Spring 4-25-2022

Implementation of a Decision Tree to Address Moral Distress

Tijuana Milton
tijuana.milton@bobcats.gcsu.edu

Implementation of a Decision Tree to Address Moral Distress

TCP Chair:	Flor A. Culpa-Bondal, PhD, APRN, PMHCNS/NP-BC
TCP Co-Chair	Sheryl H. Winn, DNP, APRN, ANP-BC
TCP Committee Member:	Debra Hagerty, DNP, RN, NHA, CDP, CADDCT, LBSW, IP-BC, CDONA, FACDONA, FACHCA
Date of Submission:	July 26, 2022

Abstract

Healthcare workers (HCW) face daily challenges in the workplace environment. A relatively new problem called moral distress (MD) may present itself, but it may go unrecognized. The healthcare profession is being robbed of qualified personnel due to moral distress. The overall objective of this project was to help healthcare workers identify moral distress and seek resources to assist with the mitigation of moral distress. The outcome of this project demonstrated bedside HCWs showed higher levels of MD. Leadership must be intentional with providing education about signs and symptoms of MD and assist employees to recognize and utilize available resources to mitigate MD. Age, gender, years of work experience, and education showed no correlation to the level of MD. The project demonstrated there was a statistically significant difference in MD scores with consideration to depart the healthcare profession due to MD. Higher levels of MD may lead to departure from the healthcare profession.

Keywords: Moral Distress, Decision Tree, Healthcare Workers

Table of Contents

Implementation of a Decision Tree to Address Moral Distress

According to the American Association of Colleges of Nursing, nursing schools are not growing fast enough to meet the demands of society's need for nurses (AACN, 2020). Moreover, more than 16 percent of newly graduate registered nurses are leaving the medical profession due to moral distress (Van den Bulcke et al., 2019). Moral distress has a negative impact on the healthcare profession, culminating in a departure from the profession. Inadequate staffing and job dissatisfaction are also major consequences of moral distress. Health care workers (HCW's) who can recognize the signs and symptoms of moral distress and seek appropriate resources to address the constraints that come with it may be less likely to leave the medical profession. According to a 2019 study conducted by Van den Bulcke et al., with intensive care units (ICU) HCW's, 18 to 23 percent of workers planned to leave the field owing to moral distress-related difficulties. The replacement cost of a registered nurse is $88,000 (Li and Jones, 2012); while a physician's replacement cost is $1 million (Shanafelt and Noseworthy, 2017). Overall, research supports the importance that organizations need to educate healthcare workers about moral distress to minimize the loss within the profession.

There is currently a shortage of healthcare workers to care for an aging and longer living society. The American Association of Colleges of Nursing (AACN, 2020) depicts that the U. S. is likely to face a scarcity of Registered Nurses (RNs) as the baby boomer group grows and the need for health care increases. Nursing schools across the country are struggling to expand capacity in order to meet the increasing demands for care, and the dilemma of the national march toward healthcare reform, exacerbate the shortage problems. To raise awareness of this shortage issue, the AACN is collaborating with schools, policymakers, nursing groups, and the media.

Dr. Peter Buerhaus and colleagues (2017) discovered that more than 75 percent of healthcare workers, more specifically, RNs, consider the staffing shortage to be a big problem for the quality of patient care and the quantity of time spent with patients. This leads to nurses quitting the profession due to feeling overworked and understaffed. The limited quality of work, care, and quantity of time with patients are all factors that may create moral distress. But the problem of moral distress may not even be noticed, which cheats the healthcare profession of its personnel.

Background

Originally introduced by Jameton in 1984, moral distress is a relatively new phenomenon. Moral distress, according to Jameton, occurs when a person understands what they should do but cannot because of organizational policies (2013). Healthcare workers (HCWs) experience moral distress because they are functioning in challenging work environments (Malone, 2021). Providing care during the COVID-19 pandemic has challenged the personal integrity and values of healthcare workers. The pandemic has also exacerbated the problem of moral distress. Unfortunately, it is possible that healthcare workers may not recognize it.

Healthcare workers may occasionally experience emotional and mental challenges, and even powerlessness along with frustration while providing care to patients. The COVID-19 pandemic has increased the feelings of powerlessness amongst HCWs. These feelings of powerlessness may be due to issues such as the sheer number of deaths, patients hospitalized and dying without family around, and the constant risk of being infected, and then infecting coworkers. Healthcare workers frustrations can be related to challenges such as a lack of personal protective equipment (PPE) or established procedures for re-use of PPE. These challenges can have an emotional or mental impact on healthcare workers. The powerlessness

and frustrations may lead to anxiety, burnout and exit from the profession (Kelly and Todd, 2017).

Experiencing maladaptive behaviors, feelings, or perceptions that emerge in reaction to participation in a morally uncomfortable situation is defined as moral distress according to Campbell et al, in a 2016 article. The inability to recognize moral distress may be due to its ambiguity and different articulations. There has been an ongoing debate about what moral distress is, and there is no universal agreement on the precise definition. Overall, moral distress has been defined in the literature in terms of specialty areas within the healthcare profession (Morley et al., 2019).

Burnout and moral distress are closely related but have different definitions. Maslach and Jackson (1981) define burnout as an individual response to chronic work pressure. The individual may develop a bad attitude toward the patients and become disengaged from the workplace. Burnout creates feelings of doubt, incompetence, and even despair that ultimately leads to moral distress. The HCWs may begin to feel disengaged and detached, which are early burnout warning signs. Patients' welfare may be negatively impacted by healthcare worker burnout (Cooper et at, 2016). Medication errors, unrelieved pain, and poor patient care are possibilities due to burnout (Van der Heijden, et al, 2019). Burnout is associated with a decrease in the quality of care a patient receives. According to one study, patients with burned out HCWs had a higher risk of urinary tract and surgical site infections (Cimiotti, et al., 2012).

Moral distress can appear as physical, emotional, and psychological symptoms. The American Association of Critical-Care Nurses (Makic, 2011) identifies physical symptoms such as headaches, nausea, vomiting, and diarrhea. Losing autonomy, anxiety, guilt, and anger are all considered emotional symptoms (Makic, 2011). HCWs are more likely to develop depressive

disorders and other mental health problems, as well as leave their jobs due to moral distress (Van der Heijden, et al, 2019). According to a qualitative study, many HCWs shared that they reach a point where they have had enough and decide to leave the profession (McAndrews et al., 2011). Unresolved moral distress leads to the decision to leave the profession. Ethical issues and job dissatisfaction have led to up to 15% of new nurses leaving within the first year of employment (Corley, 2002). This further supports that a healthy work atmosphere is critical for patient outcomes, employee satisfaction, and providing high-quality care (Vaclavik et al., 2018).

Problem Statement

According to the American Association of Critical Care Nurses (AACN), moral distress is a major issue in the healthcare profession (2021). Problems such as communication among team members, staffing, end-of-life care, and safety are all contributors to moral distress (Karakachian & Colbert, 2017). Many healthcare workers (HCW) are not aware of moral distress, nor trained about how to deal with it. The lack of education exacerbates moral distress. When HCW's are unaware of how to define moral distress, they clearly are not aware of the signs and symptoms associated with it. Healthcare workers who were subjected to moral distress instruction while in clinical practice were more likely to speak up and pursue solutions to ethical issues once licensed. This suggests that incorporating moral distress in clinical training is extremely beneficial (Nuttgens & Chang, 2013).

The inability to recognize signs and symptoms of moral distress leads to defensive mechanisms to mitigate the distress, which consequently inflicts harm to others. Defense mechanisms used by some healthcare workers may include blaming family, the work routine or environments, other coworkers, or healthcare professionals, or simply avoid contact with perceived difficult patients to avoid experiencing moral distress (Bruggemann et al, 2018).

HCWs have even spent as little time as possible in a patient room to avoid the feelings of moral distress. An example of avoidance occurred in a hospital, where an adolescent was hospitalized for a prolonged period with a terminal illness. The healthcare worker caring for the patient provided the bare minimum of treatment to prevent attachment to the patient as a result of learning that the adolescent was nearing the end of his life (Bruggeman et al, 2018).

A study conducted by Lawrence (2011) showed that some HCWs use moral disengagement as a method to avoid moral distress. Moral disengagement is the belief that ethical standards do not apply to oneself in a given situation (Bruggeman et al, 2019). Moral disengagement is best described as inhumane feelings after witnessing unethical actions. Other employees just simply do not get involved, which is referred to as bystander passivity (Bruggeman et al, 2018).

Avoidance, absenteeism, and changing shifts have been methods workers have used to avoid experiencing moral distress. Healthcare workers have used techniques such as avoiding the patient, which causes stress, calling out sick on days when they realize which patient they will have to care for, or changing shifts to another floor, according to a project studied by the University of Kentucky from 2013 to 2017 (Altman & Delgado, 2021). The problem with failing to recognize moral distress is that health-care workers are not performing to their fullest capabilities. HCWs are making statement such as "I can't interact with patients at the high level that I used to" as stated in the Fall 2020 edition of the National Nurses Organization (Richardson, 2020). To avoid this attitude, it is evident that moral distress must be recognized and addressed.

The first step to resolving moral distress is to identify and recognize it. If HCWs are encouraged to discern moral distress, anxiety, and burnout, then departure from the profession

may be reduced (AACN, 2020). There has been minimal research into healthcare workers' abilities to recognize indications and symptoms of moral distress in rehabilitation facilities. Most studies have been conducted in critical care units (Vincent et al, 2020) or oncology (Lievrouw et al, 2016). A common theme in the literature supports that, moral distress is a real-life problem affecting all healthcare workers.

For this project, the definition of moral distress by Jameton (2013) will be adopted, defined as a situation in which an individual believes he or she knows the morally appropriate course of action to pursue but is unable to do so due to policies or procedures. Therefore, the healthcare worker may experience emotional, psychological, or physical stresses within themselves.

Purpose of the Project

This translational project was to offer an education workshop about moral distress to 1) explore the frequency and level of moral distress experienced by healthcare workers in a nursing rehabilitation center and, (2) establish a decision tree to aid in the seeking of resources to mitigate moral distress.

Clinical Questions

1. What is the level and frequency of moral distress pre-education as evaluated by the data from the Measures of Moral Distress for Healthcare Processionals (MMD-HP)?
2. Is there a relationship between age, gender, years' work experience, education, role, and the level and frequency of moral distress?
3. Is there a difference in the level and frequency of moral distress between 2 groups, one group completing the MMD-HP prior to education, the other group completing the MMD-HP after education?

4. What is the utility and effectiveness of the decision tree for HCWs in a nursing rehabilitation facility for mitigating moral distress as evaluated by a 6-weeks post implementation qualitative survey?

Needs Assessment

As stated by the AACN, any medical professional with the greatest of resilience will eventually break down due to an unhealthy work environment (Kelly & Todd, 2017). Nurse educators teach students to wash their hands to prevent infection, and nursing staff educate patients on health promotion to prevent disease and injury, but healthcare professionals lack education to avoid moral distress. Moral distress contributes to the depletion of healthcare profession's supply of well-educated and qualified healthcare professionals. Due to moral distress, the medical profession loses 16-23 percent of newly acquired healthcare workers within the first year (Van den Bulcke et al, 2019).

The setting for this project was a nursing rehabilitation facility in the Southeastern United States. An in-person meeting was scheduled to assess the organizational climate with the facility's representative. The representative acknowledged that "every company's most valuable assets are the personnel" and the facility "has a great desire to assess and educate the staff about moral distress to improve the organizational climate" (J. Lucke, personal communication, May 11, 2021). The representative of the facility also stated, "we'd love to take much better care of our people, but due to COVID and the changes of the facility we haven't had a chance to do so yet." The representative further stated, "our HCWs have been dealing with no visitors for the inpatient clients, PPE issues, and short staff as a result of COVID" (J. Lucke, personal communication, May 11, 2021). Information provided by this facility administrator addresses the organization's desire to provide better care for the HCWs functioning within their facility,

and to show that administration supports the staff's mental health and well-being. According to a study conducted in 2020, HCWs are in high demand for emotional and mental health services following the COVID-19 pandemic, and it is critical that healthcare institutions utilize existing facets within their healthcare system to support HCWs (Miotto et al., 2020).

Organizations that undergo a change in management and ownership are more likely to have staff resist and undermine the change, with only 26% of organizational change succeeding (Satell, 2019). This resistance in change has occurred at the rehabilitation facility. Significant changes have occurred within the organization, including new owners, administrators, building remodeling, and contracts with local hospice facilities. This has caused the organization's administration to notice a shift in employee morale, which is concerning.

As change occurs, and frustration and resistance among employees arise because of their natural aversion to change, it is critical that organizational administrators address employee concerns. The most successful change occurs by enabling employees within the organization to drive the change. When planning new initiatives, it is critical to solicit support from employees and involve them in the planning process (Watkins, 2013). Involving employees aid in the development of ownership in the change and increases the chances of employees supporting and even advocating the change. This further supports the organizations desire to improve the organizational climate and empower the staff member by educating about moral distress.

All the beforementioned stressors creates more pressure on the HCWs to perform and function without regards for themselves. The opportunity has presented itself for an educational intervention about the signs and symptoms of moral distress. Upon a presentation to the departmental meeting on February 26th, with departmental representation from human resources, director of nursing, administration, dietary, social services, admissions, and residential services,

all agreed of education about moral distress and decision tree implementation to assist with employee welfare and growth.

Summary

Moral distress can be a difficult problem to recognize. The majority of HCWs are completely unaware of what they are experiencing. The inability to recognize signs and symptoms of moral distress can lead to defensive viewpoint by HCWs which in time will create an unhealthy work environment. It is possible that an unhealthy work environment will cause harm to other professionals as well as harm to patients.

When HCWs fail to recognize and treat the moral distress problems, emotional, physical, and psychological problems may develop. When the HCW is overwhelmed by moral distress, he/she may be unaware of available resources to help. To avoid the negative consequences of moral distress, health-care workers (HCWs) must receive appropriate training and support.

To support recognition of moral distress, as well as to help individuals who are distressed, the AACN has developed framework and tools. The workshop investigated how often and to what degree the HCW has experienced moral distress. It was also hoped that the workshop will assist the HCWs in identifying resources that are available to them, their unit, and their organization in order to relieve moral distress.

Chapter II

Literature Review

Moral distress is a term that has only recently been coined. As a result, little to no information exists about how to resolve or manage moral distress. The CINAHL and MEDLINE databases were searched for research-based articles published in the English language from 2016 to the present. First, the terms "moral distress," "nursing,", AND "education" search generated 242 articles. There were few studies which commented on practices for handling moral distress. To focus the search and access relevant and available literature for process of handling moral distress, additional terms used were "decision tree," "ethics," "lack of information," and "resources". After carefully reviewing all the articles and narrowing the search to scholarly peer-reviewed articles, eleven articles were found to be appropriate and relevant to this project.

Definition of Moral Distress

There is an increase in concern about moral distress in nursing practice. The exposure of nurses in various practice experiences in healthcare makes them meet multiple ethical dilemmas. These dilemmas result in moral distress when the nurse is prevented from practicing what they believe is suitable due to various organizational barriers. Different literature has expressed the definition of moral distress, and similarity across them is the concept of ‘ethical dilemmas.’ According to Nassehi et al. (2019), philosopher Jameton was the first to introduce the concept in 1984. Jameton (2013) said moral distress is the awareness of healthcare staff on the correct practice but failure to pursue because of existing barriers in the organization. Consequentially, Hossain and Clatty (2020) examine moral distress as injury on nurses’ ethical decisions in critical care experiences. Lizarondo (2020) supports Hossain and Clatty (2020) by saying that moral distress is a significant issue for healthcare staff working in acute care conditions. Such

conditions include end-of-life or life support decisions, poor communication with other healthcare and patient family, ineffective application of resources, and giving false hope (Hossain & Clatty, 2020; Lizarondo, 2020; Vaclavik et al., 2018). The vast literature on moral distress derives their definition of the concept from Jameton's. According to DeGrazia et al. (2021), various symptoms are associated with moral distress, such as emotional turmoil, anxiety, poor appetite, depression, and poor sleep. Dacar et al. (2019) further added that nurses or healthcare staff would feel powerless and frustrated due to the ethical dilemma experiences.

Ramifications of Moral Distress

Different literature highlights ramifications associated with moral distress in healthcare practice. End-of-life care or life-threatening diseases in acute care are the highest causative experiences of moral distress in nursing. The consequences around this issue are highly related to the symptoms associated with moral distress. According to Vaclavik et al. (2018), moral distress affects the mental well-being of nurses. This might be impactful in the entire nursing care delivery practices, especially on patients and other staff. Burnout and compassion fatigue might also make a nurse consider different alternatives to nursing practice or abandon the nursing profession entirely (Vaclavik et al., 2018). Morley et al. (2017) show some contradictions and highlight a possibility that there could be moral distress that exempts the distress feeling. Morley et al. (2019) said that moral distress could revolve around making a judgment that cannot be psychologically or physiologically impactful. Other definitions of moral distress have been termed as emotional fallout, which is an experience reported by many nurses, especially when dealing with patients involved in substance abuse or those requiring behavioral health (Wolf et al., 2016). The study by Wolf et al. (2016) incorporated focus groups that reported that lack of organizational support led them to carry out unprofessional practices. The group said that most

healthcare organizations are economically driven and overlook some professional practices to maintain this aspect.

Another ramification associated with moral distress involves physical injury. Different works of literature have done studies on nurses and found that there are physical symptoms associated with this issue. For instance, Wolf et al. (2016) said that nurses reported having difficulties eating, sleeping, and developed high blood pressure, fatigue, and gastric issues. The study by DeGrazia et al. (2021) also shows similar results to that of Wolf et al. (2016) concerning physical symptoms around moral distress.

According to Vincent et al. (2020), there have been many professional implications resulting from moral distress. Supporting what is said by Wolf et al. (2016), Vincent et al. (2020) said that nurses would feel incompatible or less powerful when made to work in clinical settings they are not familiar with. This might lead to adverse patient outcomes as part of a general ramification from moral distress. Nurses frequently develop feelings of inferiority when they feel that their practices do not align with what they think is right.

Furthermore, nurses have little power to alter these practices, leading to high-stress levels. As Vaclavik et al. (2018) support this point, nurses who feel underappreciated or inferior might consider the option of abandoning the nursing profession entirely. The study by Woods (2020) also found out that most participants in the survey reported having thoughts on quitting nursing and considering another profession. According to them, the burnouts resulting from moral distress were overwhelming and demoralizing. In addition, the causes of moral distress such as lack of organizational support and bullying felt like a betrayal to a profession, they always considered passionate. The article by Nassehi et al. (2019) highlights the positive effects of moral distress. According to the article, ethical dilemmas result in an increased sensitivity

towards morality in healthcare practice. It contributes to the development of decisions around morality.

Interventions for Moral Distress

The aspects surrounding causative factors of moral distress in healthcare have been the basis for developing appropriate interventions. According to Rathert et al. (2016), there are different interventions around moral distress, such as ethics communication and increased organizational support. Hossain and Clatty (2020) and Vincent et al. (2020) agrees with Rathert et al. (2016) on the factor of organizational support. They further add personal interventions that can be used to reduce moral distress levels. As Rathert et al. (2016) said, communication is key in various interventions in healthcare. Both nurses, managers, and the organization's executives should hold staff meetings to discuss these ethical dilemmas and aspects surrounding them. These communication interventions are necessary for promoting information sharing as supported in the Social Cognitive theory.

The Social Cognitive theory states that learning can occur when people are informed about other's experiences and actions as well as the consequences that result from it. According to Vincent et al. (2020), research done by a physician concluded that communication through a team effort is essential in reducing levels of moral distress. The article adds that team communication improves coherence among the staff and facilitates idea-sharing on the issue. Hossain and Clatty (2020) also highlight organizational support in the context of COVID-19, which presented end-of-life experiences, especially when the crisis was overwhelming due to a lack of resources and staff.

According to Hossain and Clatty (2020), everyone in the healthcare organization should recognize the causes and effects of moral distress. Workplace stress is reduced by organizational

support. A supportive and healthy work environment is one of the most important factors in achieving job satisfaction and employee motivation. The results of supportive leadership equate to positive patient impacts. Physiological and psychological turmoil requires assistance through motivational support from colleagues and organizational leaders (Vincent et al., 2020). A healthy work environment acknowledges and recognizes meaningful achievements, which creates a sense of value and fulfillment. Nurses should be motivated and acknowledged for their achievements to prevent them from being affected by moral distress. According to Hossain and Clatty (2020), person-centered interventions include moral resilience and self-stewardship. Moral resilience is the boldness and strength to face moral distress. Self-stewardship is taking care of oneself and remaining strong through challenging situations. Programs and in-training sessions can be effective in fostering confidence among nurses to help them deal effectively with moral distress.

Prevention of Moral Distress

Vincent et al.(2020) and Hossain and Clatty (2020) highlight interventions that can be used to mitigate moral distress. According to the articles, one of the key preventive measures in alleviating moral distress is through support and motivation. Moral distress affects the psychological and physiological needs of a nurse or healthcare staff. Motivation can be provided through peer groups or management. According to the articles, it is advisable that leaders are key to facilitating motivation and providing confidence to all healthcare staff. Support also ensures the nurses in moral distress receive relevant help before it results in dire consequences.

Settings/Population of the Studies

The article by Vincent et al. (2020) was conducted in a southwest hospital at the end of 2017. It applied the Moral Distress Scale-Revised (MDS-R) survey which was issued to

healthcare staff in acute care settings. The moral distress scale was designed to measure moral distress amongst critical care nurses.

Various methods have been utilized for collecting data about moral distress within the healthcare profession. The article by Wolf et al. (2016) used a semi-structured focus group to collect data. The setting was in the US and involved eighteen English-speaking adult nurses that were registered. The article by Woods (2020) applied a thematic analysis of information obtained from a questionnaire. The questionnaires were distributed to registered nurses who were from New Zealand. The study by Rathert et al. (2016) used an internet-based survey method to collect data. Data was collected from healthcare staff in acute settings across US hospitals as they were all invited.

Instruments to Measure Moral Distress

According to Epstein et al. (2019) and Nassehi et al. (2019), Corley introduced a moral distress scale in 2001. Corley is a professor at Virginia Commonwealth University who has written and published over 43 articles about moral distress. The moral distress scale was designed to measure moral distress amongst critical care nurses. This tool had 38 items and was revised nine years later to only feature twenty-one items. The reduction in the number of items improved the validity and reliability of the scale. It is now commonly known as the Moral Distress Scale-Revised (MDS-R). The studies by Woods (2020), Vincent et al. (2020), and Vaclavik et al. (2018) utilized the MDS-R Questionnaire. Woods (2020) applied the MDS-R questionnaire, which had 21 items, and it aimed to measure the frequency and levels of moral distress. Vaclavik et al. (2018) also used the MDS-R as he sought to measure the appropriateness of mindfulness intervention in reducing moral distress levels. According to Morley et al. (2019), the MDS-R tool has been undergoing frequent reconstruction from different researchers to

improve its reliability in recording moral distress. The moral distress thermometer (MDT), developed in 2009 by Wocial simply measures moral distress on a 1-10 scale among nurses in a hospital setting. The MDS-R is the most used instrument for assessing frequency and intensity intervention effectiveness and the prevalence of moral distress among nursing or healthcare workers.

The Measure of Moral Distress for -Healthcare Providers (MMD-HP) was developed to cover all healthcare providers. It is a relatively new tool to measure the intensity and frequency of moral distress. Epstein et al., (2019), developed the MMD-HP to provide consistency in measuring moral distress amongst healthcare professionals. This tool is recommended by the founder for use in Long-term Acute care hospital (LTACH) areas and a diverse group of healthcare personnel. This tool can also be used to help guide specific quality improvement (QI) projects to reduce moral distress (Epstein et al, 2019).

Theoretical Framework

When it comes to dealing with moral distress, one of the frameworks that has been identified is the 4 A's to Rise Above Moral Distress (2004), developed by the American Academy of Critical Care Nurses. Making changes are required to address moral distress. Most people find change to be unsettling. To assist in addressing change, the American Association of Critical Care Nurses (AACN) framework of four As' (AACN, 2004) is a technique that can be used to overcome moral distress. The four As' are the words "ask," "affirm," "assess," and "act." The four As' framework was created to promote a healthy work environment, specifically to provide a voice for HCWs who are experiencing moral distress. The four As is a continuous cycle, which may have repeated evaluations of each area before victory is declared.

The first step, ask, is to be aware of moral distress and how it manifests itself. Because the HCW may be unaware of the exact nature of the problem, he or she must investigate. Determine whether the stress is caused by oneself or by the environment. As a result, it's critical to understand the signs and symptoms of moral distress. Being aware of the signs and symptoms can help the HCW identify the problem. The overall goal of the "ask" step is to identify the presence of moral distress.

The second step is to acknowledge that it is a matter of moral obligation to confront moral distress. The HCW must commit to validating specific emotions and feelings related to the situation causing moral distress. By their obligation to call attention to the moral distress dilemma, all health care workers bear the burden of raising awareness about it. Moral distress could potentially be impacting others, but no one has yet raised the issue. The current priority is to "affirm" the distress and decide how to address it.

The next step is to "assess" and analyze the risk of the actions required to tackle moral distress. HCWs may fear reprisal or the possibility of loss of employment due to speaking up about a problem that bothers them morally. This is the point when the HCW determines risk and benefits about mentioning the distressing situation and the ramifications if left unattended. At this point, the overall goal is to determine a course of action.

The final step is to "act", which entails bringing about change. The act step is a purposeful action taken to effect change or raise awareness of a moral issue. The HCWs conclude that they need to make a conscious effort to confront their ambivalence and address the problem. This framework has a set of components that enable healthcare workers to identify how to move forward without compromising their fundamental values. HCWs who have access to the four As' framework are empowered and enabled to help reduce moral distress in the

workplace while at the same time helping to create a supportive workplace. Overall, the 4 A's is an uncomplicated and effective method for HCWs to recognize and address moral distress.

Summary

In summary, the framework's goal is to enable HCWs to communicate about any morally uncomfortable circumstance. First and foremost, the HCW must assess whether the situation is truly moral distress. The HCW then confirms that, sure, this is a moral distress. Following that, the HCW considers the consequences of reporting or not reporting the morally upsetting situation. We are expected to report any compromises with patient safety, child endangerment, or any risk that may cause harm as health care practitioners. When considering reporting a morally disturbing circumstance, HCWs must adopt the same mindset. We disclose compromising situations out of a sense of obligation and safety. Finally, our actions should motivate us to pursue the best possible resolution. The act is based on our instincts and ethical obligations.

Chapter III

Methodology

Inadequate staffing and frustration with the work environment have huge impact on the development of moral distress. Health care workers (HCWs) who can recognize and are mindful of moral distress may seek the necessary resources to reduce the associated stressors. HCWs who do not recognize moral distress, may be less inclined to face the situation and seek employment elsewhere. This translational project was to offer an education workshop about moral distress to 1) explore the frequency and level of moral distress experienced by healthcare workers in a nursing rehabilitation center and, (2) establish a decision tree to aid in the seeking of resources to mitigate moral distress.

Clinical Questions

1. What is the level and frequency of moral distress in participants in the study as evaluated by the data from the MMD-HP?

2. In all the participants in the study was there a relationship between age, gender, years' work experience, education, role, and the level and frequency of moral distress?

3. Was there a statistically significant difference between the two groups on moral distress? One group completing the MMD-HP prior to education, the other completing the MMD-HP after education?

4. What is the utility and effectiveness of the decision tree for HCWs in a nursing rehabilitation facility for mitigating moral distress as evaluated by a 6-weeks post implementation qualitative survey?

Project Design

A mixed-method study design was utilized for this translational project. A quantitative survey utilizing the Measure of Moral Distress for -Healthcare Professionals (MMD-HP) tool was collected pre-implementation of moral distress education and after the training. An assessment of the utility of the decision tree was conducted post implementation using a qualitative survey**.**

Step 1 Recruitment

The participants for this translational project were recruited by the PI. The PI met with the HCWs during weekly staff meetings to explain the project, the informed consent process, workshop training dates and times, and how to complete the MMD-HP survey. The HCWs were informed that the MMD-HP survey will be disseminated by a facility administrator through the organizations' email. The PI gave the HCWs the opportunity to ask any questions and address any concerns about the project. Flyers/brochures (Appendix F) were posted on message boards and throughout the facility as a reminder to complete the online MMD-HP survey prior to the workshop training dates.

Step 2 Informed Consent and Pre-Workshop Survey

The MMD-HP survey was sent via email to all HCWs. The email contained an explanation of the project and participants were given the opportunity to sign an informed consent prior to completion of the MMD-HP through the online survey.

Step 3 Educational Training Workshop

The moral distress education workshop was conducted by the PI initially to the department of human resources, the administration, and the departmental managers of all units. The purpose for completing initial training is to establish and clarify available resources in the

organization that will aid in the development and implementation of the decision tree for mitigating moral distress. After the initial training, the workshop will be expanded to all healthcare workers in the organization.

Six to eight moral distress workshops were held for all HCWs. A Chick-Fil-A breakfast or lunch was provided for individuals attending the workshops. The workshops were conducted during the change of shifts to encourage optimal participation of HCWs. The workshop will be based on the information provided by the standards of the American Association of Critical Care Nurses Recognizing and Addressing Moral Distress training modules (Appendix D). The American Association of Critical Care Nurses has granted permission to all healthcare facilities to use this tool as a helpful resource to create a healthy work environment (American Association of Critical Care Nurses).

Step 4 Creation of the Decision Tree

During the training workshops, the PI assisted the HCWs in an opportunity to expand upon the decision tree within the organization. Resources identified for self, unit, and organization will be used to develop a decision tree for the mitigation of moral distress. The decision tree process involves the following six-steps. 1) The HCW will describe the emotions experienced during a morally distressing situation, 2) The next step is to be very specific about the source of the distress 3) then evaluate were any constraints caused the problem of moral distress. 4) The HCW must consider any conflicting roles. 5) Recognize possible actions to address the situation and 6) The final step is to decide what must be done to mitigate moral distress.

Step 5 Implementation of the Decision Tree

After each training sessions, the PI will collect and consult/validate the resources for implementing the decision tree using the Moral Distress Support within the facility template provided by AACN Moral Distress Training Modules (Appendix D, slide 5). Once made, the decision tree template will be visible throughout the facility for recall use for HCWs. The decision tree implementation is for use when HCWs are experiencing moral distress. Based on the origin of the distress, appropriate resources can be selected to address moral distress.

Step 6 Post Decision Tree Implementation Survey

A qualitative survey questionnaire was emailed to HCWs six to eight weeks after the workshop to get feedback on the workshop and decision tree implementation. Measure of Moral Distress for -Healthcare Professionals (MMD-HP) survey was collected post-implementation of moral distress education at 6-8 weeks after the training. Flyers/brochures was posted on message boards and throughout the facility as a reminder to complete the online survey.

Settings

This project will be implemented at a nursing rehabilitation facility located in the southeastern United States region. The facility is a 186-bed nursing unit that provides services such as Clinical Labs, Dental Care, Dietary, Mental Health, Nursing, Occupational Therapy, Pharmacy, Physician, Physician Extender, Podiatry, Physical Therapy, Social Work, and Speech Pathology**.**

Participants

Approximately 100-120 Healthcare workers, consisting of CNAs (45), RN/LPN (30), Dietary personnel (19), and Environmental Services personnel (20) were recruited for the project. The administration personnel to include, human resources, and the departmental managers of all units will also participate.

Ethical Considerations

Site approval permission was received from Riverview Facility (Appendix E) and Georgia College & State University. IRB approval for this project had the timeline of implementation from July 2021 to January 2022.

Data Security

Respondents' information will be kept strictly confidential in accordance with HIPAA rules and regulations. To maintain anonymity, no names or personally identifiable information will be collected. Information will be secured on a single laptop with only the investigator having access. All responses will be kept anonymous. The purpose of the project, its benefits, and risks, as well as respondents' understanding of confidentiality was explained.

Study Instrument

The tool used for collection of moral distress frequency and level of distress was the Measure of Moral Distress for HealthCare Professionals (MMD-HP) (see Appendix B).
The survey is a 27-item Likert survey that assesses the frequency and severity of moral distress. The amount of moral distress encountered is determined by how frequently a circumstance arises and how upsetting it is when it does. Because both are involved in creating moral distress, these must not be studied independently. The frequency and distress ratings for each item should be multiplied to obtain a total score composite item score, ranging from 0 to 16. The overall score, based on 27 items, will range from 0 to 432. The MMD-HP has good to excellent reliability with a Cronbach's alpha of 0.77 to 0.95 (Epstein et al., 2019). Permission has been granted by Epstein for use of the MMD-HP (Appendix A). This translational project will also incorporate a qualitative survey developed by the principal investigator (PI) about Implementation and Use of

a decision tree (Appendix C). Demographics such as age and date of birth will be collected for variable comparison.

Because this is a new tool, we cannot yet determine which results correspond to high versus low moral distress. One method as recommended by the author of the tool is to create "cut scores." Hamric and Blackhall (2007) placed the scores into three categories (low, medium, and high) and then compared the high and low scorers against selected variables. The selected variable for comparison in this study is the consideration to leave the profession.

Epstein et al., (2019), developed the MMD-HP to provide consistency in measuring moral distress amongst healthcare professionals. This tool is recommended by the founder for use in Long-term Acute care hospital (LTACH) areas and a diverse group of healthcare personnel. This tool can also be used to help guide specific quality improvement (QI) projects to reduce moral distress (Epstein et al, 2019).

Data Analysis

Analysis of data for quantitative and qualitative data was analyzed using SPSS 27.0 software. Descriptive and correlational analysis was performed for the quantitative data of the MMD-HP Survey, pre and post. Thematic analysis was used for the qualitative data assessment.

Chapter 4

Results

The results of this mixed-method study to evaluate the frequency and intensity of moral distress as evaluated by the Measure of Moral Distress for Healthcare Professionals (MMD-HP) tool along with the qualitative assessment of the decision tree are reported here. Findings include descriptive information concerning the participants, the reliability of the instrument and data addressing the clinical questions. One group completed the MMD-HP prior to receiving education about moral distress and the other group completed the MMD-HP after receiving the education.

Data screening was performed prior to conducting the statistical analyses. Eight participants completed the surveys through Qualtrics. Many participants were unfamiliar with computer surveys which required the PI to provide a written version of the MMD-HP to the facility for distribution. The remaining participants utilized pen and paper for completing the survey, therefore those participants' surveys were manually entered into SPSS. Data were verified using a double entry method where two separate databases are created and compared. Random input verification was achieved by examining each subsequent record for the accuracy of the input data. Any discrepancies were reconciled with the participants original data. The collected study surveys were examined for missing data. Out of the fifty-four (N=54) total participants, fourteen did not complete the level of distress subscale of the MMD-HP (n=14). No substitution data will be recorded for those missing items. The frequency and level of distress subscale will be analyzed utilizing 40 participants.

The original data was coded with a number to correspond to the participant's year of birth. (e.g., 1= 1950, 2=1951, 3=1952, etc.) The demographic variable of the participants' year of

birth was recoded to reflect the participants' current age. The participants' age was calculated by subtracting the current year from the participants' year of birth and then manually entered to state the current age, instead of year of birth. Table 1 shows the variables, the instrument used to measure the variables, and the generated measurements.

Table 1
Variables, Instrument, and Generated Measurements

Variables	Instrument / Source of Data	Generated Measurements
Frequency Level of Distress	Measures of Moral Distress for Healthcare Professionals (MMD-HP)	This instrument uses interval/ratio levels of measurement. The frequency and level of distress subscale rankings for each item are to be multiplied to acquire a composite score, each item possible choices from 0 to 16. The produced score, based on 27 elements, will span from 0 to 432.
Age	Participant	Scale
Gender	Participant	Nominal
Years of Experience	Participant	Scale
Current Role	Participant	Scale

After reviewing all interval and ratio level data for central tendencies, it was found that the overall collected Measures of Moral Distress for Healthcare Professional (MMD-HP) was not normally distributed. The descriptive analysis showed a skewness of 1.143 and kurtosis of 0.575 (Munro, 2012). Further examination of the data revealed one participant's score was nearly three standard deviations above the mean (Tabachnick & Fidell, 2013). After conducting the inverse natural logarithm, the variable was normally distributed with a skewness of -0.876 and Kurtosis of -0.215. All remaining data were normally distributed and met the assumptions of all the parametric statistical analyses used to answer the clinical research questions.

Description of the Participants

The participants of this study consisted of two groups. Group one was participants who completed the MMD-HP prior to education about moral distress (*n*=22) versus group two who completed the MMD-HP survey after receiving the same education (*n*=18). The education consisted of the signs and symptoms of moral distress, recognizing the source of moral distress, along with the available resources to assist with mitigation of moral distress.

Of the 40 participants in this study, 4 were males (10%), 36 were female (90%). Eleven participants had a bachelor's degree or higher educational level (27.5%). Nine work as certified nurse assistants (22.5%), two worked as licensed practical nurses (5%), two worked as registered nurses (5%), eight worked in administration (20%), ten were listed as department managers (25%), one was environmental services (2.5%), two worked in dietary (5%), social services accounted for five (15.5%) and maintenance had one (2.5%).

The Study Instrument

This section describes the study instrument, it's reliability in this sample, the mean scores and standard deviations, the percentage of the study participants above the normal ranges (Table 2). The Measure of Moral Distress for Healthcare Professionals (MMD-HP) is a tool for determining presence of moral distress level. Cronbach's alpha for the sample was an acceptable at 0.98 (Tabachnick and Fidell, 2013).

Table 2

Descriptive of Research Instrument

Variable	M(SD)	Observed range	Possible Range	Cut-off	α
MMD-HP	70.55 (75.20)	0 - 269	0 - 432	0 low (n=13) 2 - 32 middle (n = 13)	.98

	> 90 high (n = 14)

Analysis of the Research Questions

Prior to beginning the analysis, the independent variables (gender, education level, job roles, and assigned departments) were examined for multicollinearity. There were several significant correlations between the independent variables, however none were strong *(r <.51)* indicating that multicollinearity was not a problem with those variables.

Clinical Questions 1: What is the level and frequency of moral distress in the participants in the study?

Descriptive analysis was used to examine the level and frequency of moral distress of participants in this study as surveyed by the MMD-HP. The MMD-HP has a possible score from zero to 432. The participants of the study scored ranged from zero to 269, as levels of moral distress. As directed by MMD-HP scoring and interpretation guidelines, due to this instrument being new, cut scores are developed into 1/3 groups. The groups are labeled as low, medium, and high. Scores ranging from 0-16 constitutes as a low level of MD (*n*=13), scores ranging from 20-81 equates to a medium level of MD (*n*=13), and a score of 90 or greater represents a high level of MD (*n*=14). The consideration to leave a position in the past or in the present were the variables selected for comparison to the cut-scores. In this sample, there was a statistically significant difference in the past consideration of leaving a position due to moral distress between cut scores (x^2(2, 40) =6.44, p=0.04). Ten of the 13 participants in the low-cut scores have not considered leaving. While 11 of the 14 participants in the high cut-scores have left (*n*=2) or have considered leaving (*n*=9), see table 3.

There was also a statistically significant difference in present consideration of leaving a position due to moral distress between cut scores ($x^2(4, 40) = 16.2$, p=0.003). In the lower-level cut scores 13 out of 13 participants have not considered leaving while in the higher level cut scores, five of the 14 participants are considering leaving their position (table 4).

The participants in the higher cut-score level of moral distress will potentiality depart the position due to moral distress.

Table 3

Considered or have Left Position Due to Moral Distress (MD)

Levels of MD	No, have not considered	Yes, but did not leave	Yes, I have left	*n*	Measure
1	10	2	1	13	$x^2(2, 40) =6.44$,
2	7	1	5	13	p=0.04
3	3	9	2	14	

Table 4

Presently Considering Leaving Due to Moral Distress

Level of MD	No, have not considered	Yes, have considered	*n*	Measure
1	13	0	13	$x^2(4, 40) = 16.2$,
2	8	5	13	p=0.003
3	9	5	14	

Clinical Question 2: Was there a relationship between age, gender, years of work experience, education, role, and the level and frequency of moral distress?

Correlational analysis was used to examine if participants' age had a statistically significant correlation with moral distress. The Spearman Rho was used to evaluate age and moral distress. Data indicated that age does not significantly correlate with the scoring of moral distress (rs= .35, p> .05). Moral distress does not vary with age in this study.

Chi square analysis was done to determine if there were any statistically significant differences in moral distress attributed to gender in the study. There were no statistically significant differences between male and females in the study (x^2(30, 40) =18.3 p=0.95). The level of moral distress does not differ between genders.

Spearman rho analysis was used to determine the correlation between years of experience in healthcare and the frequency and level of distress. Analysis shows no significant correlation between years of experience in healthcare and level of moral distress (rs 0.218, p=0.18). Likewise, years in current role is not significantly correlated with frequency and level of moral distress (rs 0.14, p=0.37). Newer and older employees do not differ in their moral distress level.

Correlational analysis was also used to examine education and moral distress levels. Data indicated a statistically non-significant correlational between education and moral distress. (rs -.06, p=0.72). Participants in this study demonstrated that education level does not increase nor decrease the levels of moral distress.

Groups were formed by similar job functions to evaluate roles in regard to the level of moral distress. The roles were nursing, administration, and ancillary services as noted on table 5. The nursing roles were the participants who were assigned as RNs, LPNs, and CNAs. The administration roles were participants assigned as department head, administrators, and secretary. The ancillary roles were participants who functioned as social workers, dietary, and maintenance. A one-way ANOVA was used to test the differences in moral distress in terms of job roles. Prior to beginning the analysis, the data were examined to determine if it met the assumptions for ANOVA. The Levene's test was significant indicating equal variance could not be assumed. Post ad hoc testing was done using the Tamhane Post Hoc test. Results indicated

the nursing group (M 4.5, SD 0.74) had significantly higher moral distress (F (2,34) = 16.53, p < 0.019) as compared to administration, (M 3.06, SD 1.65) and the ancillary group (M 3.37, SD 1.53). Nursing roles are more likely subjected to a higher level of moral distress as compared to ancillary services (social work, dietary, maintenance) and administrators (department managers, secretaries, etc.).

Clinical Question 3. Was there a statistically significant difference between the two groups on moral distress?

An independent sample t-test was used to evaluate if there were statistically significant differences between those who completed the MMD-HP prior to receiving education about moral distress and those who completed the MMD-HP after the training. There was no significant differences demonstrated between the two groups (t(33,40)= -1.02, p=0.311).

To control for confounding variables, a comparison of the demographics between the group who completed the MMD-HP before the education and the group who complete the MD-HP after education was performed. No statistical differences were found between the two groups. Data indicated that the two groups did not differ in age t(37)1.11, p=0.27, level of education x^2(90,40) =95.49 p=0.32 and years of experience x^2(120,39) =127.0 p=0.31 (table 5).

A two-way ANOVA was used to test the differences in moral distress between the 2 groups in terms of job roles. There were no statistically significant differences between the before and after education groups (F (5, 34)=17.97, p=0.14). After education the nursing role remains high in moral distress. Data indicated that the level and frequency of moral distress did not change for the nursing HCWs before (M 4.8, SE 0.70) and after (M4.4, SE 0.47), nor for

admin roles before (M2.8, SE 0.47) and after (M 3.4, SE 0.63), or for ancillary before (M 3.3, SE 0.63) and after (M 3.4, SE 0.81) regardless of the education intervention on moral distress.

Table 5

Comparison of Educational Groups

		Group1		Group 2	
Variables	N (%)	M(SD or SE)	N(%)	M(SD or SE)	Measure
Age	22	51.5 (10.5)	17	47.2 (13.3)	*t*(37)1.11, p=0.27
Gender					
Male	2(11.1)		2 (11.1)		
Female	20 (86.1)		16 (88.9)		
Yrs of Work Exp	18		17		x^2(120,39) =127.0 p=0.31
1-2	1		5		
3-4	4		2		
5-6	2		1		
7-8	0		4		
9-10	1		5		
11>	10				
Education	18		17		x^2(90,40) =95.49 p=0.32
HS Dip	8		11		
2-3Coll	4		3		
Bach	4		3		
Masters	2		0		
Job Role					
Nursing	4	4.8 (0.70)	9	4.4 (0.47)	
Admin	13	2.8 (0.47)	5	3.4 (0.63)	
Ancillary	5	3.3 (0.63)	4	3.4 (0.81)	

Clinical Question 4. What is the utility and effectiveness of the decision tree for HCWs in a nursing rehabilitation facility for mitigating moral distress as evaluated by a 6-weeks post implementation qualitative survey?

Due to the pandemic, results were gathered immediately post education versus the planned six-week period. Twelve (*n*=12) study participants completed a qualitative survey

concerning questions about the ease of use and their thoughts about the effectiveness of the decision tree to address moral distress. The most noted remarks were about the utility of the decision tree. Some specific comments were "it is helpful and easy to understand", "it will be helpful in different situations", "I think it's okay", "easy to follow and understand", another participant stated, "the effectiveness of the decision tree would be excellent if employees would use it."

Summary

This chapter presented the results of this translational clinical project. A total of 54 participants with a remaining N of 40 responded to the recruitment to participate by posters, email, and word-of-mouth at the facility work location. Participants were a combination of two groups. One group completed the moral distress survey prior to education moral distress. The other group received the education about moral distress, then completed the survey. The study evaluated frequency and intensity of moral distress for such variables as age, gender, experience in the healthcare profession, education, and job role.

In this sample, past consideration of leaving a job due to moral distress differed significantly amongst cut scores. Ten of 13 low-scoring participants have not thought about leaving. Eleven of the 14 high-scoring participants have left or are leaving.

There was also a statistically significant difference in considering leaving a job due to moral distress. Lower-level cut scores have 13 of 13 participants not considering leaving, while higher-level cut scores have 5 of 14 considering leaving. These results indicate the higher the score for moral distress, the higher the potential of the healthcare worker departing the medical profession.

Chapter 5

Discussion

The DNP project was aimed to educate HCWs in a nursing care facility about recognizing moral distress and establishing a decision tree to aid in the proper selection of resources to address moral distress. Understanding and recognizing sources and limitations about moral distress is critical in evaluating moral distress among HCWs (Anabila et al., 2019). The PI educated HCWs at a southeastern rehabilitation health care facility about the signs and symptoms of moral distress, as well as the implementation and effectiveness of a decision tree, by utilizing the AACN Recognize and Address Moral Distress PowerPoint. The presentation consisted of scenarios which allowed the HCW's to identify whether the origin of the moral distress is from oneself, the unit or the organization. The most appropriate resource was selected from the decision tree depending on the origin of the moral distress. Hence, the study aimed to educate about the appropriate actions HCWs should take when experiencing moral distress and self-care techniques for maintaining mental health and well-being.

Two sessions, consisting of two separate groups, on moral distress education and the use of a decision tree were conducted among the facility's HCWs. The list of available resources within the organization to address moral distress was provided by the Human Resources department and departmental managers during the initial session. These resources were listed on the decision tree. Few participants completed the MMD-HP survey via Qualtrics, necessitating the use of a written copy of the survey prior to the education to encourage participation. The second group received training and completed the MMD-HP after the training workshop. The HCWs were quite interactive and demonstrated proper use of the decision tree. More ancillary

department personnel participated in the surveys than direct contact medical healthcare personnel such as CNAs, LPNs, or RNs. Each HCW attending the training workshops was provided a copy of the decision tree with resources listed according to the healthcare facility's HR department. In addition, the decision tree was posted throughout the facility as a reminder of the resources available to the HCWs when experiencing moral distress.

In this study, moral distress did not differ by age, gender, and education. There is no difference in the level of moral distress before and after education training. The results indicated that moral distress education and intervention has to be an ongoing process and reinforced regularly to become a standard part of the participants' mindset.

Age and Moral Distress

The results of the study show that age does not correlate with the occurrence and scoring of moral distress. Some studies have shown that age has an inverse association with moral distress. However, this finding is limited to other healthcare professionals since, in nurses and physicians, age does not influence the occurrence of moral distress (Dodek et al., 2016). Other studies indicate that younger practitioners below 37 years often report more severe moral distress as compared to practitioners above 37 years (Almutairi et al., 2019). The concept of age correlates with experience, where health care practitioners often start working between 23 and 25 years. During this age, they experience difficulties adjusting to the environment and coping with the work stressors (Almutairi et al., 2019). As a result, they experience a high risk of moral distress.

Gender and Moral Distress

The results of the study did not show any differences between gender in the scoring of moral distress. The literature presents contradicting association between gender and moral distress. Other studies show that women often have more severe mental distress than men (Almutairi et al., 2019) while other studies indicate that female physicians have a reduced likelihood of experiencing moral distress than their male counterparts (Wocial et al., 2020). However, most studies agree that women face higher risks of low job satisfaction, severe burnout symptoms, and disrespect (Burns et al., 2019). They were also more likely to be uninformed of the policies that are available to address disrespect. Lastly, women are less confident in their ability to take actions to address inclusivity (Burns et al., 2019). These conditions result in a higher risk of moral distress, thus supporting the occurrence of higher moral distress in female healthcare practitioners (O'Connell, 2014). However, gender-based studies are often biased as they include a higher number of female practitioners as compared to males. As such, it is not clear whether these findings are due to an unfavorable ratio or an accurate representation of mental distress among the groups.

Overall, both male and female practitioners report increased moral distress when they follow a family's wishes in discontinuing life support. However, males report higher rates of increased distress when initiating actions to save a life when they will only prologue death (O'Connell, 2014). This finding shows that female and male practitioners have conflicting views regarding continuity of care in patients facing imminent death. Males are more inclined to support withholding treatment when the patient has no chance of recovery and vice versa. As a result, gender directly influences the factors that result in distress.

Experience and Moral Distress

Years of experience in healthcare or the years in a current role do not correlate with the level of moral distress. This finding is opposed to other studies that state that training and experience create moral strength by giving healthcare professionals the confidence and clarity they need to make decisions without a risk of feeling morally distressed (Ulrich and Grady, 2019). Additionally, reduced experience increases the occurrence of moral distress. Junior physicians are unable to prevent the escalation of potentially inappropriate treatment as compared to senior physicians (Rosenwohl-Mack et al., 2020). They are also uncomfortable and less likely to speak up when interacting with patients or other practitioners. As such, they often feel unable to advocate for their patients, leading to a higher level of moral distress (Rosenwohl-Mack et al., 2020). These findings suggest that experience reduces the occurrence of moral distress.

In contrast, other studies in nursing report that experience negatively impacts moral distress. Increase level of experience of the same negative situations and repeated exposure to moral distress increases the baseline for both moral distress and moral residue, thus continuously increasing the moral distress level (Dodek et al., 2016). This finding is attributed to the occurrence of the crescendo effect (Epstein and Delgado, 2010). Often, the repeated moral distress is not addressed, leading to a frequent moral residue that builds up over time. Eventually, the nurse often has a feeling of “here we go again” when dealing with similar cases (Epstein and Delgado, 2010). This repetition that is attributed to experience increases the moral distress baseline. As a result, nurses with a higher experience have increased levels of moral distress, a higher baseline, and an increased likelihood of leaving a position.

Education and Moral Distress

The study results demonstrate that level of education does not influence the occurrence and the level of moral distress. This result supports other studies that show no statistical difference in the prevalence of severe moral distress between those with high education levels and those with lower ones (Almutairi et al., 2019). However, some studies indicate that in nurses, those with a bachelor's degree have a higher distress level than those with lower levels of education (Krautscheid et al., 2017; Wenwen et al., 2016). This moral distress frequently occurs before licensure, during which they are exposed to high levels of compassion fatigue and apathy.

Nursing students face frequent dilemmas when determining whether they should speak up or remain quiet and allow a standard practice that is potentially harmful to occur. They are also unsure of actions to take when their supervisor demonstrates infection control breaches or disrespect to their patient or other students (Krautscheid et al., 2017). These situations result in high moral distress that affects them when they obtain their license and begin their practice.

Alternatively, nurses with high education levels have extensive knowledge in patient care but may still be forced to take unreasonable or incorrect care measures that they are convinced would be painful to the patient (Wenwen et al., 2016). Also, they have good judgment on treatment but are forced to rely on the opinion of doctors who may even have a lower level of experience (Wenwen et al., 2016). These situations create high moral distress as the nurse is forced to implement a care plan although they know it may not be the best course of care for the patient.

Role and Moral Distress

While moral distress is still prevalent among all healthcare providers, overall, this project has demonstrated as the literature has shown that bedside healthcare personnel experience a much higher level of moral distress as compared to other healthcare professionals. The study

results show that the type of job influences the occurrence of moral distress. This finding is similar to results in other studies that show the occurrence of moral distress in physicians and other professional groups (Dodek et al., 2016).

In this study, nursing groups have higher moral distress levels as compared to ancillary services and administrators. This result is consistent with other studies, which show that nurses have higher moral distress levels as compared to other professions in the hospital (Giannetta et al., 2021). Nurses are often directly interacting with patients as they provide care. They are in close proximity to patients than other healthcare professionals (Giannetta et al., 2021). As a result, they are often exposed to morally distressing events, which leads to a higher rate of moral distress.

Nurses are also exposed to other conditions that increase job dissatisfaction and moral distress. These conditions include burnout and the lack of collaboration with physicians during patient care (Dodek et al., 2016). Mental distress due to burnout is often associated with adverse events and failure to report errors, which negatively affects patient safety (Dodek et al., 2016). Therefore, mental distress negatively affects both the health care workers and their patients. Also, moral distress is higher among nurses as they are exposed to the feeling of powerlessness, especially due to the occurrence of hierarchy. Care is directed by physicians, and nurses rely on physicians' directions to determine the course of treatment. Health care practitioners in ICUs often report a higher rate of moral distress as compared to primary care physicians (Dodek et al., 2016). These findings suggest that the higher the moral distress level, the greater the likelihood of a healthcare worker entering the job market for another profession.

Qualitative Survey

Because of the pandemic, results were collected immediately following the education workshop rather than over a six-week period. Participants in the study completed a qualitative survey that included questions about the decision tree's ease of use and their opinions on its usefulness in addressing moral distress. The decision tree's utility was the topic of most discussion. Participants made statements such as, "It is beneficial and easy to comprehend," "it will be helpful in many scenarios," "I think it's okay," "easy to follow and understand," and "the effectiveness of the decision tree would be good if employees would apply it." The decision tree is an effective means of addressing moral distress, where participants found it helpful and easy to understand. It can also be used to evaluate a decision that has been made, thus ensuring that HCW's can view the consequences of their choices under imagined conditions. It is an effective means of determining the best resources to use to combat moral distress. The decision tree was positively received by the participants. Overall, once described, the participants generally considered the decision tree to be user-friendly.

There is no one-size-fits-all solution for reducing moral distress amongst HCWs. The American Association of Critical-Care Nurses recently revised its moral distress web page, which now includes a toolbox to assist with recognizing moral distress and taking action to resolve it. The criteria of healthy work environments established by the American Association of Critical-Care Nurses are an essential resource. Realizing that moral distress is obviously a huge phenomenon, leaders who help promote an overarching healthy work environment have the optimum chance of creating a safe community HCWs to function effectively.

Strengths and Limitations

Strengths

The study strength was support and assistance from the rehabilitation facility's human resources (HR) department. The training was initially scheduled to be conducted face-to-face. However, due to the pandemic, the training was conducted via Zoom. The HR department representative was readily adaptable to changing the meeting locations and coordinating the meetings through Zoom sessions. Another area requiring adaptation was the completion of the MMD-HP survey. The preferred method of completion of the MMD-HP survey was through Qualtrics. After discussion with the HR department, it was recommended to resort to a written version of the MMD-HP for completion prior to conducting the training. This method proved to be much more effective for completing the MMD-HP survey before the education was provided, as the number of participants increased from eight to 22 participants. The total number of participants who completed the survey after education was held was 18.

The use of a decision tree to address moral distress in a southeastern healthcare facility proved to be effective. The participants were eagerly involved and participated in the training as it was presented. A post qualitative survey was conducted about the use and effectiveness of the decision tree. Participants commented, "it would be quite effective if employees utilize the decision tree." Other comments included that the decision tree was "easy to follow and use once explained." During thematic analysis, the most noted remarks were noted as the decision tree is effective. Some specific comments were "it is helpful and easy to understand," "it will be helpful in different situations," "easy to follow and understand." As a result of the participants' candid remarks, the decision tree appeared to be highly effective if employees used it.

Study Limitations

The Covid-19 pandemic prevented in-person initial visit training; necessitating training conducted via Zoom. Moreover, many participants were unfamiliar with computer surveys which

required the PI to provide a written version of the MMD-HP to the facility for distribution. Consequently, data was entered by the PI using the double-entry method for the survey results into the SPSS program. The use of the written survey was identified as a more efficient method for the senior HCWs who were not familiar with technology compared to their younger counterparts. Another critical limitation in the survey was difficulties following up the initial group compared to the second training session. Therefore, the PI did not get the same individuals consistently during the survey.

The MMD-HP scores were only completed on 40 participants because 14 participants did correctly mark the MMD-HP survey. The 14 participants were missing the level of distress aspect of the MMD-HP survey; therefore, the MMD-HP score could not be fully calculated for all 54 participants resulting in lower sample size.

Another limitation of the study was the absence of a well-balanced representation of all disciplines. The majority of the participants were from ancillary services, such as food service personnel, maintenance, and administration. Few direct contact medical healthcare personnel (CNAs, LPNs, and RN) participated in the study.

Future Research

Recommendations for future research should include the education and training of HCWs about moral distress and resources to address the situations. Future research should emphasize means to improve the quality of healthcare by addressing moral distress among the HCWs (Beaussier and Cabane, 2020). The healthcare system is constantly changing due to several factors shaping decisions in the healthcare industry. Factors driving the healthcare industry are increased healthcare cost-sharing due to a rise in medication and healthcare services. This changing healthcare environment factor significantly impacts the HCWs moral distress

situations. Furthermore, a combination of factors created within such a complex healthcare environment has greatly increased HCW's moral distress. Future studies should consider how HCWs meet and address their mental well-being (Beaussier and Cabane, 2020). Moreover, the HCWs have to be informed and trained in moral distress that may occur due to the work environment. Thus, in the digital era, many HCWs have to work towards improved healthcare by using technological means (Mannion & Davies, 2018). There are apps available to assist with mental well-being for HCWs.

Additional implications for future research should consider how the healthcare industry change is driven by demographic changes and its impacts on HCWs' moral distress (Melo, 2018). Globally, the growing population as a result of high birth rates and migration has increased the demand for healthcare services. In addition, future research should take the novel approach of addressing moral distress by utilizing AACN's toolkit to identify and assist with mitigating moral distress (Mannion & Davies, 2018). This toolkit will improve education about moral distress among the HCWs, allowing healthcare management the opportunity to promote a quality healthcare work environment.

Moreover, the state of healthcare management in understanding moral distress among various HCWs in the healthcare system should also be considered as a future research topic. Healthcare service management and HCWs should aim at efficiency in care provision (Upadhyai et al., 2019). The rise in the use of national healthcare schemes has led to increased access to healthcare by many people and increased workload on the HCWs. Funding and capitation of the healthcare system is a huge challenge to the government due to increased healthcare needs, consequently impacting the welfare of the HCWs (Khan and Boardman, 2017). As a result of the transformation of the healthcare system, the need for effective management of HCWs is crucial

to reduce the rate of job turnover, change of work environment, and risk of leaving service. Replicating this study in other similar institutions may bolster the same findings.

Implications to Nursing Practice

As leaders in today's healthcare professionals, our moral obligation is to provide HCWs with information and resources to address their mental well-being. The current pandemic has wreaked havoc on the healthcare profession due to misinformation and mistrust of the profession responsible for providing education (Nicolaou & Kentas, 2017). Moral distress must be addressed, and HCWs must be educated about the ramifications. The healthcare profession continues to lose qualified personnel due to the inability to identify and treat moral distress. Moreover, the HCWs have to express their perspectives concerning their working environment. Therefore, after completing the training about moral distress and using a decision tree, healthcare workers will be better equipped to provide quality healthcare services to the consumers. Thus, the study is significant to improving healthcare quality by creating awareness of moral distress among HCW and its impacts through the decision tree approach.

Sustainability

The sustainability of this project is highly probable and cost-effective. Moral distress education and training can be conducted as in-person or virtual sessions. Implementing this education as a part of the orientation process at any medical facility is highly recommended. The AACN provides a wealth of information for moral distress training, including a PowerPoint presentation, a toolkit, and surveys of safe work environments.

Conclusion

This project consisted of implementing the decision tree to address moral distress. The primary desired outcome was for HCWs to recognize and address moral distress. The idea was to use the decision tree as a guide to identify the source of the stress and recognize resources available to assist in diminishing moral distress. The project showed that informed HCWs could feel empowered and cared for by management. The HCWs attending the training were very involved and actively participated in the questioning and scenarios about situations creating moral distress. Participants spoke up about the need of training for newly hired personnel and needing training about tasks to perform. Based on the American Association of Colleges of Nursing (AACN, 2020) report, the rate of development of the HCWs is lower than the demand for healthcare services in the US and globally. Moreover, significant levels of moral distress harm the healthcare profession, culminating in a high turnover rate. The research paper further supports healthcare organizations' importance in educating healthcare workers about moral distress to minimize the high rate of job turnover and resignation within the healthcare profession.

The training about moral distress must be intentional and directed towards the bedside personnel. AACN training PowerPoint demonstrates all the major areas of recognizing and alleviating moral distress. The training must include education about the resources available to mitigate moral distress.

All healthcare workers (HCWs) feel moral distress, albeit different professions have varied viewpoints and experiences with it (Whitehead, 2015). Even though there are multiple definitions of moral distress given in the health care system, there is no consensus on how to interpret them. This lack of clarity has an impact on not only nursing practice and research, but also on moral distress education and policy formation. Burnout, low job satisfaction, and high

turnover of HCWs have all been linked to moral distress in prior studies (Dzeng, 2018). Moral distress can manifest itself physically, psychologically, behaviorally, and even socially. This project has shown that the higher the level of moral distress, the greater the potential for position assignment change or leaving the profession. The fundamental issue, according to an analysis of the theories of moral distress, is the impact on the quality of healthcare, in addition to the negative effects on the HCWs (Wilson, 2018).

Inadequate staffing and job dissatisfaction are major consequences of moral distress among the HCW. HCWs' staffing shortage may be a big problem for the quality of patient care and the quantity of time spent with patients. Thus, HCWs may quit their job due to feeling overworked and understaffed in healthcare facilities. However, if more healthcare professionals can recognize the signs and symptoms of moral distress and seek appropriate resources to address its constraints, they are less likely to leave the medical profession.

Thus, after completing training on moral distress and using a decision tree, healthcare workers will be better equipped to provide high-quality healthcare to health consumers. Improving the quality of healthcare by creating awareness about moral distress among HCWs is critical to ensuring the sustainability of the nursing profession.

References

AACN Fact Sheet. Available at: http://www.aacnnursing.org/Portals/42/News/Factsheets/Faculty-Shortage-Factsheet.pdf Accessed April 12, 2021.

AACN Moral Distress Tool. Available at: https://www.aacn.org/~/media/aacn- website/clincial-resources/moral-distress/recognizing-addressing-moral-distress-quick- reference-guide.pdf. Accessed April 12, 2021.

Almutairi, Adel F. (2019) Prevalence of severe moral distress among healthcare Providers in Saudi Arabia. *Psychology Research and Behavior Management, 12,* 107-115. Accessed May 26, 2022.

Altman, M., & Delgado, S. (2021). Nurse Strong: Recognizing and mitigating moral distress resources for moral distress. American Association of Critical-Care Nurses. Available at: https://www.aacn.org/clinical-resources/moral-distress. Accessed April 12, 2021.

Anabila, P., Kumi, D. K., & Anome, J. (2019). Patients' perceptions of healthcare quality in Ghana: A review of public and private hospitals. *International journal of health care quality assurance*.

Beaussier, A.-L., & Cabane, L. (2020). Strengthening the EU's response capacity to health emergencies: Insights from EU crisis management mechanisms. *European Journal of Risk Regulation, 11*(4), 808–820.

Bruggemann, A., Forsberg, C., Colnerud, G., Wijma, B., & Thornberg, R. (2018). Bystander passivity in health care and school settings: Moral disengagement, moral distress, and opportunities for moral education. *Journal of Moral Education*, *48*(2), 199–213. Retrieved February 12, 2021, from https://doi.org/10.1080/03057240.2018.1471391

Buerhaus, P., Auerbach, D., Skinner, L., & Staiger, D. (2017). State of the Registered Nurse Workforce as a New Era of health reform emerges: *Nursing Economics*, *35*(5), pp229-237. Retrieved February 12, 2021, from https://www.aaacn.org/sites/default/files/documents/StateoftheRegisteredNurseWorkforce.pdf

Burns, Karen E. A. (2019) Gender differences in career satisfaction, moral distress, and incivility: A national, cross-sectional survey of Canadian critical care physicians. *Canadian Journal of Anesthesia/Journal Canadien D'anesthésie,* 66 (5), 503-511.

Campbell, S. M., Ulrich, C. M., & Grady, C. (2016). A broader understanding of moral distress. *The American Journal of Bioethics*, *16*(12), 2–9. Retrieved January 20, 2021, from https://doi.org/10.1080/15265161.2016.1239782

Cimiotti, J. P., Aiken, L. H., Sloane, D. M., & Wu, E. S. (2012). Nurse staffing, burnout, and health care-associated infection. *American journal of infection control*, *40*(6), 486–490. https://doi.org/10.1016/j.ajic.2012.02.029

Cooper, S. L., Carleton, H. L., Chamberlain, S. A., Cummings, G. G., Bambrick, W., & Estabrooks, C. A. (2016). Burnout in the nursing home health care aide: A systematic review. *Burnout Research*, *3*(3), 76–87. https://doi.org/10.1016/j.burn.2016.06.003

Corley, M. C. (2002). Nurse Moral Distress: a proposed theory and research agenda. *Nursing Ethics*, *9*(6), 636–650. https://doi.org/10.1191/0969733002ne557oa

Corley, M. C., Elswick, R. K., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of advanced nursing*, *33*(2), 250–256. https://doi.org/10.1046/j.1365-2648.2001.01658.x

DeGrazia, M., Porter, C., Sheehan, A., Whitamore, S., White, D., Winter Nuttall, P., Blanchard, T., Davis, N., Steadman, J., and Hickey, P. (2021). Building moral resiliency through the nurse education and support Team Initiative. *American Association of Critical-Care Nurses 30: pp95-102*

Dodek, Peter M. (2016). Moral Distress in intensive care unit professionals is associated with profession, age, and Years of experience. *Journal Of Critical Care, 31*(1) 178-182. Accessed May 26, 2022.

Dzeng, E., & Curtis, J. R. (2018). Understanding ethical climate, moral distress, and burnout: a novel tool and a conceptual framework. *BMJ Quality & Safety*, *27*(10), 766–770. https://doi.org/10.1136/bmjqs-2018-007905

Epstein, E. G., Whitehead, P. B., Prompahakul, C., Thacker, L. R., & Hamric, A. B. (2019). Enhancing understanding of moral distress: The measure of moral distress for health care professionals. *AJOB Empirical Bioethics*, *10*(2), 113–124

Epstein, E. and Sarah D. (2010) Understanding and addressing moral distress. OJIN: *The Online Journal of Issues In Nursing, 15*(3), 2010. Accessed May 26, 2022.

Giannetta, N. (2021). Levels of moral distress among health care professionals working in hospital and community settings: A cross sectional study. *Healthcare, (9)*12, 1673. Accessed May 26, 2022.

Hamric, A. B., and Blackhall, L., J. (2007). Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine 35* (2):422–9. doi: 10.1097/ 01.CCM.0000254722.50608.2D.

Hossain, F., & Clatty, A. (2020). Self-care strategies in response to nurses' moral injury during COVID-19 pandemic. *Nursing ethics*, *28*(1), 23–32. https://doi.org/10.1177/0969733020961825

Jameton, A. (2013). A reflection on moral distress in nursing together with a current application of the concept. *Journal of Bioethical Inquiry*, *10*(3), 297–308. Retrieved June 28, 2021, from https://doi.org/10.1007/s11673-013-9466-3

Karakachian, A., & Colbert, A. (2017). Moral distress. *Nursing*, *47*(10), 13–15. Retrieved May 21, 2021, from https://doi.org/10.1097/01.nurse.0000525602.20742.4b

Kelly, L., & Todd, M. (2017). Compassion fatigue and the healthy work environment. *AACN Advanced Critical Care*, *28*(4), 351–358. Retrieved February 3, 2021, from https://doi.org/10.4037/aacnacc2017283

Khan, M., and Boardman, J. (2017). Employment and mental health. *Royal College of Psychiatrists*. https://www.rcpsych.ac.uk/docs/default-source/mental-health/work-and-mental-health-library/op101-final.pdf

Krautscheid, L. (2017) Moral distress and associated factors among baccalaureate nursing students: A multisite descriptive study. *Nursing Education Perspectives, 38 (6)* 313-319. Accessed May 26, 2022.

Lawrence, L.A. (2011), Work engagement, moral distress, education level, and Critical reflective practice in intensive care nurses. *Nursing Forum*, *46*: 256-268. https://doi.org/10.1111/j.1744-6198.2011.00237.x

Li, Y. & Jones, C. (2012). A literature review of nursing turnover costs. Journal of nursing management. Retrieved June 2, 2021, from 21.10.1111/j.1365-2834.2012.01411.x.

Lievrouw, A., Vanheule, S., Deveugele, M., Vos, M., Pattyn, P., Belle, V., & Benoit, D. (2016). Coping with moral distress in oncology practice: Nurse and physician strategies. *Oncology Nursing Forum*, *43*(4), 505–512. Retrieved May 13, 2021, from https://doi.org/10.1188/16.onf.505-512

Lizarondo, L. (2020). Evidence Summary. Moral Distress (Nurses): Interventions in Critical Care Settings. *The JBI EBP Database*, JBI23872.

Makic M. B. (2011). Management of nausea, vomiting, and diarrhea during critical illness. *AACN advanced critical care*, *22*(3), 265–274. https://doi.org/10.1097/NCI.0b013e3182248a2b

Malone, R. (2021). Covid-19, sars-cov-2: Impact on healthcare workers in the pandemic's initial months: Rapid review. *International Journal of Occupational and Environmental Safety*, *5*(1), 1–15. Retrieved March 24, 2021, from https://doi.org/10.24840/2184-0954_005.001_0001

Mannion, R., & Davies, H. (2018). Understanding organizational culture for healthcare quality improvement. *BMJ (Clinical research ed.)*, *363*, k4907. https://doi.org/10.1136/bmj.k4907

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, *2*(2), 99–113. Retrieved June 18, 2021, from https://doi.org/10.1002/job.4030020205

McAndrew, N. S., Leske, J. S., & Garcia, A. (2011). Influence of moral distress on the professional practice environment during prognostic conflict in critical care. *Journal of trauma nursing: the official journal of the Society of Trauma Nurses*, *18*(4), 221–230. https://doi.org/10.1097/JTN.0b013e31823a4a12

Miotto, K., Sanford, J., Brymer, M. J., Bursch, B., & Pynoos, R. S. (2020). Implementing an emotional support and mental health response plan for healthcare workers during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S165–S167. https://doi.org/10.1037/tra0000918.

Morley, G., Ives, J., Bradbury-Jones, C., & Irvine, F. (2019). What is 'moral distress'? a narrative synthesis of the literature. *Nursing Ethics*, *26*(3), 646–662. Retrieved March 10, 2021, from https://doi.org/10.1177/0969733017724354

Munro, B. H. (2012). Statistical methods for health care research (6th ed.). Lippincott Williams & Wilkins.

Nassehi, A., Cheraghi, M. A., Hosseini, A. S., Pashaeypoor, S., & Mahmoudi, N. (2019). Moral distress in nursing: A concept analysis. *Drug Invention Today*, *11*(5).

Nicolaou, N. and Kentas, G., (2017) Total quality management implementation failure reasons in healthcare sector. *Journal of Health Science 5* 110-113 doi: 10.17265/2328-7136/2017.02.007

Nuttgens, S. & Chang, J. (2013). Moral distress within the supervisory relationship: Implications for practice and research. *Counselor Education and Supervision*. 52

O'Connell, C. (2014) Gender and the experience of moral distress in critical care nurses. *Nursing Ethics 22*(1) 32-42. Accessed May 26, 2022.

Rathert, C., Ma, D., and Chung, H., (2016). Nurse moral distress: A survey identifying predictors and potential interventions. *International Journal of Nursing Studies 53*, 39-49

Richardson, J. (2020). Sins of omission how government failures to track covid-19 data have led to more than 1,700 health care worker deaths and jeopardize public health. https://www.nationalnursesunited.org/

Rosenwohl-Mack, S., (2020). Understanding experiences of moral distress in end-of-life care among US And UK physician trainees: A comparative qualitative study. *Journal Of General Internal Medicine, 36(7)* 1890-1897

Satell, G. (2019). 4 Tips for managing organizational Change. *Harvard Business Review.* Retrieved June 12, 2021, from https://hbr.org/2019/08/4-tips-for-managing-organizational change

Tabachnick, B. G., & Fidell, L. S. (2013). Using multivariate statistics (6th ed.). Pearson/Allyn & Bacon.

Ulrich, Connie, and Christine Grady. (2019). Moral Distress and Moral Strength Among Clinicians in Health Care Systems: A Call for Research. *National Academy of Medicine,* Accessed May 26, 2022.

Vaclavik, E., Staffileno, B., & Carlson, E. (2018). Moral distress: Using mindfulness-based stress reduction interventions to decrease nurse perceptions of distress. *Clinical Journal of Oncology Nursing*, *22*(3), 326–332. Retrieved May 11, 2021, from https://doi.org/10.1188/18.cjon.326-332

Van den Bulcke, B., Metaxa, V., Reyners, A. K., Rusinova, K., Jensen, H. I., Malmgren, J., Darmon, M., Talmor, D., Meert, A.-P., Cancelliere, L., Zubek, L., Maia, P., Michalsen, A., Kompanje, E. O., Vlerick, P., Roels, J., Vansteelandt, S., Decruyenaere, J., Azoulay, E.,...Benoit, D. (2019). Ethical climate and intention to leave among critical care clinicians: An observational study in 68 intensive care units across Europe and the United States. *Intensive Care Medicine*, *46*(1), 46–56. Retrieved June 2, 2021, from https://doi.org/10.1007/s00134-019-05829-1

Van der Heijden, B., Brown Mahoney, C., & Xu, Y. (2019). Impact of job demands and resources on nurses' burnout and occupational turnover intention towards an age-moderated mediation model for the nursing profession. *International Journal of Environmental Research and Public Health*, *16*(11), 2011. https://doi.org/10.3390/ijerph16112011

Vincent, H., Jones, D. J., & Engebretson, J. (2020). Moral distress perspectives among interprofessional intensive care unit team members. *Nursing Ethics*, *27*(6), 1450–1460. Retrieved April 27, 2021, from https://doi.org/10.1177/0969733020916747.

Watkins, M. D. (2013). What is organizational culture? And why whould we care? *Harvard Business Review Digital Articles*, 2–5.

Wenwen, Z. (2016) Moral Distress and its influencing factors: A cross-sectional study in China. *Nursing Ethics, 25* (4), 470-480. Accessed May 26, 2022

Whitehead, P. B., Herbertson, R. K., Hamric, A. B., Epstein, E. G., & Fisher, J. M. (2015). Moral Distress Among Healthcare Professionals: Report of an Institution-Wide

Survey. *Journal of Nursing Scholarship*, *47*(2), 117–125. https://doi.org/10.1111/jnu.12115

Wilson, M. A. (2018). Analysis and evaluation of the moral distress theory. *Nursing Forum*. 53, 259– 266.

Wocial, L. (2020). Factors associated with physician moral distress caring for hospitalized elderly patients needing a surrogate decision-maker: A prospective study. *Journal Of General Internal Medicine 35(5)* 1405-1412.

Wolf, L. A., Perhats, C., Delao, A. M., Moon, M. D., Clark, P. R., & Zavotsky, K. E. (2016). "It's a Burden You Carry": Describing Moral Distress in Emergency Nursing. *Journal of Emergency Nursing*, *42*(1), 37–46. https://doi.org/10.1016/j.jen.2015.08.008

Woods, M. (2020). Moral distress revisited: the viewpoints and responses of nurses. *International Nursing Review*, *67*(1), 68–75. https://doi.org/10.1111/inr.12545

Appendix A: Permission to use Measures of Moral Distress-Healthcare Professionals (MMD-HP)

Hi Tijuana,

Thanks for your email. I'd be delighted for you to use the scale. We've recently revised and updated it and so have attached the new scale and the paper we published that outlines our revision and testing.

If I can help you as your project moves forward, please don't hesitate to reach out.

Beth

Beth Epstein, PhD, RN, HEC-C, FAAN
Associate Professor and Interim Director of Academic Programs
School of Nursing and UVA Center for Health Humanities and Ethics

E meg4u@virginia.edu
P 434.982.3285
M 434.242.5927

University of Virginia
School of Nursing
McLeod Hall 4062
202 Jeanette Lancaster Way
Charlottesville, VA 22903

From: tijuana milton <tijuana.milton@bobcats.gcsu.edu>
Sent: Friday, June 4, 2021 5:54 PM
To: Epstein, Beth (meg4u) <meg4u@virginia.edu>
Subject: Fwd: DNP Project Proposal

Greetings Dr. Epstein,

I am Tijuana T. Milton, a DNP student at Georgia College & State University.
I am learning about Moral Distress and desire to educate about the signs and symptoms of Moral Distress and mention available resources for healthcare workers experiencing Moral Distress.
I am conducting my DNP project about Moral Distress at a Nursing Rehabilitation Facility located in Savannah, GA.
I am respectfully requesting permission to use your instrument, the Moral Distress Scale-Revised, for my project.

Please kindly let me know if I have permission. I'm looking forward to your response.

Kind Regards,
Mr. Tijuana T. Milton, MSN-Ed, RN

On Tue, Jun 29, 2021 at 6:12 AM Epstein, Beth (meg4u) <meg4u@virginia.edu> wrote:

> Good morning,
>
> Yes, you may mail it by paper or distribute it electronically.
>
> Beth

Beth Epstein, PhD, RN, HEC-C, FAAN
Associate Professor and Interim Director of Academic Programs
School of Nursing and UVA Center for Health Humanities and Ethics
E meg4u@virginia.edu
P 434.982.3285
M 434.242.5927
University of Virginia
School of Nursing
McLeod Hall 4062
202 Jeanette Lancaster Way
Charlottesville, VA 22903

> ---
>
> **From:** tijuana milton <tijuana.milton@bobcats.gcsu.edu>
> **Sent:** Monday, June 28, 2021 7:18 PM
> **To:** Epstein, Beth (meg4u) <meg4u@virginia.edu>
> **Subject:** Re: DNP Project Proposal
>
> Good Evening Ma'am,
>
> This is Tijuana Milton; I am the DNP student who contacted you earlier about using the MMD-HP.
> I am seeking clarification authorization about the use of the MMD-HP.
> Can I place the survey electronically, meaning to send it via email to the participants? I want to email the MMD-HP to the healthcare professionals before I arrive at the facility to educate them about moral distress. Also, completing the MMD-HP before I arrive assures anonymity.
> And completing it before I arrive allows more time for education, instead of waiting to complete a form.
>
> Very respectfully,
> Thank you.
> Mr. Tijuana T. Milton, MSN-Ed, RN

Appendix B: Measures of Moral Distress-Healthcare Professionals (MMD-HP)

Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of constraints or barriers. This survey lists situations that occur in clinical practice. If you have experienced these situations they may or may not have been morally distressing to you. Please indicate how frequently you have experienced each item. Also, rank how distressing these situations are for you. If you have never experienced a particular situation, select "0" (never) for frequency. Even if you have not experienced a situation, please indicate how distressed you would be if it occurred in your practice. Note that you will respond to each item by checking the appropriate column for two dimensions: *Frequency* and *Level of Distress*. *AJOB Empirical Bioethics* 10(2): 113-124.

	Frequency					**Level of Distress**				
	Never				Very frequently	None				Very distressing
	0	1	2	3	4	0	1	2	3	4
1. Witness healthcare providers giving "false hope" to a patient or family.										
2. Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient.										
3. Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments.										
4. Be unable to provide optimal care due to pressures from administrators or insurers to reduce costs.										
5. Continue to provide aggressive treatment for a person who is most likely to die regardless of this treatment when no one will make a decision to withdraw it.										
6. Be pressured to avoid taking action when I learn that a physician, nurse, or other team colleague has made a medical error and does not report it.										
7. Be required to care for patients whom I do not feel qualified to care for.										
8. Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.										
9. Watch patient care suffer because of a lack of provider continuity.										
10. Follow a physician's or family member's request not to discuss the patient's prognosis with the patient/family.										
11. Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.										
12. Participate in care that I do not agree with, but do so because of fears of litigation.										
13. Be required to work with other healthcare team members who are not as competent as patient care requires.										
14. Witness low quality of patient care due to poor team communication.										

15. Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.										

	Frequency					**Level of Distress**				
	Never Very frequently					None distressing				Very
	0	1	2	3	4	0	1	2	3	4
16. Be required to care for more patients than I can safely care for.										
17. Experience compromised patient care due to lack of resources/equipment/bed capacity.										
18. Experience lack of administrative action or support for a problem that is compromising patient care.										
19. Have excessive documentation requirements that compromise patient care.										
20. Fear retribution if I speak up.										
21. Feel unsafe/bullied amongst my own colleagues.										
22. Be required to work with abusive patients/family members who are compromising quality of care.										
23. Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.										
24. Be required to care for patients who have unclear or inconsistent treatment plans or who lack goals of care.										
25. Work within power hierarchies in teams, units, and my institution that compromise patient care.										
26. Participate on a team that gives inconsistent messages to a patient/family.										
27. Work with team members who do not treat vulnerable or stigmatized patients with dignity and respect.										
If there are other situations in which you have felt moral distress, please write and score them here:										

Have you ever left or considered leaving a clinical position due to moral distress?

- ☐ No, I have never considered leaving or left a position.
- ☐ Yes, I considered leaving but did not leave.
- ☐ Yes, I left a position.

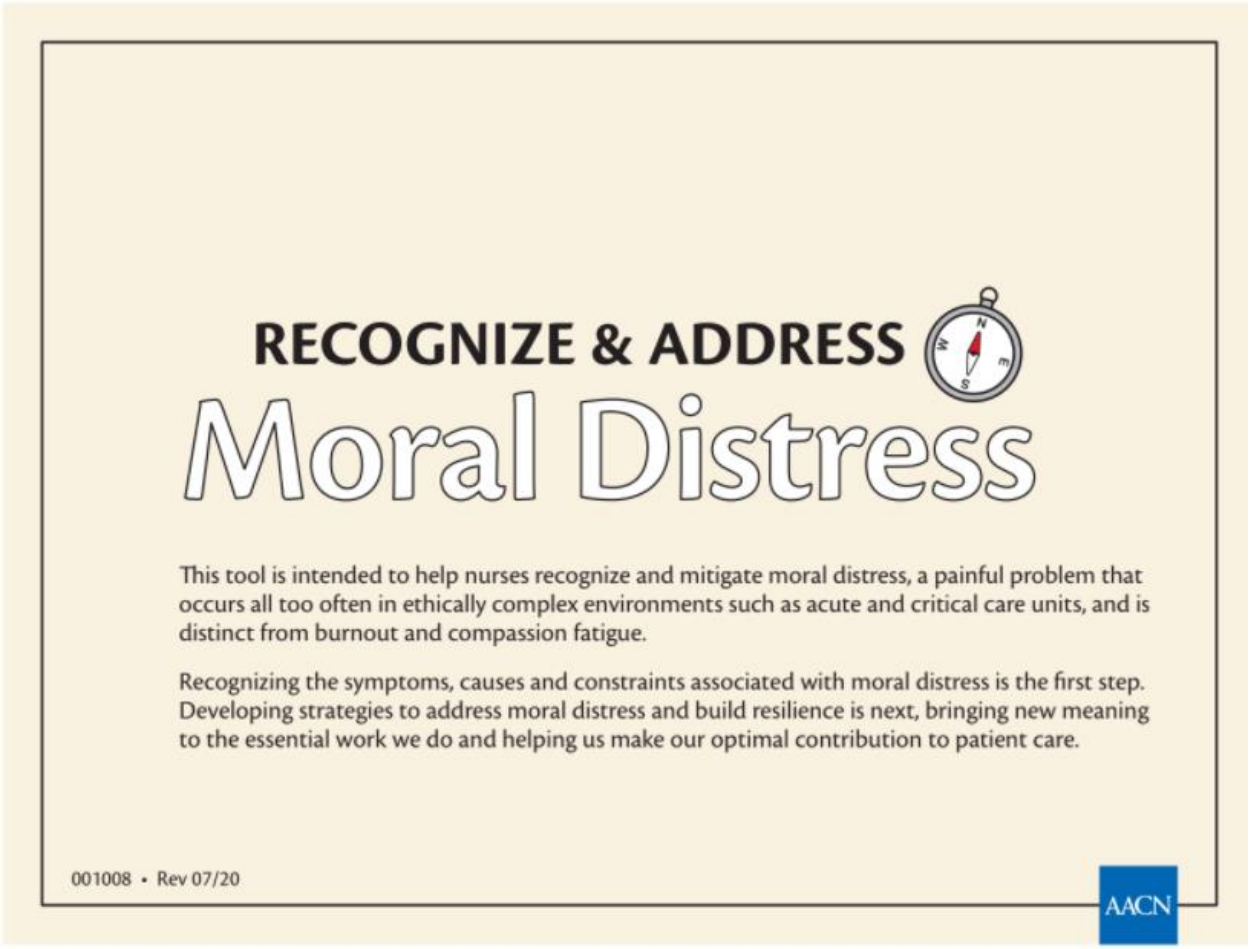
Are you considering leaving your position now due to moral distress?

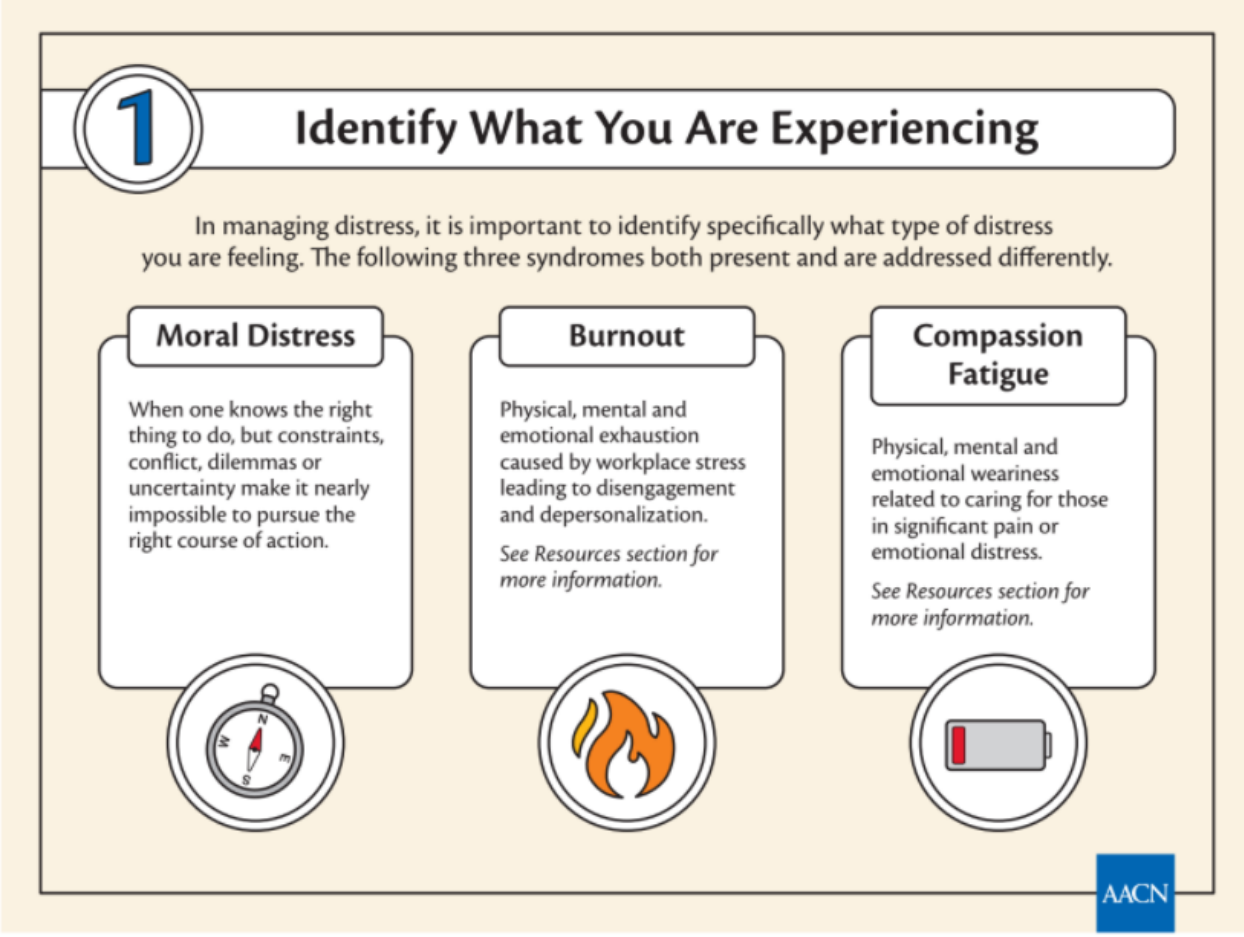
- ☐ Yes
- ☐ No

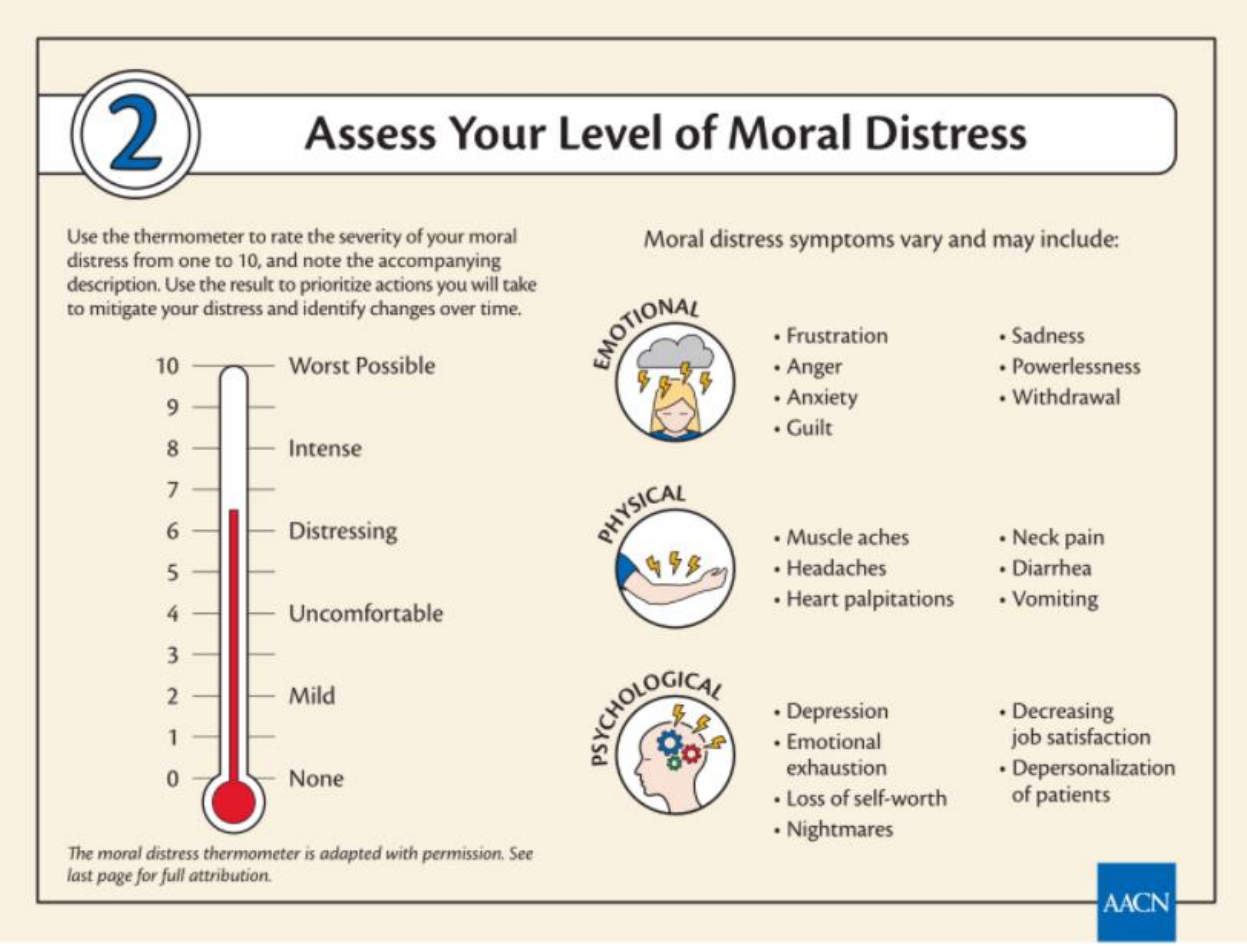
Appendix C: Qualitative Survey about Implementation and Use of a Decision Tree (Post-Survey)

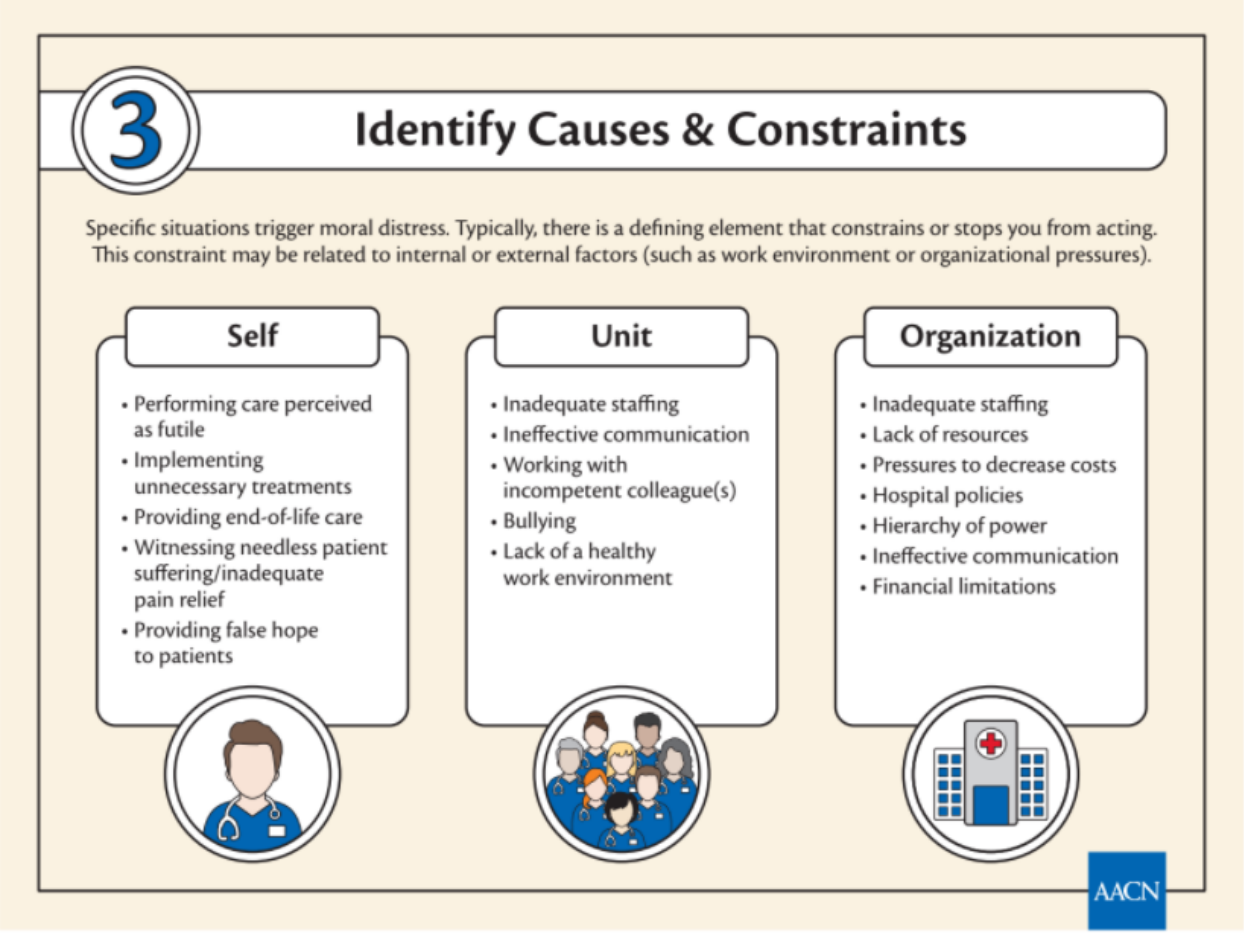
1. Did you know there is a decision tree to help you access resources for moral distress?
2. Did you use a decision tree when experiencing moral distress?
3. What do you think of the effectiveness of the decision tree to help with moral distress?
4. How easy or difficult was it to utilize the decision tree?
5. Any additional comments about the decision tree?

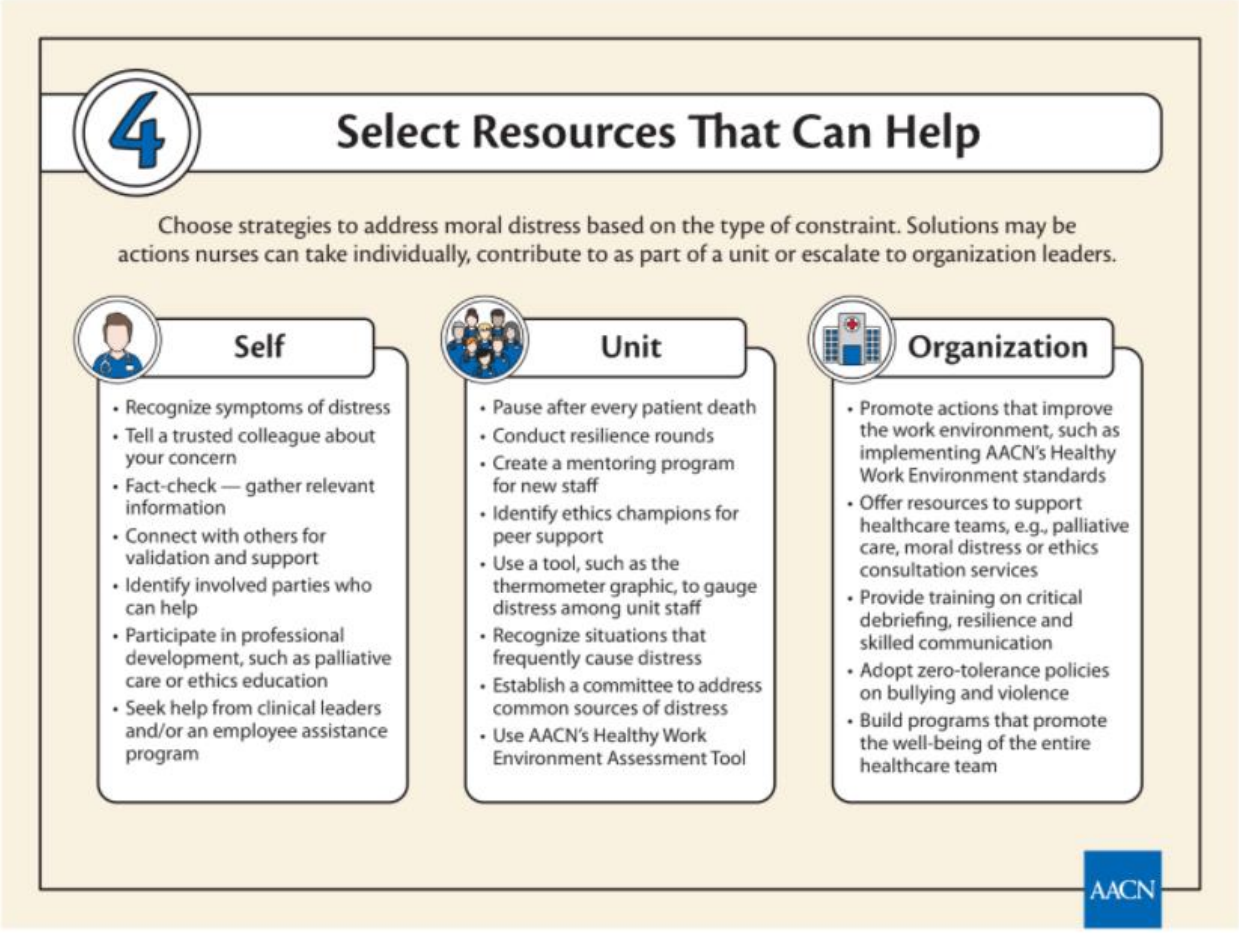
Appendix D: American Association of Critical Care Nurses (AACN) Recognizing and Addressing Moral Distress Training Modules

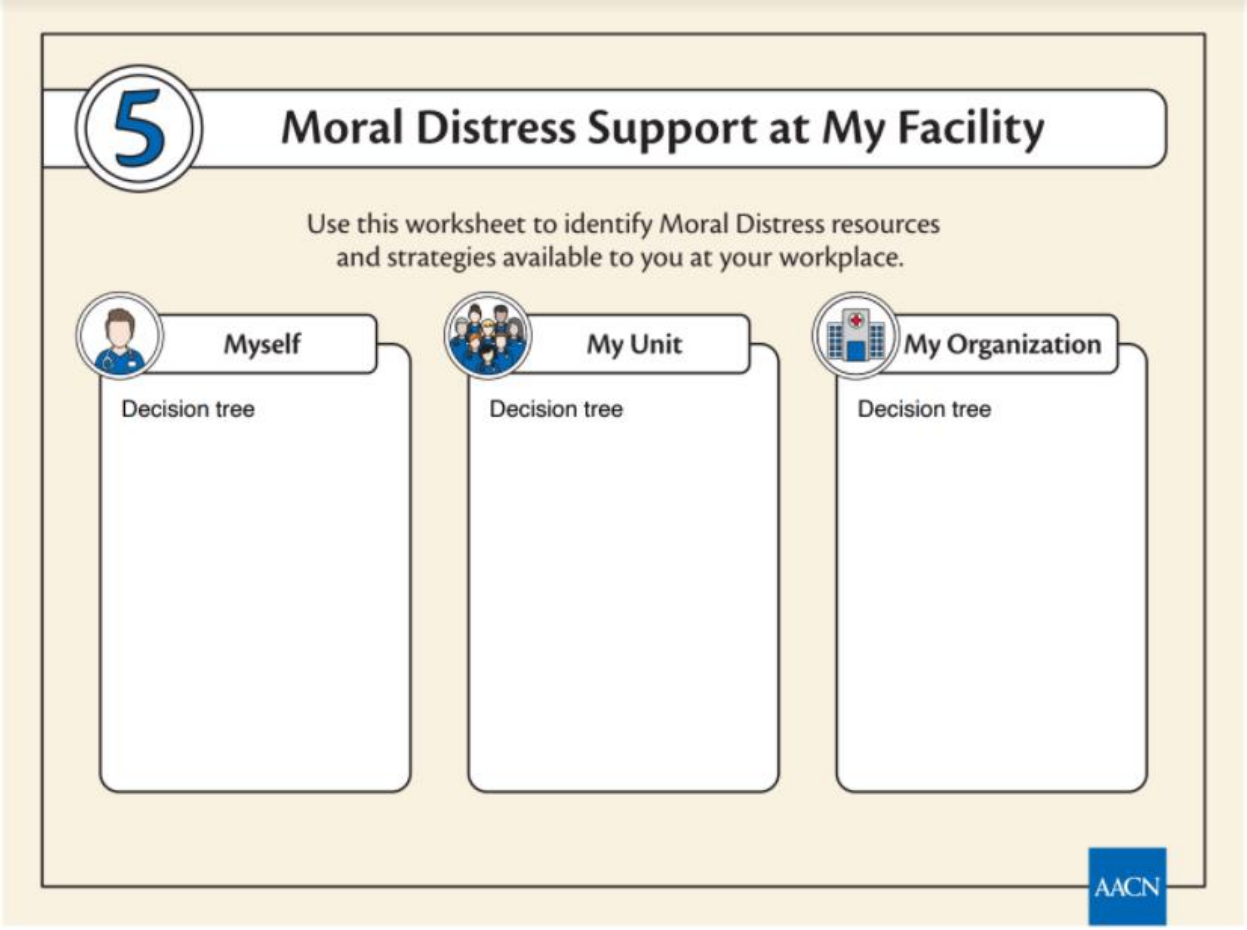



1
Identify What You Are Experiencing
In managing distress, it is important to identify specifically what type of distress you are feeling. The following three syndromes both present and are addressed differently.
Moral Distress
When one knows the right thing to do, but constraints, conflict, dilemmas or uncertainty make it nearly impossible to pursue the right course of action.
Burnout
Physical, mental and emotional exhaustion caused by workplace stress leading to disengagement and depersonalization.
See Resources section for more information.
Compassion Fatigue
Physical, mental and emotional weariness related to caring for those in significant pain or emotional distress.
See Resources section for more information.
AACN


2
Assess Your Level of Moral Distress
Use the thermometer to rate the severity of your moral distress from one to 10, and note the accompanying description. Use the result to prioritize actions you will take to mitigate your distress and identify changes over time.
10 Worst Possible
9
8 Intense
7
6 Distressing
5
4 Uncomfortable
3
2 Mild
1
0 None
The moral distress thermometer is adapted with permission. See last page for full attribution.
Moral distress symptoms vary and may include:
EMOTIONAL
• Frustration
• Anger
• Anxiety
• Guilt
• Sadness
• Powerlessness
• Withdrawal
PHYSICAL
• Muscle aches
• Headaches
• Heart palpitations
• Neck pain
• Diarrhea
• Vomiting
PSYCHOLOGICAL
• Depression
• Emotional exhaustion
• Loss of self-worth
• Nightmares
• Decreasing job satisfaction
• Depersonalization of patients
AACN


3
Identify Causes & Constraints
Specific situations trigger moral distress. Typically, there is a defining element that constrains or stops you from acting. This constraint may be related to internal or external factors (such as work environment or organizational pressures).
Self
• Performing care perceived as futile
• Implementing unnecessary treatments
• Providing end-of-life care
• Witnessing needless patient suffering/inadequate pain relief
• Providing false hope to patients
Unit
• Inadequate staffing
• Ineffective communication
• Working with incompetent colleague(s)
• Bullying
• Lack of a healthy work environment
Organization
• Inadequate staffing
• Lack of resources
• Pressures to decrease costs
• Hospital policies
• Hierarchy of power
• Ineffective communication
• Financial limitations
AACN


4
Select Resources That Can Help
Choose strategies to address moral distress based on the type of constraint. Solutions may be actions nurses can take individually, contribute to as part of a unit or escalate to organization leaders.
Self
• Recognize symptoms of distress
• Tell a trusted colleague about your concern
• Fact-check — gather relevant information
• Connect with others for validation and support
• Identify involved parties who can help
• Participate in professional development, such as palliative care or ethics education
• Seek help from clinical leaders and/or an employee assistance program
Unit
• Pause after every patient death
• Conduct resilience rounds
• Create a mentoring program for new staff
• Identify ethics champions for peer support
• Use a tool, such as the thermometer graphic, to gauge distress among unit staff
• Recognize situations that frequently cause distress
• Establish a committee to address common sources of distress
• Use AACN's Healthy Work Environment Assessment Tool
Organization
• Promote actions that improve the work environment, such as implementing AACN's Healthy Work Environment standards
• Offer resources to support healthcare teams, e.g., palliative care, moral distress or ethics consultation services
• Provide training on critical debriefing, resilience and skilled communication
• Adopt zero-tolerance policies on bullying and violence
• Build programs that promote the well-being of the entire healthcare team
AACN


5
Moral Distress Support at My Facility
Use this worksheet to identify Moral Distress resources and strategies available to you at your workplace.
Myself
Decision tree
My Unit
Decision tree
My Organization
Decision tree
AACN

Appendix E: Official Site Permission Letter

Riverview
Health & Rehabilitation Center

Riverview Health and Rehabilitation Center
6711 LaRoche Avenue
Savannah, Ga 31406
(912) 354-8225

Administrator, Riverview Health and Rehabilitation Center

June 22, 2021

Dear GC IRB,

Based on my review of the proposed research by **Tijuana T. Milton, MSN-Ed, DNP Student**, I give permission for him to conduct the study entitled **Implementation of a Decision Tree to Address Moral Distress within Healthcare Workers** within the Riverview Health and Rehabilitation Center. As part of this study, I authorize the researcher(s) to conduct a translational project, which is to **offer an education about the signs and symptoms of moral distress and assist with establishing a decision tree to aid in the seeking of resources to mitigate moral distress. Data will be collected by use of the Measures of Moral Distress for Healthcare Providers (MMD-HP) Survey.**

Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: **providing a designated location to implement the workshop training, assistance with disbursing the survey to healthcare workers, assistance with recruitment for attendance.** We reserve the right to withdraw from the study at any time if our circumstances change.

We understand that the research will include "**Pre-survey questionnaire provided 2-3 weeks prior to the training to assess Moral Distress, several training sessions about Moral Distress for healthcare workers and a post-qualitative questionnaire, approximately 4-6 weeks after the education workshop**.

This authorization covers the time period of **July 2021 to Jan 2022.**

I confirm that I am authorized to approve research in this setting.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the Georgia College IRB.

Sincerely,

Jo Lucke, CNHA, GNHP, FACHCA, CMDP, CEA
Administrator
www.riverviewhealth.net

APPENDIX F: Recruitment Flyer / Brochure