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Moral Distress in Critical Care and Emergency Department Nurses

An Honors College Project Presented to
the Faculty of the Undergraduate
School of Nursing
James Madison University

by Morgan Timberlake and Nicole Phillips

Accepted by the faculty of the School of Nursing, James Madison University, in partial fulfillment of the requirements for the Honors College.

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PUBLIC PRESENTATION

This work is accepted for presentation, in part or in full, at the James Madison University Honors Symposium on April 5, 2019.

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INTRODUCTION

Moral distress, first defined by Andrew Jameton in 1984, is a phenomenon that occurs when a person is unable to carry out what they believe is the ethically appropriate action due to various external constraints (Jameton, 1984). Moral distress which has recently been identified as a problem experienced by many nurses, can lead to alarming consequences such as burnout, turnover, fatigue, frustration, physical illness and decreased quality of patient care (Ulrich & Hamric, 2008). Specifically, nurses in high acuity settings such as the Intensive Care Unit (ICU) and Emergency Department (ED) experience moral distress that is exacerbated by the general unpredictability of the setting and frequent inability to carry out what they believe is right due to various constraints. These constraints include situations such as initiating life sustaining actions when the nurse does not feel it is in the best interest of the patient, or perceived powerlessness in following orders of the patient's provider. Dr. Ann Baile Hamric expanded on the definition of moral distress to include initial distress and moral residue (Ulrich & Hamric, 2008). Initial distress can be described as the immediate, acute emotional response to the situation at hand. However, if the situation is not resolved in an effective and timely manner moral residue can result, which can have long lasting effects. Known as the Crescendo Effect, this is an accumulated build up of moral distress occurring over time as a result of the moral residue of the unresolved issue (Epstein & Hamric, 2009). This moral residue can have detrimental effects on nurses' physical and emotional health and in turn lead to increased fatigue, stress, and burnout. If issues causing moral distress are better understood, other nurse researchers, administrators, and practicing nurses will be better able to address and resolve moral distress early on. This literature review seeks to explore the interventions that are most effective in reducing moral distress in ICU and ED nurses who have experienced moral distress in practice.

LITERATURE REVIEW

Root Causes of Moral Distress

In many critical care settings medical professionals are faced with decisions related to withdrawal of medical treatment, although the ultimate decision to withdraw care usually lies with the family. Despite what the healthcare team may suggest, some families want everything possible done for the patient. This can result in moral distress for nurses when they are required to perform extreme medical interventions on patients even if they believe that it is not in the best interests of the patients. Fernandez-Parsons, Rodriguez, and Goyal (2013), utilized the Moral Distress Scale- Revised (MDS- R), a subjective tool measuring the frequency and intensity of an experienced disturbance, to study moral distress in nurses. They found that the situation with the highest score of moral distress was when nurses were required to follow the family's wishes to continue life support even though they believed it was not in the best interest of the patient (Fernandez-Parsons et al., 2013). Another study conducted in 2016 explored the relationship between moral distress and coping in ED nurses and reported that the most frequently occurring experience that caused moral distress was carrying out physician orders for what the nurse considered to be unnecessary treatment (Zavotsky & Chan, 2016). In Robinson and Stinson's study (2016), nurses expressed feeling moral distress when facing conflicts of opinion and an obligation to carry out treatment plans with which they did not agree. In addition, Lusignani, Gianna, Re, and Buffon (2016) found that limited nursing experience was another significant factor that scored high levels on the MDS-R. Nurses with less experience were found to be highly vulnerable for experiencing moral distress (Lusignani, et al., 2017).

In the workplace, ethical climate is defined as the moral atmosphere and the degree of ethics practiced (Theiring, 2016). The overall ethical climate of a unit plays a significant role in the moral distress nurses experience (Altaker, Howie-Esquivel, & Cataldo, 2018). Altaker et al. found a relationship between moral distress and poor ethical climate scores using the Hospital Ethical Climate Survey, leading to burnout and patient care avoidance. A significant correlation was found between moral distress and compassion fatigue in a pilot study conducted with surgical ICU nurses. Compassion fatigue, where caregivers demonstrate a reduced capacity over time to empathize with the traumatizing events patients experience, may be a possible cause of moral distress or, potentially, have the same precipitating causes (Mason et al., 2014). Analysis of these studies indicated high levels of moral distress in ED and ICU nurses, particularly those with less experience in carrying out actions per physician orders or family wishes that they deemed medically futile.

Effects of Moral Distress

Continued exposure to moral distress can have detrimental effects, not only on nurses' physical and mental health, but also on the quality of patient care. One of the most obvious effects of moral distress on nurses can be seen through registered nurse turnover rates, which indicate how quickly nurses are leaving their jobs. High turnover rates can be indicative of nurses experiencing burnout which results in their resignation (Wolf, Perhats, Delao, Moon, Clark, & Zavotsky, 2016). However, before reaching the point of resignation, many nurses attempt to cope with the moral distress in various ways. One defense mechanism, described by a nurse in a 2016 study is coined as "flipping the switch" where nurses shut off their emotions and feelings in an attempt to deal with the negative side effects of moral distress when they become overwhelmed (Robinson & Stinson, 2016). This method of suppressing emotions and distancing

oneself only leads to further emotional stress and negative effects on the nurse's mental health. As one nurse said, "It affects my family life, it affects my relationships, it affects my patients, and my relationships with my peers" (Robinson & Stinson, 2016, p. 238). This emotional stress can carry over into the nurse's personal life as well as affect their relationships outside of the workplace.

In a survey conducted in 2013, 73% of nurses reported that their work performance was impacted in some way by their experience of moral distress (Wilson, Goettemoeller, Bevan, & McCord, 2013, p. 1460). In high acuity settings such as the ED, any degree of influence on work performance can have a dangerous impact on patient care and outcomes (Wilson, et al., 2013). Nurses have noted that they do not have time to adequately address their feelings during their shift and therefore carry moral residue with them to the next patient (Robinson & Stinson, 2016). By not fully addressing these feelings associated with a morally distressing situation, moral residue builds up and can create a heightened emotional and physical response to the next distressing scenario. In this way, the negative impacts of moral distress continue to snowball. In the 2016 study one nurse commented on the repeated exposure to moral distress by saying it is "very harmful emotionally, professionally, and for the integrity of the nurse (Robinson & Stinson, 2016, p. 238). It is therefore imperative that nurses be able to fully address and resolve their feelings in an appropriate and timely manner in order to move on in a healthy way. While moral distress has been studied extensively in nursing, there is limited research related to interventions to help nurses deal with moral distress.

Interventions for Moral Distress

While the topic of moral distress in nursing is still being researched and possible interventions are being explored, the need for intervention is extremely evident. The American

Association of Critical Care Nurses has recognized addressing moral distress as a priority goal and developed one of the most basic strategies to minimize moral distress: *The 4 A's Model to Rise Above Moral Distress* (American Association of Critical Care Nurses, 2004). This model includes 4 components: ask, affirm, assess and act. While this is a straight-forward model, there is a lack of evidence on its effectiveness in minimizing moral distress. A variety of additional methods have also been suggested including ethics committees, individual counselling, debriefing sessions and workshops. The complexity of these interventions should not be overlooked, and as suggested by Mobley, Rady, Verheijde, Pate, and Larson (2007) they should emphasize the development of critical thinking skills to empower nurses to address issues related to collaboration and ethical conflicts.

Wilson et al. (2013) indicated the top two suggested resources that nurses viewed as helpful in dealing with moral distress were ethics committees and debriefing sessions. The role of hospital ethic committees is to provide ethical consultations regarding patient care scenarios while facilitating education about issues in the clinical setting. Browning and Cruz (2018) implemented a reflective debriefing session for nurses who had experienced moral distress and the MDS-R scale was used to evaluate the levels of moral distress before the session and at the end of the 6-month period. They found that 100% of the participants requested to continue the reflective debriefing sessions, speaking to the beneficial impact of this particular intervention in dealing with moral distress (Browning & Cruz, 2018). While these studies have shown the immense potential of various interventions in combating moral distress, there remains a need for more research to be conducted and action is needed to implement these interventions in hospitals.

METHODS

Electronic searches of CINAHL and PubMed were performed through the library database at James Madison University. Keywords used were “moral distress” AND “critical care” AND “nurse”. Additional search terms that were used included “emergency nurses”, “nursing”, “nurses” and “interventions”. Exclusion criteria included a publication date greater than 15 years from January 2019, and anything not written in the English language. The two researchers individually reviewed each article for relevancy, study design and date of study and came to an agreement on each article that would be included in the literature review.

RECOMMENDATIONS

Although all nurses are at risk for developing moral distress, the high acuity patients and life-sustaining measures taken to save patients in emergency department and critical care settings contribute to nurse vulnerability. This risk also increases in nurses with fewer years of experience. This distress is not only detrimental for the health of the nurse, but is shown to have a negative impact on the outcome of the critical patient. Although working as a nurse will always involve high stress situations, certain interventions, once implemented, may decrease the intensity and frequency of these common roots of moral distress. After analyzing the collected data regarding the efficacy of potential interventions, it is recommended that each hospital have an easily accessible ethics committee to consult in times where the nurse or other healthcare staff may need assistance in addressing particular conflicts or uncertainties related to patient care. The role of the ethics committee is to provide a safe, confidential, and supportive system to guide in the decision- making process in situations with potentially medically futile outcomes or other stressful scenarios. The hospital’s ethics team is to communicate closely with all involved staff as well as patients and families to ensure the best solution is reached.

Another recommendation based on the review of the literature would be for each unit of the hospital to offer nursing debriefing sessions composed of both experienced and less experienced nurses. Since nurses with fewer years of experience were found to be particularly vulnerable to moral distress, facilitating communication between more experienced nurses and newer nurses would allow for discussion of these high stress situations that occur specific to each unit. By debriefing, whether following the sudden death of a patient or regarding any particular feelings of doubt or uncertainty in care or functioning, nurses may have a higher likelihood of resolving morally distressing events early on, rather than keeping thoughts to themselves and enabling a harmful crescendo effect.

Lastly, a potential recommendation to implement at each emergency department and critical care unit would be a 5-minute rounding “huddle” to take place every 12 hours at the beginning of each shift, with the participation of all staff. These “huddles” would allow for a time for physicians, nurses, and technicians to gather and discuss topics they would like to address with the unit as a whole, and allow an opportunity for interdisciplinary collaboration and communication that may not present itself during a typical shift. With the implementation of ethics committees, debriefing sessions, and staff-wide rounding sessions, moral distress of emergency department and critical care nurses may decrease in frequency and intensity, allowing for improved nursing job satisfaction and positive patient outcomes.

CONCLUSION

It is clear from the research and through conducting the literature review that moral distress is a disheartening issue that is negatively affecting nurses, specifically in the critical care and emergency settings. While the causes of moral distress can range from patient-oriented problems to facility-based issue, the effects are similar across the board; nurses are getting overstressed, burnt out, and leaving the profession. With America already in a nursing shortage the healthcare system cannot afford to lose any more nurses, which is why implementing simple interventions such as debriefing sessions to aid nurses in dealing with moral distress need to be implemented in all hospitals.

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