped in a moral dilemma when they are forced to provide care to a patient which they feel is futile and may cause their patients more suffering. One nurse described their experience saying, "It began to feel like we were torturing this fragile little human; their (the neonatologists) focus was on the tasks at hand and the continued focus on 'cure at all costs'." (Lewis, 2017). When nurses can provide care which they feel is appropriate and aligns with the patient's desires, less distress is experienced across the board. For example, nurses who can contribute to goals of

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care discussions experience less moral distress because they are able to discuss patient care management with transparency. Transparency allows all participants to be on the same page, which reduces uncertainty and role ambiguity among nurses. In a heightened emotional climate such as the ICU, medical decision making can be divisive among team members. However, open discussions about end-of-life care can mitigate conflict that may arise in ethical decision making (Nikbakht Nasrabadi et al., 2021). Not only did their perception of responsibility to provide ethical care mitigate distress, but their preparation to provide care did as well. Research reveals nurses receive little to no formal end of life education; therefore, much of the training takes place in clinical practice, which does not provide nurses with any preparation in dealing with difficult patient interactions. Caring for a dying patient can be a stressful event, and nurses providing end-of-life care with no formal training or education could understandably suffer from greater stress. In contrast to most findings, one study revealed nurses who did receive specialized end of life critical care training experienced greater levels of moral distress (Altaker et al., 2018). This is because with an increased knowledge in end-of-life care, they were more keenly aware of management and interventions being offered to patients at the end of life that would cause more harm than benefit, and thus contributing to distress that comes with providing care not aligned with what patients end of life wishes.

In addition to the responsibility the critical care nurses feel in providing high level care, many nurses shared experiences highlighting the moral and emotional toll felt by those providing palliative end of life care. Nurses repeatedly shared the feeling of shared grief and loneliness. Some NICU nurses experienced this shared grief as they were constant care providers to infants and often grew attached to their patients who often had long stays in the NICU. Those same nurses experienced loneliness when they felt they were the only ones seeing the infant's

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suffering, while the parents and physicians were often more focused on the hope of the infant surviving their ICU stay (Lewis, 2017). Other nurses were deeply affected by providing end of life care and shared they would often have persistent negative thoughts. One nurse communicated, “I have images running through my head about the things we saw. I hear the parents’ sounds of crying. That is the worst sound in the world.” (Groves et al., 2022). Emotional distress was reported when nurses perceived that a patient was not at peace, suffering, had a poor quality of life, or there were unrealistic expectations from the families of the patients (Lief et al., 2018). These collective experiences are important to understanding the effect on the mental health of critical care nurses who are providing end of life care. As the influence of loss on critical care nurses is understood, future interventions may be developed to mitigate the negative mental health impacts that arise from providing end of life care in the ICU.

Limitations and Gaps

Existing research identifies factors shown to increase moral distress and poorly affect the mental health of nurses. Most quantitative studies in existing literature utilize a survey tool to measure a response from the participant, and while the conclusions made from these studies is useful, there remains a gap in literature of quantitative studies in which an intervention with the intent to decrease the mental health effects has been studied. Many available studies examining potentially useful interventions are studying nurses outside of the United States, highlighting yet another substantial gap in research. None of the studies included in this review collected data for a participant's spiritual/religious/cultural beliefs surrounding suffering and death. Future research might explore the significance these beliefs may have on the experience of providing end-of-life care. Nurses who identify as white and female have been the majority population in most studies,

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leaving a substantial gap in studying how other demographics are impacted by providing end of life care.

The studies reviewed in this paper share a similar limitation of a small sample size, and with that comes inherent limitations of the ability to generalize results to a larger population. The overall level of evidence of these studies is low, and there is a need for higher level studies to examine the efficacy of interventions. It is also worth mentioning five of the fourteen studies were published in the time of the Covid pandemic and it is difficult to tell if data collection was impacted or limited by restrictions in place due to the pandemic.

Conclusions and Practice Implications

The conclusions made from research can guide understanding and inform interventions to mitigate the negative effects on mental health critical care nurses are facing. From existing evidence, it is clear the mental health of nurses is worrisome and providing end of life care in the critical care setting can be distressing. Nurses are expected to provide end-of-life care to more people every day. There is evidence when incorporating interventions into practice one can diminish or prevent the distress associated with providing palliative care, and it is reasonable nursing leadership should consider adopting similar strategies to help mitigate the distress on their nurses who provide end of life care. Understanding the impact of repeated loss on critical care nurses can also lead to the development of grief and bereavement support programs for nurses. While many of these studies provide us with rich data in which we can understand the grief experiences of ICU nurses, it does not tell us what they do with their experiences, or how their experiences can be improved, and so more research is needed. The specific impact of providing end of life care on critical care nurses' mental health must continue to be investigated.

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Table 1. Literature Review Table of Evidence

Author	Year	Study Design	Aim of Study	Outcome of Study	Sample Size	Setting/ Population	Implications for practice	Level of Evidence
Todaro-Franceschi, Vidette	2013	exploratory descriptive study with qualitative and quantitative components – utilized two survey instruments- Perceptions and Ability to Care for the Dying tool (PPACD) and the Professional Quality of life (ProQOL R-IV)	perceptions of preparedness and ability to provide end of life care in relation to their Professional Quality of Life (PQOL)	There is a relationship between perceptions of preparedness and ability to care for the dying and their PQOL, with higher satisfaction scores, lower compassion fatigue scores, and lower burnout scores for those who perceived themselves more prepared and better able to provide end of life care.	473	Members of the American Association of Critical Care Nurses 441 women, 32 men 21-75 years (mean -45 years) 90% white, Average years of experience- 7.5 years	Interventions to enhance perceptions of preparedness and ability to care for the dying can potentially improve PQOL for nurses working in ICU areas, diminishing the incidence of compassion fatigue and burnout	VI
Phyllis Ann King and Sandra P. Thomas	2013	existential phenomenological study utilizing an interview	lived experiences of caring for dying patients	Themes of “promises to keep,” “promise to be truthful,” “promise to provide comfort,” “promise to be an advocate,” “promise that could not be kept”, “promise to remain connected”	14	ICU nurses 12 female and 2 males 13 white 1 African American average years of experience between 2-30 years	More research to be done on willingness of nurses to initiate conversations about impending death with patients and or families	VI
Groves et al	2022	online survey with demographic questions and an open-ended, qualitative	To what degree do pediatric critical care (PCC) nurses experience	four major themes among pediatric critical care (PCC) nurses when asked about grief symptoms and distress following the suffering or death of a patient in the PICU:	104	Pediatric ICU nurses 97% female	Understanding the impact of repeated loss on these specialized nurses may inform the	VI

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		question about grief experiences.	symptoms of grief or distress following the suffering and/or death of a patient in the PICU	(I) continuum of emotional responses; (II) emotional prompts; (III) coping, and (IV) resilience		Average age- 29 96% Caucasian 88% BSN 35% <3 years' experience	development of more effective grief and bereavement support programs for healthcare providers	
Lewis	2017	Submit a written narrative about an EOLC experience during which the nurse experienced strong emotions.	The purpose of this study was to explore the affective, interactional, and meaning-related responses, coping strategies, and changes in practice NICU nurses have because of caring for dying infants and their families.	Narrative analysis revealed many affective responses, but 3 were the most frequent: responsibility, moral distress, and identification. Coping methods included healthy and less healthy strategies, such as colleague support, informal and formal debriefing, practicing intentional gratefulness, avoidance, and compartmentalization. Changes in practice identified were universally described as professional growth using reflective practice	36	NICU nurses Average age of experience – 23 100% white females	Educators should discuss the range of emotions experienced by caregivers related to EOLC and healthy coping strategies and encourage the use of reflective practice as a facilitator of professional growth. Nurse leaders should promote supportive environments in NICUs and ensure debriefing opportunities for nurses who have recently cared for a dying infant. Future research should focus on formulating interventions to utilize debriefing with NICU nurses and the development of EOLC mentors	VI

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Browning, Annette M.	2013	<p>cross-sectional descriptive survey design</p> <p>utilized 2 survey instruments: Moral Distress Scale (MDS) and the Psychological Empowerment Instrument (PEI)</p> <p>responses scored on Likert scale of 1-7</p>	Does empowerment among nurses decrease moral distress and enhance patient care outcomes at the end of life	No decrease in moral distress intensity in relationship to increased empowerment but ICU nurses who perceived themselves as more psychologically empowered experience moral distress less frequently	277	<p>Critical care nurses</p> <p>Average age-47</p> <p>Average years of experience-17.45</p> <p>47% with BSN, 29% ADN, 19.7% MSN, 3.3% DNP</p>	More research examining empowerment as it relates to moral distress is needed to find methods that may decrease moral distress in ICU nurses.	VI
Wolf, Alexander T.	2019	<p>quantitative, descriptive study with a survey design</p> <p>utilized the Moral Distress Thermometer (MDT)</p>	perceived knowledge of palliative care and recent experiences of moral distress	Many ICU nurses do not feel prepared to provide palliative care. When palliative care access is perceived as inadequate, nurses may be more apt to experience moral distress. Most reported issues contributing to moral distress were unclear goals of care, prolonging dying, lack of consensus regarding treatment plan, inadequate staffing, or experience, and providing false hope to patients or families.	167	<p>7 ICUs</p> <p>academic hospitals in Virginia</p> <p>142 women and 21 men</p> <p>61% age 22-35</p> <p>92% white</p> <p>62% BSN</p> <p>45% with 1-5 years of experience</p> <p>Included neonatal, pediatric, cardiothoracic, medical, neuro, surgical, coronary units</p>	Health system leaders and educators must identify opportunities for palliative care education for ICU nurses and interprofessional teams and strengthen resources for preventing and managing moral distress and empower ICU nurses to identify and eliminate barriers to high-quality palliative care.	VI
Marjorie E. Bateman	2020	<p>Randomized controlled trial.</p> <p>Clinician burnout will be measured by Maslach Burnout Inventory</p>	Will participation in regular debriefing Death Café sessions influence	The outcomes of this study have not yet been published.	200 (100 physicians and 100 non-physicians;	Academic medical centers in New Orleans, LA	May prove to be an effective tool to avert clinical burnout	II

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		(MBI); Secondary outcomes like depression and anxiety will be measured by Patient Health Questionnaire 8 (PHQ-8) and the Generalized Anxiety Disorder 7-item scale (GAD-7)	burnout in ICU clinicians?		nurses, pharmacists, therapists)			
<u>Lindsay Lief</u>	2018	Interview Likert scale to respond to questions	Patient and family factors associated with nurses' emotional distress in caring for dying patients in the ICU.	Patients' emotional distress, physical distress, and perceived quality of death are associated with nurse distress. Unrealistic family expectations for patients may be source of nurse emotional distress.	100	Academic medical centers in the northeast Did not describe demographics of participants	Improving patients' quality of death, including enhancing their dignity, reducing their suffering, and promoting acceptance of an impending death among family members may improve emotional health of nurses.	VI
<u>Cynda Hylton Rushton</u>	2015	Cross sectional survey 6 survey tools: Maslach Burnout-Inventory; a moral distress scale; perceived stress scale; resilience scales; meaning scale; State Hope Scale	What are the characteristics for burnout and what are the factors involved in burnout, moral distress, and resilience.	Moral distress was a significant predictor of all 3 aspects of burnout. Greater resilience protected nurses from emotional exhaustion and contributed to personal accomplishment. Spiritual well-being reduced emotional exhaustion and depersonalization; physical well-being was associated with personal accomplishment. Meaning patient care and hope were independent predictors of burnout. Higher levels of resilience were associated with increased hope and reduced	114	6 high stress units from 4 different hospitals (all in 1 health system) 89% female 86% white Median age 22-67 67% BSN 49% adult ICU	These findings provide the base for an experimental intervention in phase 2 of this study which is designed to help participants cultivate strategies and practices for renewal, including mindfulness practices and	VI

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				stress. Resilience scores were flat over the years of experience.		Average years of experience -10	personal resiliency plans.	
<u>Catherine Urso</u>	2022	<p>Pilot study with a Mindfulness Based Intervention (MBI), Living Optimally in Times Under Stress (LOTUS)</p> <p>Depression, Anxiety and Stress Scale (DASS-21)</p> <p>Maslach Burnout Inventory-Human Services Survey for Medical Personnel (MBI_HSSMP)</p>	<p>Will a Mindfulness Based Intervention (MBI) alleviate burnout, stress, anxiety, and depression in nurses of oncology ICY</p>	<p>Post MBI, prevalence of depression, anxiety, stress, emotional exhaustion, and depersonalization remained low and similar between both groups. Professional efficacy scores improved.</p>	<p>45 staff</p> <p>(21 in the control group and 24 in the intervention group)</p> <p>84% nurses and 16% PCT</p>	<p>Oncology Icu</p> <p>MD Anderson hospital</p> <p>78% female</p>	<p>This study faced low compliance and participation, and so further research should be done to investigate the intervention.</p>	III
Krista Wolcott Altaker	2018	<p>Web based survey.</p> <p>Moral Distress Scale;</p> <p>Psychological Empowerment Index, Hospital Ethical Climate Survey</p>	<p>What is relationship among moral distress, empowerment, ethical climate, and access to palliative care in the ICU</p>	<p>Poor ethical climate, unintegrated palliative care teams, and nurse empowerment are associated with increased moral distress.</p>	238	<p>ICU nurses</p> <p>90% women</p> <p>82% white</p> <p>Age range 20-70with average age-38</p> <p>Average years of experience 8</p> <p>62% BSN</p>	<p>These findings highlight the need to promote palliative care education and palliative care teams that are well integrated into ICUs.</p>	VI
Kapoor et al	2018	<p>ten-question online anonymous survey</p>	<p>To study the impact of the ritual of sacred pause on the attitudes and</p>	<p>Seventy-nine percent respondents believed that the practice brings closure and has helped them overcome the feelings of disappointment, grief, distress, and failure after</p>	<p>38 (12 ICU physicians and 26 nurses)</p>	<p>ICU physicians and nurses in the 18-bed medical ICU of Baylor St. Luke's Medical Center, Houston, Texas</p>	<p>Adoption of this ritual can improve ICUs' overall well-being. Further studies looking</p>	VI

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		The responses were graded on the Likert rating scale (strongly agree, agree, undecided, disagree, and strongly disagree).	behaviors of the ICU physicians and nurses.	the death of their patient in ICU. Seventy-three percent felt that the practice has instilled and encouraged a sense of team effort among the ICU team. Eighty-two percent responded that the practice makes their efforts feel appreciated. Seventy-three percent felt that the practice has improved their professional satisfaction. Eighty-five percent felt that the practice of sacred pause should be a universal phenomenon in all ICUs. Only 55% of respondents felt that the practice has a potential to decrease ICU burnout, many of them (42%) were undecided. Most (70%) were of the belief that the practice has helped their bodies handle stressful situations in ICU better			at validated measures of burnout are warranted, but the ritual has a potential to decrease burnout when used with other key interventions.	
Piscitello, Gina et al.	2022	prospective cohort study	to assess whether increased palliative medicine consults and scheduled family meetings for critically ill patients may be associated with improved moral distress of MICU nurses	The intervention of initiating triggers for palliative medicine consults in the medical intensive care unit over a 6-week period was not associated with change in moral distress of nursing staff	48 completed pre survey and 33 completed posts	MICU nurses urban academic medical	Further research is needed to determine interventions which may improve moral distress for critical care nurses.	IV
Kathleen A. DiGangi Condon	2021	pilot study, we used a pretest-posttest design	To evaluate the effect of nurses' use of a palliative	nurses' administration of a palliative care screening tool to their patients may reduce the frequency of nurses' moral	17	critical care nurses	Further research is warranted with	VI

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			care screening tool on their moral distress and perceptions of empowerment	distress and increase their sense of empowerment		Magnet-designated teaching hospital	a larger sample size	
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Figure 1. Prisma Flow Diagram of Search Results

