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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

EXPLORING MORAL DISTRESS AND REFLECTIVE DEBRIEFING AS A POTENTIAL INTERVENTION AMONG INTENSIVE CARE UNIT NURSES

A Scholarly Research Project Submitted in Partial
Fulfillment of the Requirements for the Degree
of Doctor of Nursing Practice

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College of Natural and Health Sciences
School of Nursing
Nursing Practice

December 2023

This Scholarly Project by: Tegan Camille Jones

Entitled: *Exploring Moral Distress and Reflective Debriefing as a Potential Intervention Among Intensive Care Unit Nurses*

has been approved as meeting the requirement for the Degree of Doctor of Nursing Practice in College of Natural and Health Sciences in the School of Nursing, Program of Nursing Practice.

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ABSTRACT

Jones, Tegan Camille. *Exploring moral distress and reflective debriefing as a potential intervention among intensive care unit nurses.* Unpublished Doctor of Nursing Practice Scholarly Project, University of Northern Colorado, 2023.

Moral distress is recognized in the literature as a significant problem for nurses working in the intensive care unit (ICU). Moral distress occurs when one knows the right course of action but is unable to follow it due to team or organizational constraints. Moral distress may lead to physical and psychological symptoms resulting in burnout, job attrition, and a negative impact on patient care. While interventions for reducing moral distress among ICU nurses are limited in the literature, one potentially promising approach is reflective debriefing. This Doctor of Nursing Practice (DNP) scholarly project aimed to explore the intensity, frequency, and root causes of moral distress among registered nurses in an adult ICU setting and the feasibility of reflective debriefing as a potential intervention. Using the knowledge to action framework as a guide for project development, this exploratory project utilized a valid and reliable survey to assess the level and root causes of moral distress among a sample of 42 ICU nurses at the project site. The results indicated a moderate level of moral distress with 33% (n = 14) of nurses indicating they were considering vacating their current position due to this issue. Root causes of moral distress were primarily related to aggressive end-of-life treatment decisions. An evidence-based debriefing guide was developed and implemented over a total of 10 sessions attended by 15 nurses. Barriers to participation in reflective debriefing at the project site were attributed to heavy workloads and high patient acuity. Findings from this project might influence support

mechanisms for nurses at the personal, team, and organizational levels at the project site and more broadly in the critical care setting.

Keywords: moral distress, intensive care unit, nurse, debriefing

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CHAPTER I

INTRODUCTION

Moral distress is a phenomenon that impacts healthcare professionals from many specialties; yet, it is particularly evident in intensive care unit (ICU) nurses. As many as 80% of ICU nurses reported they have experienced moral distress at least once in their careers (Hickey, 2022). Moral distress may contribute to burnout, compassion fatigue, and consideration of changing positions or leaving the profession (Hickey, 2022). Given that the existing national nursing shortage will be further exacerbated by elevated attrition levels, it is imperative that healthcare teams and organizations take action to reduce moral distress to support nurses, maintain staffing, and protect patient safety.

Background

Jameton (as cited in Morley et al., 2019) first defined moral distress in 1984 as occurring "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 467). Since then, the concept of moral distress has been explored in depth in the literature to describe the phenomenon and identify contributing factors (Morley et al., 2019). Morley et al. (2019) synthesized 34 papers and found the critical components of moral distress included experiencing a morally distressing event, the resulting distress, and a causal relationship between the two.

According to the American Association of Critical Care Nurses (AACN, 2020), frequent triggers for moral distress among nurses include personal, systemic, and environmental factors. These factors include providing care perceived as futile, engaging in end-of-life care, witnessing

human suffering, experiencing staffing shortages or workplace bullying, lack of organizational resources, and perceived powerlessness (AACN, 2020). The COVID-19 pandemic further exacerbated many of these issues through increased staffing and supply shortages, fears about personal safety, frequent policy changes, and nurses' perceived lack of organizational support (Andersson et al., 2022; Hickey, 2022; Rhéaume et al., 2022). When a nurse experiences a morally distressing event, residual distress often continues to cause emotional and psychological harm. As the nurse is faced with additional distressing situations, there is a cumulative effect Epstein et al. (2019) refer to as *moral residue*. Moral residue accelerates the negative impacts of moral distress on ICU nurses who are repeatedly faced with distressing patient care scenarios related to the high acuity and complexity of the critical care setting.

Defining Moral Distress

Two related, yet distinct terms are often confused with moral distress. Burnout is an occupational phenomenon that occurs due to chronic job stress and can lead to physical and emotional exhaustion, cynicism, and depersonalization (AACN, 2020; Vaughn, 2023). Compassion fatigue is a related condition that occurs in individuals providing care to someone who is suffering (Vaughn, 2023). It can lead to secondary trauma, resulting in caregiver distress, detachment, reduced ability to empathize, and a negative impact on job performance and satisfaction (AACN, 2020; Vaughn, 2023). In contrast, moral distress specifically occurs when individuals cannot follow the perceived right course of action due to structural constraints (AACN, 2020). While burnout, compassion fatigue, and moral distress are interrelated concepts, they are distinct and require different interventions to address them. This Doctor of Nursing Practice (DNP) scholarly project focused on moral distress.

Impact of Moral Distress and Potential Interventions

Moral distress may cause physical and psychological distress, burnout, and attrition among nurses (Abbasi et al., 2019; Morley et al., 2019). The symptoms arising from moral distress may cause nurses to neglect their professional duties and can negatively impact patient care (Hickey, 2022). Moral distress may also lead nurses to consider leaving their jobs or the profession (Browning & Cruz, 2018). With the ongoing national nursing shortage, there is an imminent need to address moral distress and reduce its negative impacts on the profession.

Recent research examined the concept of moral distress along with contributing factors and triggers. Notably, a limited number of studies explored interventions to reduce moral distress among nurses. This narrow body of literature examined the impacts of palliative care consults, educational interventions, strategies for fostering moral resilience, and the efficacy of reflective debriefing with varying results (Abbasi et al., 2019; Andersson et al., 2022; Hickey, 2022; Morley et al., 2022; Piscitello et al., 2022; Rushton et al., 2021). In 2022, Hickey performed a systematic review of interventions to address moral distress among ICU nurses and identified six studies that met inclusion criteria. Interventions in the selected studies included providing education on moral distress, changing the clinical environment through an empowerment program for nurses, and enhancing coping skills through interventions such as reflective debriefing. However, all of the included studies had small sample sizes, lacked control groups, and most failed to show a statistically significant reduction in moral distress (Hickey, 2022). A variety of instruments were used to measure moral distress levels among participants in the studies. These instruments are discussed in more detail in the next chapter of this written document. Overall, this recent systematic review demonstrated the need for further research into interventions to reduce moral distress in general and among ICU nurses specifically.

Despite somewhat heterogeneous studies and mixed results, one intervention appeared frequently within the literature and showed promising results: reflective debriefing. Several studies suggested a reduction in moral distress levels among nurses following the implementation of this intervention (Browning & Cruz, 2018; Hickey, 2022; Jarden et al., 2018; Reilly & Jurchak, 2017). In addition, qualitative findings suggested the nurses reported feeling their concerns were recognized through participation in reflective debriefing and they appreciated the opportunity to discuss the emotional components of their jobs (Browning & Cruz, 2018; McAndrew & Hardin, 2020).

Problem Relevance to Project Site

This DNP scholarly project aimed to explore the intensity, frequency, and root causes of moral distress among a sample of ICU nurses at an urban hospital in Washington state and to assess the feasibility of reflective debriefing as a potential intervention. Although it has not been formally measured, nurses at this institution anecdotally reported frequently being exposed to morally distressing events and lacking the tools or resources to address this condition. Nursing leadership at the project site have also acknowledged a lack of structured interventions to reduce moral distress among the ICU nursing staff and recognized it as a pressing issue that was negatively impacting morale and performance. As previously mentioned, moral distress could contribute to elevated attrition rates among nurses, which is of particular concern in the critical care setting in the post-COVID-19 era. For example, replacing a single highly specialized ICU nurse costs healthcare systems approximately $64,000 USD (Hickey, 2022). By recognizing and responding to moral distress using interventions such as reflective debriefing, nurses at the project site may improve their coping and resiliency skills. This may in turn lead to reduced nurse turnover and improved patient care (AACN, 2020).

Statement of the Problem

Intensive care unit nurses are particularly susceptible to moral distress given their regular exposure to patient suffering, complex ethical dilemmas, and close proximity to end-of-life care. Factors that contribute to moral distress include personal considerations, team dynamics, organizational constraints, the perception of providing futile care, and feelings of powerlessness (AACN, 2020; Giannetta et al., 2022; Lusignani et al., 2017). Moral distress can cause physical and psychological distress, prompting nurses to consider changing jobs or leaving the profession (Andersson et al., 2022). Moral distress can also negatively impact clinical outcomes when nurses feel unmotivated about their work and disengaged from their patients (Hickey, 2022). Although research into interventions for reducing the impact of this phenomenon among critical care nurses is limited, reflective debriefing is a promising evidence-based approach calling for further testing (AACN, 2020).

Purpose of the Project

The purpose of this DNP scholarly project was to explore the intensity, frequency, and root causes of moral distress among registered nurses in an adult intensive care unit (ICU) setting and the feasibility of reflective debriefing as a potential intervention.

Need for the Project

Moral distress occurs in up to 80% of ICU nurses, contributing to physical and psychological distress, job attrition, and negative impacts on patient care (Hickey, 2022). The registered nurses and leadership in an ICU in Washington state have expressed recognition to the primary investigator of this scholarly project that moral distress is an important issue calling for attention. Several studies have examined a variety of interventions to reduce moral distress and demonstrated mixed results. However, reflective debriefing was identified in the literature as a

potential strategy for reducing moral distress levels among nurses (Hickey, 2022). This DNP project explored the current level of moral distress among a sample of ICU nurses at the project site and assessed the feasibility of an evidence-based reflective debriefing intervention.

Project Questions

Q1 What are the intensity, frequency, and root causes of moral distress among ICU nurses at the project site?

Q2 What is the feasibility of reflective debriefing as a potential intervention for decreasing the impact of moral distress among ICU nurses at the project site?

Objectives of the Project

O1 Develop an evidence-based reflective debriefing intervention designed to be administered over a two-week period to a convenience sample of practicing ICU nurses at the project site.

O2 Measure the intensity, frequency, and root causes of moral distress among a sample of ICU nurses using a valid and reliable research instrument.

O3 Evaluate the participation level of ICU nurses at the project site in the reflective debriefing intervention.

O4 Perform additional descriptive and inferential analyses of the project findings and disseminate all results to the project site including making recommendations to leadership about the feasibility of implementing reflective debriefing as a future intervention.

Summary

The concept of and contributing factors to moral distress are thoroughly explored in the existing literature. However, interventions to address moral distress have not been sufficiently researched. Moral distress can lead to physical and psychological distress among nurses and those who work in critical care may be especially susceptible due to the complexity and intensity of the ICU environment. Moral distress may also contribute to systemic problems such as increased nurse turnover and poor-quality patient care. To enhance support of ICU nurses, healthcare teams and organizations should implement evidence-based measures to reduce moral

distress. This project aimed to explore the intensity, frequency, and root causes of moral distress among registered nurses in an adult ICU setting and the feasibility of reflective debriefing as a potential intervention.

Definition of Terms

Burnout. Disengagement due to a stressful work environment that leads to physical and emotional exhaustion (AACN, 2020).

Compassion Fatigue. Physical and emotional exhaustion that arises in those caring for patients experiencing pain and distress (AACN, 2020).

Debrief. To retrospectively review and analyze incidents and phenomena (Cant & Cooper, 2011; Merriam-Webster, 2022a).

DNP. Doctor of Nursing Practice.

Intensive Care or Critical Care. Utilizing advanced medical technology and trained staff to continuously monitor and treat severely ill hospitalized patients (Merriam-Webster, 2022b).

Intervention. Interfering in a process to reduce harm or improve the outcome (Merriam-Webster, 2022c).

Moral Distress. The inability to follow the perceived right course of action due to organizational or interpersonal constraints (AACN, 2020).

Moral Residue. The cumulative effect of recurrent moral distress that never completely disappears between episodes (Epstein et al., 2019).

Reflective Practice. A structured method to analyze a situation, identify the emotions associated with that situation, and consider opportunities for improvement in future distressing situations (Browning & Cruz, 2018).

CHAPTER II

REVIEW OF THE LITERATURE AND THEORETICAL FRAMEWORK

It has been nearly 30 years since moral distress was first defined in the literature and it continues to be deeply explored in nursing research. The following section presents the history of the term “moral distress” and the evidence surrounding the topic. A synthesis of current literature follows, which aims to explore the contributing factors, consequences, measurement of, and potential interventions to reduce and prevent moral distress among intensive care unit (ICU) nurses. The purpose of this DNP scholarly project was to explore the intensity, frequency, and root causes of moral distress among registered nurses in an adult ICU setting and the feasibility of reflective debriefing as a potential intervention. This purpose is supported in the literature synthesis below. In addition, the application of the knowledge-to-action framework as the theoretical basis for this scholarly project is explored in detail.

Historical Background

Since Jameton (as cited in Morley et al., 2019) first defined moral distress in 1984, nursing research on the topic has grown exponentially and the definition has evolved based on an advanced understanding of the concept. Moral distress was first observed in nursing and while numerous studies demonstrated elevated levels of moral distress among nurses, especially in the ICU setting, it has also been recognized in other disciplines such as medicine and social work (Abbasi et al., 2019; Epstein et al., 2019). In a 2020 manuscript, Deschenes et al. explored the evolution of the concept of moral distress since Jameton’s seminal paper in 1984. The authors

note that in 1993, Rodney and Starzomski (as cited in Deschenes et al., 2020) recognized that moral distress occurred when nurses were unable to act upon their moral choice, most often attributed to situational constraints. In 2000, Webster and Baylis (as cited in Deschenes et al., 2020) addressed the fact that a feeling of personal failing may play a role in moral distress. This could be due to an error in judgment or it may be due to factors out of the nurse's control.

As our understanding of moral distress evolved, the methods to assess and address it did as well. Research in the early 2000s explored methods for evaluating and measuring moral distress. In 2001, Corley et al. developed the Moral Distress Scale, which measured the frequency and intensity of moral distress among nurses (Morley et al., 2019). This scale was the gold standard for many years, consistently demonstrated high reliability and validity metrics, and underwent several revisions and updates over a 20-year period (Morley et al., 2019). During this era, the research also continued to redefine moral distress while also exploring the implications for nurses. In 2006, Nathaniel (as cited in Deschenes et al., 2020) noted that moral distress can have a negative impact on nurses' minds, bodies, and relationships. Austin et al. (as cited in Deschenes et al., 2020) recognized that this phenomenon can lead to nurses feeling jaded, numb, and powerless. In 2017, Fourie (as cited in Deschenes et al., 2020) recognized that moral distress negatively impacted nurses' well-being and potentially led to job attrition. It was only within the past decade that researchers began to explore potential interventions to reduce moral distress as described in more detail below.

Methodology

A systematic search of the literature on interventions to reduce moral distress in ICU nurses occurred between September and October 2022. The search terms used were "critical care or intensive care or ICU," "adult or adults or aged or elderly," "moral distress or ethical dilemma

or moral stress," and "interventions;" with the Boolean operator "AND." Two databases were searched: the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and the National Library of Medicine (PubMed). The search was limited to articles published between 2017 and 2022 to capture the most current evidence.

The initial search returned 381 articles, 286 of which were excluded before screening using filters for all-adult, peer-reviewed, human subjects, and English language. Titles and abstracts of the remaining 95 articles were screened; 36 were eliminated due to not being relevant to the project, 15 were eliminated due to a focus on the pediatric patient population, five were excluded as duplicates, and two were excluded as they needed to be translated into English. Of the remaining 37 articles, 11 were eliminated due to not being focused on moral distress, four were not specific to nursing, two were not research articles, one was not focused on the ICU setting, and one was validating a language translation of a research instrument that was not relevant to this project. This left 18 articles included in this review. Appendix A provides the preferred reporting items for systematic reviews and meta-analyses diagram detailing this selection process.

Of the 18 articles included in this literature review, the level of evidence ranged from two through six. Three systematic reviews (Giannetta et al., 2022; Hickey, 2022; Jarden et al., 2020) and one randomized control trial were included (Abbasi et al., 2019). Seven of the studies performed quantitative analyses (Abbasi et al., 2019; Browning & Cruz, 2018; Giannetta et al., 2022; Lusignani et al., 2017; Piscitello et al., 2022; Rushton et al., 2021; Sirilla et al., 2017), seven performed qualitative analyses (Jarden et al., 2018, 2020; Kang et al., 2021; McAndrew & Hardin, 2020; Morley et al., 2022; Reilly & Jurchak, 2017; Rhéaume et al., 2022), and two utilized mixed methods (Andersson et al., 2022; Vincent et al., 2020). Hickey (2022) performed

an integrative review of six experimental studies about moral distress but did not apply any statistical analysis to the cohort. Six studies used the Moral Distress Scale–Revised (MDS-R) to measure moral distress (Andersson et al., 2022; Browning & Cruz, 2018; Giannetta et al., 2022; Lamiani et al., 2017; Lusignani et al., 2017; Sirilla et al., 2017; Vincent et al., 2020), and one used the updated Measure of Moral Distress in Healthcare Professionals (MMD-HP) (Piscitello et al., 2022). The themes and findings of these studies are explored in detail in the following sections. Please see Appendix B for the Table of Evidence.

Synthesis of the Literature

After a comprehensive review of the literature on moral distress, it was noted that most articles focused on identifying the contributing factors to moral distress in ICU nurses and the associated symptoms or consequences. There were limited data on interventions to reduce moral distress among this specialty population of nurses. The following section synthesizes the available evidence and identifies areas for future research based on gaps in the literature.

Factors Contributing to Moral Distress Among Intensive Care Unit Nurses

Moral distress can occur among any type of healthcare professional. However, studies continue to demonstrate that nurses in critical care are disproportionately affected with 67-80% of ICU nurses reporting they had experienced moral distress at least once in their careers (Abbasi et al., 2019; Hickey, 2022). Moral distress stems from personal, team, and systemic factors. Intensive care unit nurses reported that providing futile care at end-of-life, along with a sense of powerlessness and lack of control, placed them in a position to act in ways contradictory to what they believe is the morally correct action (Abbasi et al., 2019; Giannetta et al., 2022). In addition to personal, team, and systemic factors, the COVID-19 pandemic exacerbated some of these

issues and recent research on the impact it is having on moral distress among ICU nurses is described further below (Andersson et al., 2022; Rhéaume et al., 2022).

Personal Factors

Several studies explored the impact demographics and personal factors played in the occurrence of moral distress. For example, it was noted that younger nurses and those with fewer years of nursing experience reported higher levels of moral distress (Giannetta et al., 2022; Lusignani et al., 2017). Some researchers hypothesized this may be due to a lack of ethical knowledge and skill in navigating ethical dilemmas along with an underdeveloped sense of self-awareness (Giannetta et al., 2022; Rushton et al., 2021). While moral distress is often specific to the professional moral code, the literature has shown that younger and less experienced nurses are more susceptible (Giannetta et al., 2022). These findings have implications for nursing leadership and healthcare organizations as they recruit, onboard, and retain their younger and newer nursing staff.

Team Dynamics

Moral distress in nurses is impacted by team dynamics such as communication style, collaboration, and mutual respect. Several studies cited poor communication as a significant contributor to moral distress, particularly when it negatively impacts patient care (Browning & Cruz, 2018; Giannetta et al., 2022; Sirilla et al., 2017; Vincent et al., 2020). Nurses also reported that working with and assisting incompetent coworkers or underqualified providers increased their moral distress levels (Andersson et al., 2022; Browning & Cruz, 2018; Giannetta et al., 2022; Sirilla et al., 2017). Some nurses reported bullying as a factor that led them to refrain from speaking up when facing a moral dilemma to avoid conflict with colleagues. Feeling bullied or silenced can prevent nurses from following the morally correct path, leading to increased moral

distress (Abbasi et al., 2019; Browning & Cruz, 2018; Vincent et al., 2020). When teams worked together, assisted less skilled coworkers, demonstrated mutual respect, and empowered one another to speak up, moral distress levels among nurses decreased (Andersson et al., 2022; Morley et al., 2022). Overall, the evidence suggests that addressing negative team dynamics such as poor communication and bullying may reduce moral distress among nurses.

Organizational Constraints

Many factors that increase moral distress can be attributed to systemic issues including chronic short staffing, lack of resources required to maintain an appropriate standard of care, pressure to cut costs, and lack of support from leadership (Browning & Cruz, 2018; Giannetta et al., 2022; Lusignani et al., 2017; Vincent et al., 2020). Several studies noted that limited access to specially trained staff members with ethics expertise and poor collaboration with palliative care teams led to increased moral distress among nurses (Kang et al., 2021; McAndrew & Hardin, 2020). When organizational priorities, such as pressure to fill empty ICU beds or cut costs, take precedence over providing high quality patient care, nurses reported an increase in patient suffering, reduced ability to provide compassionate care, and a sense of detachment (Kang et al., 2021; McAndrew & Hardin, 2020). Organizations where nurses reported positive ethical climates had lower rates of moral distress (McAndrew & Hardin, 2020). Thus, supporting nurses by addressing organizational constraints and climate issues presents an opportunity to reduce moral distress.

Futile Care

Another major contributor to moral distress among ICU nurses is providing care felt to be futile or non-beneficial. Futile treatments included those that extended life, or prolonged death, without changing the prognosis or outcome. These interventions were often associated with

increased or prolonged patient suffering. Examples of inflicting suffering described by ICU nurses included frequent blood draws, chemotherapy, cardiopulmonary resuscitation, and ventilator support (Andersson et al., 2022; Kang et al., 2021; Lusignani et al., 2017; Vincent et al., 2020). Futile care was often perceived to be at the request of family members who wanted to continue aggressive treatment despite a poor prognosis (Andersson et al., 2022; Browning & Cruz, 2018; Hickey, 2022). Many nurses attributed this scenario to providers giving the family false hope through deceptive communication and failure to clearly inform them of the poor prognosis (Andersson et al., 2022; Browning & Cruz, 2018; Giannetta et al., 2022; Kang et al., 2021; Sirilla et al., 2017). Nurses reported that witnessing suffering due to aggressive care at end-of-life led to increased moral distress, especially when it was not in line with the patient's expressed wishes (Browning & Cruz, 2018; Piscitello et al., 2022; Sirilla et al., 2017).

The nurses surveyed in several studies felt their physician colleagues often focused on saving lives without considering the patient's quality of life (Kang et al., 2021; McAndrew & Hardin, 2020). When nurses raised concerns about aggressive care despite a poor prognosis, they were met with mixed responses from the physicians. Some physicians considered the nurses' concerns, some dismissed them, and others accused the nurses of being pessimistic and giving up on their patients (Andersson et al., 2022; Kang et al., 2021; McAndrew & Hardin, 2020). This body of literature emphasizes how providing care perceived to be futile contributes to moral distress among ICU nurses and highlights the occasionally conflicting disciplinary approaches within medicine and nursing.

Powerlessness

Several studies cited perceived powerlessness as a frequent trigger of moral distress. For example, nurses felt a strong sense of moral responsibility toward their patients and a duty to

advocate for them but this was threatened when they lacked control or felt unheard (Browning & Cruz, 2018; Hickey, 2022; McAndrew & Hardin, 2020; Morley et al., 2022; Vincent et al., 2020). This sense of powerlessness is noted to arise from the hierarchy of health care where physicians often have the final say in patient care decisions and nurses sense their perspective may not be sought or appreciated (Browning & Cruz, 2018; Kang et al., 2021). Morley et al. (2022) noted that high variability in provider practice could lead to changes in the patient care plan from day to day, referred to as the 'roster lottery.' Fluctuating plans of care created a sense of confusion amongst nurses and families, leading to further distress. Particularly in the high-stakes ICU environment, feeling powerless and uncertain were linked with increased moral distress levels among nurses (Morley et al., 2022). These findings suggest that empowering nurses and creating consistency in the patient plan of care may be important components for mitigating moral distress in the critical care setting.

Coronavirus Disease-19

During the height of the Coronavirus Disease (COVID)-19 pandemic, ICU nurses were on the frontlines caring for the most critically ill patients. While many of the themes mentioned above applied during the pandemic, new challenges arose that further contributed to moral distress. The literature on this topic is limited due to the recentness and ongoing nature of the pandemic; however, several recent studies have been published exploring how COVID-19 has led to increased moral distress among ICU nurses (Andersson et al., 2022; Rhéaume et al., 2022). During the pandemic's peak, ICU nurses faced frequent (sometimes daily) policy changes that led to confusion and mistrust of hospital administration. Critical care nurses were also dealing with limited resources, including personal protective equipment, which threatened their personal safety and led to a fear of bringing COVID-19 home to loved ones (Andersson et al., 2022;

Hickey, 2022; Rhéaume et al., 2022). In addition, many hospitals were not allowing visitors to minimize community spread. As a result, some nurses expressed high levels of moral distress related to feeling like they were caring for a body rather than a person since they lacked interactions with the patient's family (Andersson et al., 2022). Visitor restrictions also meant patients were dying alone in the ICU during the pandemic and end-of-life decision-making was often a prolonged process since the family was not present to witness the suffering their loved one was experiencing and opt for comfort-focused care. This scenario intensified the sense of providing futile care and significantly contributed to elevated levels of moral distress among nurses during the pandemic (Andersson et al., 2022; Hickey, 2022; Rhéaume et al., 2022).

In addition, although nursing shortages began prior to the pandemic, there was a sudden increased demand for nurses specializing in critical care during this time. Simultaneously, many nurses were leaving the profession due to burnout and fears about personal safety. This confluence of factors exacerbated the staffing crisis and led to the addition of non-critical care nurses attempting to bridge the gap and assist with the care of ventilated patients. Nurses who worked in the ICU during the pandemic witnessed suboptimal care, medical errors, and patient harm that they attributed to staffing shortages (Andersson et al., 2022; Hickey, 2022; Rhéaume et al., 2022). When combined with the previously mentioned triggers, the new challenges of the COVID-19 pandemic further contributed to an increase in moral distress amongst ICU nurses in recent years.

Consequences of Moral Distress for Intensive Care Unit Nurses

According to Morley et al. (2022), the three requirements for moral distress to occur are a moral event, psychological distress, and a causal relationship between the two. In addition to psychological distress, moral distress can lead to physical ailments, burnout, and intention to

leave a job or the profession. Despite the apparent resolution of an episode of moral distress, nurses often experience residual distress that is cumulative over time, a concept referred to as moral residue or the crescendo effect (McAndrew & Hardin, 2020; Sirilla et al., 2017). The following sections explore the consequences of moral distress.

Physical and Psychological Distress

Several studies explored the negative impact moral distress had on nurses. Many cited symptoms of psychological distress including anger, frustration, sadness, depression, helplessness, guilt, regret, anxiety, detachment, substance abuse, and post-traumatic stress disorder (Hickey, 2022; Kang et al., 2021; Lamiani et al., 2017; Morley et al., 2022; Rhéaume et al., 2022; Sirilla et al., 2017). In addition, nurses experiencing moral distress reported physical symptoms such as sleep disruption, gastric upset, pain, fatigue, headaches, and heart palpitations (Abbasi et al., 2019). Physical and psychological symptoms of moral distress can lead to burnout and compassion fatigue. Nurses may become detached and withdraw from patient care duties, violating their professional moral code. Morally distressed nurses spend less time focused on patients, thus providing suboptimal care, risking errors, and potentially causing harm to patients (Abbasi et al., 2019; Hickey, 2022; Lamiani et al., 2017; Lusignani et al., 2017; Sirilla et al., 2017; Vincent et al., 2020). Overall, there is significant evidence suggesting the physical and psychological effects of moral distress may cause long-term harm to nurses and contribute to job attrition and unsafe patient care.

Impact on Nurse Retention

Moral distress has been cited as causing over half of critical care nurses to contemplate leaving their job or the profession (Andersson et al., 2022; Browning & Cruz, 2018; Giannetta et al., 2022; Kang et al., 2021; Lamiani et al., 2017; Lusignani et al., 2017; Sirilla et al., 2017).

Given the increasing nursing shortage, nurse turnover due to moral distress can have lasting negative consequences on patient outcomes and healthcare costs. Giannetta et al. (2022) and Hickey (2022) reported that the cost associated with nurse turnover can be as high as $64,000 including overtime pay to fulfill staffing needs, extended length of stay for patients, and costs associated with hiring and orienting new ICU nurses. This figure demonstrates how nurse attrition not only negatively impacts patient care but also has logistical and financial consequences for organizations.

Moral Residue

As mentioned above, moral residue is what remains after the apparent resolution of a morally distressing event (Epstein et al., 2019). Nurses may continue to feel guilt and regret, resulting in a baseline level of distress. As the nurse experiences additional episodes of moral distress throughout their career, the intensity has a crescendo or cumulative effect, building from the previous baseline. Each episode leads to increased levels of moral distress, exacerbating the physical and psychological symptoms described above and increasing the risk of burnout and job attrition (Andersson et al., 2022; McAndrew & Hardin, 2020; Morley et al., 2022; Sirilla et al., 2017). The cumulative effects of recurrent moral distress highlight the urgency to implement interventions to reduce moral distress in ICU nurses both early and throughout their career.

Methods to Assess Moral Distress in Intensive Care Unit Nurses

Several reputable tools are available to assess moral distress. The most widely used tool is the Moral Distress Scale–Revised (MDS-R), originally designed by Corley et al. in 2001 and revised by Hamric et al. in 2012 (Abbasi et al., 2019; Andersson et al., 2022; Lamiani et al., 2017; Lusignani et al., 2017; Sirilla et al., 2017; Vincent et al., 2020). The MDS-R consists of 21 questions assessing the intensity and frequency of moral distress along with three free-text

questions. Three studies utilized Italian versions of the tool (Andersson et al., 2022; Lamiani et al., 2017; Lusignani et al., 2017) and one used the Persian translation (Abbasi et al., 2019), all of which demonstrated adequate reliability and validity.

Most recently, Hamric et al. (2012) once again revised the MDS-R to a newer version called the Moral Distress for Healthcare Professionals (MMD-HP), which was proven reliable with a Cronbach's alpha of 0.93 and demonstrated construct validity through the testing of four hypotheses (Epstein et al., 2019; Piscitello et al., 2022). The MMD-HP includes measurement of the root causes of moral distress among healthcare professionals, a helpful addition that was missing from previous tools (Epstein et al., 2019). Other approaches for exploring moral distress included the Moral Distress Thermometer and qualitative analysis of free text responses or interviews of nurses (McAndrew & Hardin, 2020; Rushton et al., 2021; Vincent et al., 2020). Purely qualitative analysis is beyond the scope of DNP scholarly projects. In addition, the Moral Distress Thermometer is a one-item scale that quantifies moral distress level without distinguishing intensity, frequency, or root causes (Rushton et al., 2021). The MDS-R is the most widely used and validated tool used in the literature and with the updated MMD-HP demonstrating similar reliability and validity metrics yet including emerging root causes of moral distress, the latter will be selected to measure moral distress in this project (see Chapter III).

Interventions to Reduce Moral Distress in Intensive Care Unit Nurses

Most research in the field of moral distress has focused on defining moral distress and establishing its frequency, triggers, and consequences. During the review of the current literature conducted for this scholarly project, only a few studies explored interventions to reduce moral distress, and those that exist utilized heterogeneous methods making it challenging to suggest

practice recommendations (Abbasi et al., 2019; Browning & Cruz, 2018; Hickey, 2022; Jarden et al., 2020; Piscitello et al., 2022; Rushton et al., 2021). It has been suggested that efforts to reduce moral distress should target those at the highest risk of experiencing this phenomenon including ICU nurses (Giannetta et al., 2022). Interventions should focus on sustainable, unit-based and organizational practices that aim to support a safe, supported unit culture and healthy nursing workforce (Rushton et al., 2021).

Organizational Resources

As mentioned above, several studies referenced that moral distress could be partially attributed to the lack of organizational resources such as access to ethics experts and palliative care teams (Browning & Cruz, 2018; McAndrew & Hardin, 2020). Nurses suggested in the literature that with these additional support systems combined with efforts to ensure safe staffing, moral distress can be reduced (Jarden et al., 2018; Kang et al., 2021; McAndrew & Hardin, 2020; Morley et al., 2022). Piscitello et al. (2022) conducted the only recent quantitative study on this topic that met the inclusion criteria for this literature review. The authors implemented a triggered palliative care consult to recognize patients at high risk of poor outcomes and initiated family meetings by the third day of hospital admission. Unfortunately, while they saw earlier transitions to Do Not Resuscitate status and decreased length of stay, they did not see a significant reduction in moral distress, perhaps due to the overlap between the study and the COVID-19 pandemic (Piscitello et al., 2022). Of note, this literature review did not locate any studies aimed at organizational efforts to ensure safe staffing to reduce moral distress among nurses in the ICU.

Educational Initiatives

According to several studies, educational interventions may reduce moral distress among ICU nurses (Abbasi et al., 2019; Andersson et al., 2022; Morley et al., 2022). Abbasi et al. (2019) implemented a moral empowerment intervention that included a two-day workshop with didactics, role-playing, pamphlets, and storytelling. The didactics focused on defining moral distress and its symptoms, reviewing examples, identifying strategies to ask for support, and communication techniques for conflict resolution. They found that nurses who participated in the program had a statistically significant reduction in moral distress one month after the intervention compared to the control group (Abbasi et al., 2019). Hickey (2022) suggested that moral distress training should be started early and perhaps incorporated into ICU orientation. These studies demonstrated a need for early interventions to reduce moral distress among ICU nurses.

Fostering Coping and Well-Being

Enhancing coping and well-being to reduce moral distress among ICU nurses has been tested using various approaches with limited support in the literature. For example, mindfulness is an emerging practice that was shown in the literature to improve nurse well-being and to reduce burnout (Jarden et al., 2018; Rushton et al., 2021). Rushton et al. (2021) implemented a Mindful Ethical Practice and Resilience Academy (MERPA), which consisted of multiple in-person sessions over the course of two years and a daily mindfulness practice. While they did not see a reduction in moral distress, nurses reported less depression, anger, and anxiety, and increased awareness, confidence, resilience, and engagement (Rushton et al., 2021). Empowerment programs like this have been shown to increase team cohesiveness and reduce turnover (Jarden et al., 2020; Rushton et al., 2021). Journaling has been tested as a well-being

intervention to reduce moral distress but it has not been proven effective (Hickey, 2022). Further research is needed into well-being and resilience training and its effects on moral distress in ICU nurses.

Debriefing and Reflection

The most widely used method to address moral distress has been focused on formal debriefing interventions and creating a reflective practice. Debriefing has historically been used among healthcare teams following critical incidents such as a code or to improve communication and collaboration (Vincent et al., 2020). Nurses in one study suggested that formal debriefing could enhance their well-being (Jarden et al., 2018). Hickey (2022) found that in two of the six studies reviewed, a debriefing intervention combined with journaling and reflection led to a reduction in moral distress scores among nurses. Two articles located in this review of the literature utilized structured case review debriefing sessions to build awareness and self-reflection. One showed a potentially significant decrease in moral distress among those who attended a debriefing session in comparison to the control group (Browning & Cruz, 2018). The other study used qualitative methods and did not measure the level of moral distress among the nurse participants, focusing instead on nurses' perceptions of the impact of the reflective practice (Reilly & Jurchak, 2017).

However, in both studies, the nurse participants reported that participation in debriefing allowed them to discuss difficult cases with their peers and have their concerns acknowledged, leading to a greater sense of support from nursing leadership. In addition, Browning and Cruz (2018) found reflective debriefing led nurses to have increased confidence when speaking up in situations that would normally lead to moral distress such as during family meetings with overly optimistic prognostication. Nurses also described an increased sense of engagement and

collaboration after debriefing, reduced moral distress, and reduced intentions to leave their current position (Browning & Cruz, 2018; Reilly & Jurchak, 2017). Findings from both studies suggested that reflective debriefing may be a promising approach for mitigating moral distress among ICU nurses.

Gaps in the Literature

While the concept and consequences of moral distress were thoroughly explored in the literature, research on interventions to prevent and reduce moral distress was limited (Abbasi et al., 2019; Andersson et al., 2022; Browning & Cruz, 2018). Furthermore, the published intervention studies were often low quality with small sample sizes and inconsistent control groups (Hickey, 2022). Therefore, future studies should focus on testing interventions to reduce moral distress and attempt to replicate procedures from prior studies with larger and more diverse sample sizes.

Summary of the Literature Review

A systematic literature search yielded 18 recently published articles exploring moral distress in ICU nurses. The current evidence primarily focused on factors contributing to moral distress along with symptoms and consequences of moral distress for nurses, patients, and health systems. Triggers for moral distress included personal factors such as age and years of nursing experience; team dynamics including communication and respect; organizational constraints such as staffing and access to resources; provision of care perceived to be futile or harmful to patients; and a sense of powerlessness among nurses (Andersson et al., 2022; Browning & Cruz, 2018; Giannetta et al., 2022; Hickey, 2022; Lusignani et al., 2017; McAndrew & Hardin, 2020; Morley et al., 2022; Rushton et al., 2021; Vincent et al., 2020). The recent COVID-19 pandemic exacerbated moral distress triggers in ICU nurses such as staffing shortages and futility and

introduced new issues such as frequent policy changes, lack of resources/supplies, and visitor restrictions (Andersson et al., 2022; Hickey, 2022; Rhéaume et al., 2022). Moral distress has been shown to cause physical and psychological distress among critical care nurses, which can negatively impact patient care and lead to nurses leaving their job or the profession.

There are minimal data on effective interventions for reducing moral distress and the studies that exist often utilized heterogeneous methods, small sample sizes, and lacked formal control groups (Hickey, 2022). Potentially promising interventions included the implementation of triggered palliative care and ethics consults, empowerment training, mindfulness practices, and reflective debriefing interventions (Abbasi et al., 2019; Browning & Cruz, 2018; Hickey, 2022; Piscitello et al., 2022; Reilly & Jurchak, 2017; Rushton et al., 2021). However, these limited findings present an opportunity for researchers to focus on implementing larger-scale, randomized control trials focused on interventions to reduce moral distress in ICU nurses. Moral distress occurs at varying levels and frequency in most ICU nurses and can have devastating consequences for nurses, patients, and health systems. Therefore, nursing researchers should focus on developing and testing evidence-based interventions to reduce moral distress. Based on the literature review presented above, reflective debriefing sessions are a promising intervention to address this gap.

Theoretical Framework

Background of Framework

The knowledge to action (KTA) framework was published by Graham et al. in 2006 in response to a request from the Canadian Institutes of Health Research to synthesize planned action theories across multiple disciplines (Graham & Tetroe, 2010). A planned action theory is defined as a “set of logically interrelated concepts that explain, in a systematic way, the means by which planned change occurs” (Graham & Tetroe, 2010, p. 210). Planned action theories help

change agents predict and address barriers to change adoption. The authors of the KTA framework conducted a literature search for articles and dissertations using planned action theories. Their search resulted in nearly 4,000 articles that contained 31 planned action theories. Those 31 theories were then analyzed, synthesized, and organized into a framework with seven action phases. The framework was tested by applying it to a project for Health Canada that assessed completed HIV/AIDS research. Testing suggested the KTA framework was useful across multiple settings and was designed to be used by individuals, teams, organizations, policymakers, practitioners, and the public (Graham & Tetroe, 2010).

In 2014, Field et al. published a systematic review exploring the application of the KTA framework in the literature. They initially discovered 1,057 citations, 146 of which applied the framework, and 10 that fully integrated the framework into the study design (Field et al., 2014). They noted at that time, the KTA framework was among the most cited frameworks for knowledge translation projects. Since its publication in 2006, the KTA framework has not undergone any modifications. However, the Canadian Institutes of Health Research (2023), the organization that initially funded the development of the KTA framework, is planning to develop a new framework in 2023 titled Knowledge Mobilization Framework and Action Plan.

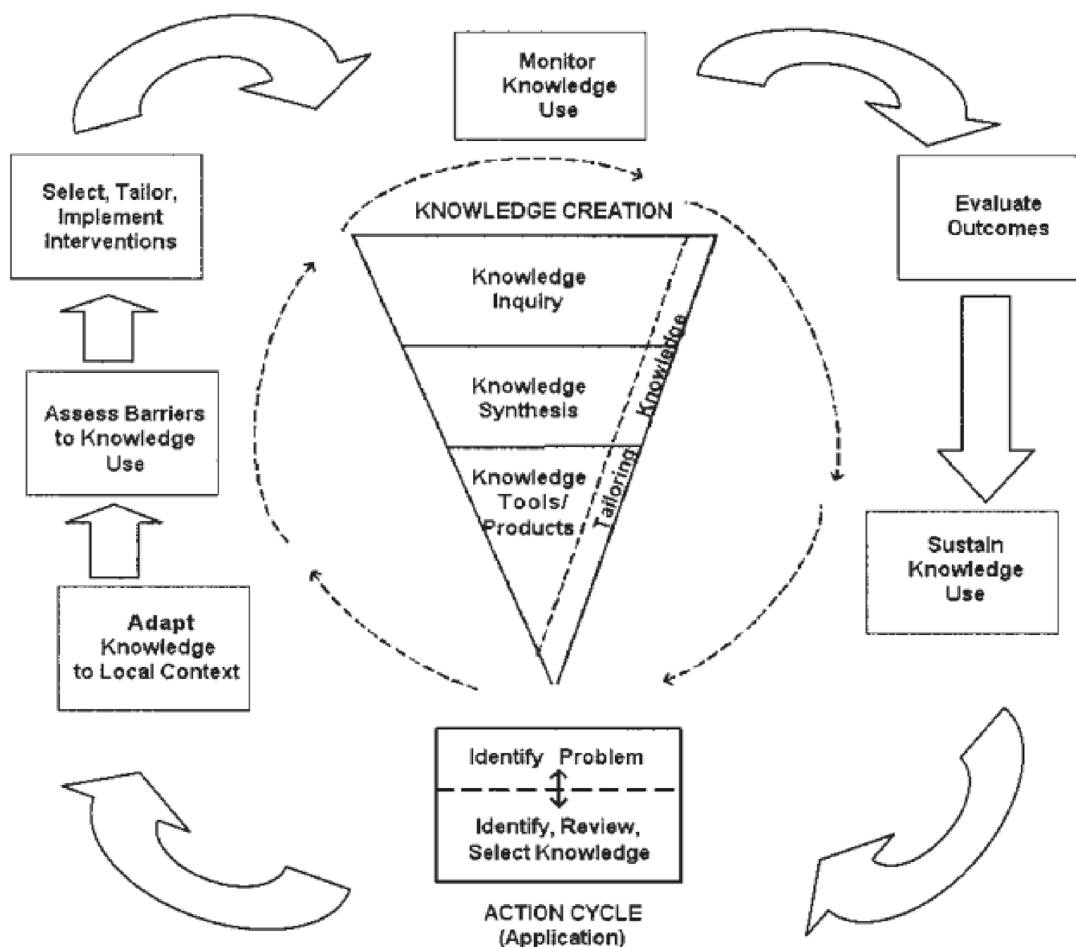
Description of Framework

The KTA framework was designed as a guide for knowledge translation projects. It could be used in all phases of knowledge development including the creation, implementation, and evaluation of the process. The framework aims to improve health care from a systems perspective by considering the local context and the users' experiential knowledge (Graham & Tetroe, 2010).

As shown in Figure 1, the KTA framework involves a central triangle, or funnel, representing knowledge creation. This includes clinical inquiry or exploration of the literature, identifying patterns and synthesizing the knowledge, and creating guidelines, algorithms, or decision aids based on the synthesis. The authors pointed out that as knowledge flows through the funnel, the information becomes more translatable to practice (Graham & Tetroe, 2010).

Figure 1

Knowledge To Action Cycle



Note. Adapted from Lost in translation: Time for a map? *The Journal of Continuing Education in Health Professions* by Graham et al. (2006). doi: 10.1002/chp.47. Used with permission from Wolters Kluwer Health, Inc. (see Appendix C).

Surrounding the funnel is a cycle of knowledge application or actions. There are seven phases and while the depiction gives the sense they are steps, the process is not always linear and the phases can be addressed in any order. Graham and Tetroe (2010) noted the use of this framework is often cyclical with knowledge being simultaneously created and acted upon.

Example of Use

A recently published quality improvement project focused on interventions to reduce moral distress among ICU nurses was implemented using the KTA model as a framework (Graham & Tetroe, 2010). Semler (2023) utilized education and self-reflection exercises to reduce moral distress and the KTA framework guided the literature review, tailoring the intervention to the local context and sustained knowledge use. The author found the intervention significantly reduced moral distress among the nurses involved and reported that the process and findings were informed by the KTA throughout (Semler, 2023). Given the similarity in scope and topic to this scholarly project, this is a good example of how the KTA can guide clinical scholarship.

Rationale for Use

The KTA framework provides organization and structure for knowledge translation projects while allowing for tailoring to the local context (Field et al., 2014; Graham & Tetroe, 2010). The KTA framework includes knowledge creation, reflected in the literature review described previously in this chapter, and an action cycle described in more detail below and in Chapter III. In this scholarly project, the AACN (2004) 4A's evidence-based debriefing tool provided a standardized structure for the debriefing sessions while allowing for the discussions to be tailored to the knowledge and experience of those in attendance at the project site.

Application of Framework

The following sections demonstrate the application of the KTA framework to this project based on the descriptions of the model provided by Graham and Tetroe (2010).

Knowledge Creation

The triangle, or funnel, in the center of the framework represents knowledge creation. This begins with inquiry and synthesis, which were explored in depth in the first part of this chapter and in the Table of Evidence (see Appendix B). Knowledge creation also involves the development of guidelines, algorithms, or decision aids (Graham & Tetroe, 2010). The literature on interventions and solutions to moral distress was limited but the AACN (2004) 4A's model for debriefing is an established debriefing guide published by a legitimate organization that was used in this project. Graham and Tetroe (2010) pointed out the KTA framework is designed to allow for an ongoing overlap of knowledge creation and application to practice. This project's impact could contribute to the existing knowledge on methods to reduce moral distress while simultaneously creating new knowledge about the feasibility of reflective debriefing as an intervention.

Action Cycle

All seven components of the action cycle were applied to this scholarly project as described below.

Identify Problem and Review Knowledge. As previously stated, moral distress is experienced by up to 80% of ICU nurses and could lead to physical and psychological symptoms as well as intentions to leave a job or the profession, all of which could negatively impact patient care and outcomes (Hickey, 2022). The literature also suggested that moral distress might contribute to the critical nurse shortage, creating a sense of urgency to address this issue. A gap

in the literature was identified with a lack of large-scale, randomized control trials evaluating the impact of interventions to reduce moral distress. The studies on existing interventions often had small sample sizes and utilized heterogeneous methods, making it difficult to draw conclusions on best practices. Nevertheless, reflective debriefing stood out as a potentially promising intervention. In addition, nurse managers and nurses from the project site identified moral distress as an issue that needed addressing and expressed their support for this project (see Letter of Support in Appendix D).

Adapt Knowledge to Local Context. Historically, palliative care and spiritual care services have been involved in informal debriefing sessions after distressing incidents at the project site. To the primary investigator's knowledge, this practice was not based on evidence nor have any data been collected to determine whether it effectively reduced moral distress among ICU nurses, which was recognized as a concern among both nursing staff and leadership at the project site. To standardize efforts to reduce moral distress among ICU nurses at the project site, this project offered a reflective debriefing intervention. While the intervention was structured based on AACN's (2004) 4A's model, the discussions at each session evolved based on the specific needs and participation of the individuals in attendance. This approach allowed for tailoring to the local context.

Assess Barriers and Supports to Knowledge Use. One anticipated barrier to this project was it could be difficult for nurses to step away from their clinical obligations to participate in debriefing sessions while on shifts. For this reason, debriefing sessions were offered before and after shift change to allow nurses from both shifts a chance to participate. Another barrier was the high likelihood that these sessions would be emotionally charged and might wander off track. To prevent this, a debriefing guide was created and reviewed at the beginning of each session so

participants were aware of the focus and timeline (see Appendix E). To support knowledge use, the primary investigator was the facilitator of each debriefing session to encourage consistency and completed additional training in the spring of 2023 from the Center to Advance Palliative Care on leading debriefing sessions including methods for redirecting participants when veering off topic. Prior to any data collection, the primary investigator held a practice debriefing session with a palliative care team member (also a member of the project team/committee) who was experienced in facilitating group sessions to elicit feedback on performance. Any needed adjustments were made prior to testing with the sample.

Select, Tailor, and Implement Interventions. The intervention involved evidence-based reflective debriefing sessions designed to reduce moral distress in ICU nurses at an urban hospital in Washington state. Key stakeholders were involved in the implementation phase including nurse managers, ICU nurses, and a palliative care specialist/project team member, although the primary investigator led the project. The debriefing sessions were structured based on the "The 4A's to Rise Above Moral Distress" guide from AACN (2004) and the revised Recognize and Address Moral Distress tool, also from AACN (2020). Permissions to use these resources are in Appendix F along with copies of each in Appendices G and H. Minimal tailoring of the AACN materials was expected as they were evidence-based and well established in the moral distress literature as being appropriate for use with critical care nurses.

Monitor Knowledge Use. Knowledge use was assessed by recording attendance and participation in the debriefing sessions. By offering several opportunities to participate during the two-week data collection period, the goal was to encourage participation in a session by as many nurses as possible. More information on the target sample size can be found in Chapter III of this written project.

Evaluate Outcomes. The intensity, frequency, and root causes of moral distress among the sample of ICU nurses at the project site were measured using the Measure of Moral Distress for Healthcare Professionals (MMD-HP) tool (Epstein et al., 2019). All ICU nurses were invited to take the MMD-HP survey before and after the two-week intervention period. Chapter III discusses the project design, methods, and measurement of outcomes in greater detail.

Sustain Knowledge Use. After analyses of the results of the MMD-HP surveys were completed, the current intensity, frequency, and root causes of moral distress among the sample were determined. In addition, analysis of the attendance at the debriefing sessions provided insight into the feasibility of reflective debriefing as a potential future intervention to address moral distress at the project site. Based on the results, there might be an opportunity and need for ongoing debriefing sessions as led by the primary investigator and other qualified stakeholders. In addition, the AACN's (2004) 4A's model was designed to guide ongoing team debriefing and provided a framework for individual nurses to utilize in the future when they experienced moral distress. The hospital in which the scholarly project took place is also part of a much larger national healthcare system. Therefore, the positive impact of this project has the potential to reach ICU nurses across the country.

Summary

Moral distress occurs in up to 80% of ICU nurses due to personal factors, team dynamics, organizational constraints, perceived powerlessness, and the provision of futile care common to the critical care setting. Moral distress could lead to physical and psychological consequences along with attrition and a negative impact on patient care and healthcare systems. The COVID-19 pandemic exacerbated moral distress among ICU nurses and worsened the national nursing shortage. Unfortunately, data on interventions to reduce moral distress were limited. However,

reflective debriefing was cited in several studies as a potentially promising intervention for reducing moral distress. Utilizing the KTA framework, this project aimed to explore the intensity, frequency, and root causes of moral distress among registered nurses in an adult ICU setting and the feasibility of reflective debriefing as a potential intervention. The KTA framework provided action phases that guided the translation of evidence into practice, allowed for the generation of new knowledge among the team members involved, and contributed to the field of knowledge on moral distress.

CHAPTER III

METHODOLOGY

This chapter explores the design and methodology utilized for this Doctor of Nursing Practice (DNP) scholarly project. In addition to describing the setting, sample, and instrumentation, the data collection and analysis plans are discussed. Additional topics covered in this chapter include the action steps for each objective, project mission and vision, timeline, and ethical considerations. The purpose of this DNP scholarly project was to explore the intensity, frequency, and root causes of moral distress among registered nurses in an adult ICU setting and the feasibility of reflective debriefing as a potential intervention.

Design

This scholarly project used a quantitative, exploratory design to assess the level and root causes of moral distress among registered nurses in the ICU at the project site along with the feasibility of reflective debriefing as a potential intervention. Data were collected using a reliable and valid survey instrument before and after the intervention to determine the impact. The debriefing sessions followed the guide developed by the primary investigator (see Appendix E). Participation in a debriefing session was not a requirement for survey completion, although participants were required in the post-intervention survey to identify whether they attended a session. This approach allowed for a default control group to be created from the convenience sample and reduced the threat to internal validity given the non-randomized design (Melnyk & Fineout-Overholt, 2019). While randomization was ideal, it was unrealistic in this scenario given the sessions were held in person during shift changes and were impacted by staffing and

scheduling constraints beyond the control of the primary investigator. In addition, since participation in the intervention could be potentially beneficial to ICU nurses, the primary investigator and project advisor determined it was more ethically sound to offer the opportunity to participate to as many nurses as possible regardless of eligibility and, therefore, a designated control group was not included in the design.

In a systematic review exploring interventions to reduce moral distress, Hickey (2022) found half of the included studies incorporated the AACN's (2004) 4A's model into their project design. After a discussion with a representative from the AACN along with the project advisor, the primary investigator developed a debriefing guide based on a synthesis of the literature, the AACN 4A's model, and the revised Recognize and Address Moral Distress tool (AACN, 2020), both used with permission (see Appendices F, G, and H). The debriefing guide was presented to the project team/committee for further review during the proposal defense and any requested adjustments were made prior to initiating the project.

Setting

This DNP project occurred within the ICUs at Saint Joseph's Medical Center (SJMC), a tertiary care hospital located in Tacoma, Washington. The SJMC provides care to the Tacoma community and surrounding areas. The hospital has a level two trauma designation and is licensed for approximately 300 inpatient beds, with 48 adult ICU beds among six sub-specialized ICUs. Written permission to conduct the project at SJMC was obtained (see Appendix D).

Sample

Approximately 200 registered nurses (RNs) currently work in the ICUs at SJMC and all were invited to complete screening to determine their eligibility to participate in the project. Inclusion criteria were nurses who had completed their ICU orientation, were currently providing

clinical care in at least one of the ICUs, and worked at least 0.5 full-time equivalency (FTE). Additionally, nurses who floated between the ICU and other departments were allowed to participate if they met the above criteria. Exclusion criteria were those not currently providing clinical care in one or more of the ICUs, not employed by the hospital (such as agency and travel nurses), working less than 0.5 FTE, and nurses still on orientation. Although only the data from the nurses meeting the above criteria were included in the analysis, all nurses were invited to participate in a debriefing session (such as those still on orientation) for ethical reasons.

Participants who voluntarily participated in a debriefing session were considered the intervention group while those who did not were defaulted to the control group. Given this project was site-specific and therefore had a limited sample from which to draw, a power analysis was not completed (Gray & Grove, 2021). Ideally, at least 30% of the potential participants ($n = 60$) would complete both the pre- and post-intervention surveys. An estimated 10% ($n = 20$) would attend a debriefing session. Participants were recruited via institutional emails, unit signage, and pre-shift huddle announcements (see Appendix I for recruitment materials). Participation was incentivized with a raffle in which participants could opt into a drawing for one of six $50 electronic Amazon gift cards. The drawing occurred after each survey had closed. Participants could opt to enter the drawing twice—once for each survey they completed. Light refreshments were also provided during the debriefing sessions and were available to anyone interested regardless of participation.

Participation in the intervention was completely voluntary and based on convenience as sessions were predicted to be attended by nurses scheduled to work that shift. To enhance external validity, debriefing sessions were offered at varying times and days, allowing nurses from day shift, night shift, and weekend shifts to attend (Melnyk & Fineout-Overholt, 2019). The

pre- and post-intervention surveys were completed electronically on a phone, tablet, or computer at any time during the designated data collection periods to further facilitate participation.

Project Mission and Vision

The mission of the project was to evaluate the moral distress levels of ICU nurses and to develop and implement a reflective debriefing intervention designed to alleviate the burden of this phenomenon. The vision was to standardize a potential intervention for reducing moral distress among ICU nurses that improved professional, patient, and systems outcomes.

Objectives with Action Steps

O1 Develop an evidence-based reflective debriefing intervention designed to be administered over a two-week period to a convenience sample of practicing ICU nurses at the project site.

a. Review the current literature on debriefing for moral distress (see Chapter II and the Table of Evidence in Appendix B);

b. Synthesize the literature review findings with the AACN (2004) 4A's model and the AACN (2020) Recognizing & Addressing Moral Distress guide to create an evidence-based moral distress reflective debriefing guide under the supervision of the project committee (see Appendix H);

c. Complete a debriefing training through the Center to Advance Palliative Care (Leff, 2023) to enhance intervention fidelity and prepare the primary investigator for session moderation;

d. Prior to any data collection, the primary investigator attended pre-shift huddles for day, night, and weekend shifts to inform the nurses about the project and answer any questions. In addition, signage was placed in breakrooms and around the unit to advertise the project (see Appendix I):

i. Prior to the first session, the primary investigator held a practice debriefing session with a palliative care team member (also a member of the project team/committee) who was experienced in facilitating group debriefing sessions to elicit feedback on performance. Any needed adjustments were made prior to implementing the intervention for the project.

O2 Measure the intensity, frequency, and root causes of moral distress among a sample of ICU nurses using a valid and reliable research instrument.

a. The pre-intervention survey included basic demographic questions to determine eligibility and sample characteristics and both surveys consisted of the MMD-HP as developed by Epstein et al. (2019);

i. The surveys were created and disseminated using a secure Qualtrics account provided by the University of Northern Colorado (UNCO). The pre-intervention survey was emailed 10 days before the first scheduled debriefing session. The survey automatically closed if the participant did not meet the inclusion criteria. The survey remained open until 12 hours before the first debriefing session was implemented.

ii. The post-intervention survey was emailed seven days after the final debriefing session was delivered. The survey remained open for 10 days. Reminder emails were sent during both data collection periods as needed to stimulate adequate response rates as detailed in the Sample section (goal of $N = 60$).

b. All participants in the project were assigned a unique identifier that they were required to enter in each survey to track completion. The master list of identifiers was maintained by the primary investigator and stored on a password-protected laptop in a secure location. It was only accessible to the principal investigator and the project advisor using UNCO's secure servers.

c. The survey results were analyzed using the statistical methods described below.

O3 Evaluate the participation level of ICU nurses at the project site in the reflective debriefing intervention

a. Deliver six approximately 30-minute debriefing sessions over a two-week period scheduled at varying times and days to maximize participation.

b. All nurses were invited to attend a session but only data from those meeting the inclusion criteria were analyzed.

c. Track the attendance at each debriefing session.

d. Explore patterns in attendance to predict what time might be the most feasible for ICU nurses to participate in debriefing sessions.

O4 Perform additional descriptive and inferential analyses of the project findings and disseminate all results to the project site including making recommendations to leadership about the feasibility of implementing reflective debriefing as a future intervention.

a. Perform additional statistical analysis as described under the Data Analysis section.

b. After completion of the project, present the findings to ICU leadership with recommendations for increasing their support of ICU nursing staff in relation to moral distress.

Project Plan

- Obtain written permission from SJMC to conduct the project on-site.
- Write and successfully defend the DNP project proposal to the project team/committee.
- Attend a debriefing training through the Center to Advance Palliative Care (Leff, 2023).
- Apply to the UNCO Institutional Review Board (IRB) for project approval (presumed to be 'exempt').
- Begin the recruitment process 10 days before the survey opens by attending pre-shift huddles to inform nurses about the project. Hang recruitment flyers in breakrooms and around the unit.
- Distribute the pre-intervention survey with unique identifiers to track participation to all eligible nurses 10 days before the first scheduled debriefing session.
- Host six debriefing sessions over a two-week period, making every effort to vary times and days to maximize participation by as many nurses as possible.
- Distribute the post-intervention survey seven days after the final debriefing session and collect data over a 10-day period.
- Once the survey has closed, randomly draw names for the optional raffle and distribute the awarded gift certificates via institutional email.
- Analyze the data using the methods described below.
- Finalize and defend the scholarly project to the project team/committee and submit for approval and dissemination by the UNCO Graduate School.

Instrumentation

One of the most widely utilized tools to assess moral distress is the Moral Distress Scale (MDS), initially developed for ICU nurses by Corley et al. in 2001 (Epstein et al., 2019). This scale has undergone several revisions, initially by Corley in 2005, then by Hamric et al. in 2012. The latter revision, the Moral Distress Scale–Revised (MDS-R), resulted in the creation of six versions that applied to different healthcare specialties (Epstein et al., 2019). In 2019, Epstein et al. further revised the MDS-R by incorporating newly recognized root causes of moral distress along with feedback from researchers, thus creating the Measure of Moral Distress for Healthcare Professionals (MMD-HP; Epstein et al., 2019). The new scale condensed the six specialized surveys into one instrument applicable across multiple specialties and acute care settings (Epstein et al., 2019).

The MMD-HP includes 27-items that utilize a Likert scale to assess the frequency and intensity of moral distress related to identified root causes at the individual, team, and system levels (Epstein et al., 2019). In addition, two nominal questions at the conclusion of the survey assess the intention to leave the current nursing position. Composite scores range from 0 to 432 with higher scores indicating increased moral distress (Epstein et al., 2019). Construct validity was assessed by testing four hypotheses and the tool was found to perform similarly to the previously validated MDS-R (Epstein et al., 2019). Reliability is demonstrated by a Cronbach’s alpha of 0.93 overall (Epstein et al., 2019). Piscitello et al. (2022) used the MMD-HP in their pre- and post-intervention study assessing if triggered palliative care consults decreased moral distress in ICU nurses and found no statistical significance. While the 2019 version has yet to be broadly adapted in the literature given its recent development, Epstein et al. (2019) demonstrated consistent reliability and validity metrics comparable to previous versions.

The MMD-HP was used for this DNP project with written permission from the lead author (see Appendices J and K). As described previously, the MMD-HP was electronically developed and disseminated using Qualtrics survey software and included the 27-item instrument along with the two nominal questions. The MMD-HP included optional write-in items at the end of the survey, which were added to identify root causes of moral distress not covered in the 27-item instrument (Epstein et al., 2019). After discussion between the primary investigator and project advisor, the decision was made to eliminate the write-in items as qualitative analysis and further instrument development was beyond the scope of this DNP scholarly project.

Data Analysis

Results of the pre- and post-intervention surveys were exported from Qualtrics into a Microsoft Excel spreadsheet for analysis. Data analysis was accomplished using basic descriptive and inferential statistical tests available in Qualtrics and Excel software. First, measures of central tendency were calculated including the mean, median, and mode of the MMD-HP composite scores. This information was used to describe the overall level of moral distress among the cohort.

Next, *t*-tests and *f*-tests were completed on the pre- and post-intervention (six planned debriefing sessions) composite scores. The *f*-test was used to determine whether the variances of the two groups were equal. An independent *t*-test was completed to determine if there was a significant ($p < .05$) difference between groups. Next, an *f*-test and independent *t*-test were completed comparing the intervention group (participants who attended a debriefing session) and the control group (participants who did not attend a debriefing session) using the unique identifiers to determine if there was a significant difference ($p < .05$) between the composite scores of the control group and the intervention group after the intervention was delivered.

Finally, responses to each individual item in the MMD-HP were analyzed to determine which factors this cohort of nurses attributed as root causes of their moral distress. These data were used to explore the current level of moral distress of the cohort and whether the debriefing intervention impacted the overall level of moral distress among the sample, if at all.

Duration of the Project

Upon proposal acceptance, approvals were obtained from the project site and UNCO's IRB (see Appendix L). Once approved, recruitment began immediately by advertising the project at pre-shift huddles and by posting flyers in the ICUs 10 days prior to the initial survey distribution. The pre-intervention survey was then emailed to potential participants and remained open for a 10-day period. A reminder email was issued since the response rate was less than 20% on day five. Six debriefing sessions were held over the following two-week implementation period. The post-intervention survey was distributed seven days after the final debriefing session and remained open for 10 days (again, with a reminder email on day five as necessary). The data were then imported into an Excel spreadsheet and analyzed with the assistance of the project advisor over a seven-day period. The results were interpreted and the final project write-up took approximately three weeks followed by preparation for and completion of the final project defense. The timeline from proposal acceptance to project completion was 22 weeks.

Ethical Considerations

Approvals were obtained from the project site along with the IRB. This project was determined to be considered "exempt" because it presented minimal risk to participants. The potential risks included a time commitment of 10-15 minutes per survey along with optional participation in a 30-minute debriefing session. Attendees of the debriefing session might experience temporary emotional discomfort in the form of anxiety, grief, or stress when discussing their experiences with moral distress. However, as discussed in the literature review,

debriefing has been shown to reduce moral distress and, therefore, the benefits were anticipated to outweigh the risks. All employees of SJMC had access to the employee assistance program should they require mental health support or counseling.

The surveys remained confidential and anonymous. Unique identifiers assigned to each participant were only used for data collection and analysis purposes. The master list of identifiers was kept on a password-encoded computer and was only accessible by the primary investigator and project advisor. Survey results were aggregated for analysis. Individual responses were not disaggregated.

The primary investigator had no conflicts of interest to disclose. They are not in a supervisory role; however, as a nurse practitioner in the ICU, there might be a perceived power differential with the RNs invited to participate. Nurses were reminded in writing (in the pre/post-intervention surveys) and verbally (at the start of each debriefing session) that their participation was voluntary and they could withdraw from participation at any time. Incentives included the opportunity to voluntarily enter a raffle for one of six $50 electronic gift cards by completing each survey as well as light refreshments provided during the debriefing sessions that were available to anyone in attendance. A statement of implied electronic consent was included at the beginning of each survey and was read by the primary investigator at the start of the debriefing sessions.

Summary

Upon a successful proposal defense and IRB approval, this exploratory DNP scholarly project began with a pre-intervention survey distributed to all eligible nurses working in the ICU at SJMC in Tacoma, Washington. Evidence-based, reflective debriefing sessions were implemented followed by a post-intervention survey. The pre- and post-intervention survey

results were analyzed using basic descriptive and inferential statistics and the final project write-up occurred. The project took 22 weeks from proposal acceptance through final project submission to the UNCO Graduate School. The findings will then be disseminated to interested leadership at the project site along with recommendations for future initiatives designed to mitigate moral distress among ICU nursing staff.

CHAPTER IV

DATA ANALYSIS AND RESULTS

This chapter reviews the data analysis and results for this DNP scholarly project. The project aimed to explore the intensity, frequency, and root causes of moral distress among registered nurses in an ICU setting and the feasibility of reflective debriefing as a potential intervention. An analysis of the two project questions and a summary are also provided in this chapter.

Results

Objective 1

O1 Develop an evidence-based reflective debriefing intervention designed to be administered over a two-week period to a convenience sample of practicing ICU nurses at the project site.

Completion of this objective included the creation of a reflective debriefing guide and preparing the primary investigator to facilitate debriefing sessions. The debriefing guide (see Appendix E) was developed through a synthesis of the current literature with the AACN's (2004) 4 A's model and the Recognize and Address Moral Distress Tool (2020), both used with permission (see Appendices F, G, and H). As discussed in Chapter II, the literature search explored interventions to reduce moral distress in ICU nurses. The initial search returned 381 articles and 18 were included in the synthesis after applying exclusion criteria. While the evidence primarily focused on defining factors that contributed to moral distress as well as potential personal and professional consequences, several studies and systematic reviews explored interventions to reduce moral distress; reflective debriefing was noted as a promising

intervention. The literature synthesis, along with the AACN resources mentioned above and feedback from the project committee members, informed the development of the reflective debriefing guide used for this DNP project. Underpinned by the 4A's model (Ask, Affirm, Assess, Act), the guide also incorporated root causes and opportunities for addressing moral distress in the workplace from the Recognize and Address Moral Distress Tool. The information in the debriefing guide was designed as a tool for the primary investigator to keep the conversation on track and provided participants with a framework to reflect on morally distressing clinical situations.

To prepare for facilitating the debriefing sessions, the primary investigator attended training through the Center to Advance Palliative Care. This training included a two-hour webinar and a small group discussion to review content and learn from other peer facilitators. The webinar was designed to teach attendees basic peer facilitator skills for debriefing. Training topics included the benefits of debriefing in health care, obtaining leadership buy-in, the structure and design of debriefing sessions, defining the role of the facilitator, encouraging participation, and strategies for addressing challenging situations that may arise during a session (Leff, 2023). The primary investigator developed debriefing skills that encouraged participation and sharing by attendees as well as refocusing cues if the conversation veered off topic. Based on the Center to Advance Palliative Care training and literature synthesis findings, the debriefing sessions for this DNP project were designed to last approximately 30 minutes and were offered at varying times to allow for increased participation from ICU nurses working different shifts.

Objective 2

O2 Measure the intensity, frequency, and root causes of moral distress among a sample of ICU nurses using a valid and reliable research instrument.

These data were collected using the MMD-HP developed by Epstein et al. (2019) and used with permission (see Appendices J and K). The MMD-HP is a 27-item survey of the frequency and intensity of known root causes of moral distress among healthcare professionals. Qualtrics survey software was used to distribute the survey to approximately 200 ICU nurses. Survey participation was incentivized with an option to enter a raffle to win one of six $50 Amazon gift cards for each survey completed. The gift cards were funded by an award received from the Sigma Theta Tau International Honor Society of Nursing, Zeta Omicron chapter. After the post-intervention survey closed on day 10 of the data collection period, the email addresses provided by those participants who opted into the drawing were exported to an Excel spread sheet and assigned a number based on order. A random number generator was then used to select the six winners. The gift cards were distributed electronically.

A total of 24 nurses completed the pre-intervention survey, which included basic demographic questions to determine eligibility to participate in the project and to describe the sample. If survey participants answered they were still on orientation, worked less than 0.5 full-time equivalent, or were not employed by the hospital (such as agency or travel nurses), their survey was excluded from data analysis (n=4). Demographic questions were not included in the post-intervention survey so the data presented below are limited to pre-intervention participants meeting inclusion criteria ($N = 20$).

Table 1

Summary of Pre-Intervention Sample Demographics

Sample Characteristic	*n*	%
Years of nursing experience		
Less than 1	3	15
1 to 2	5	25
3 to 5	3	15
6 to 9	6	30
10 or more	3	15
Years of ICU experience		
Less than 1	5	25
1 to 2	5	25
3 to 5	5	25
6 to 9	3	15
10 or more	2	10

Note: $n = 20$

The data in Table 1 showed that the 20 pre-intervention participants who met inclusion criteria represented nurses with varying levels of experience. Slightly more than half reported having less than five years of nursing experience, and 75% reported having less than five years of ICU experience. Demographic information such as gender or race/ethnicity were not collected as it was deemed irrelevant to the focus of this project.

After the pre-intervention survey closed, six debriefing sessions were held over a two-week period. The post-intervention survey was distributed seven days after the final debriefing session to allow time for nurses to potentially encounter a morally distressing situation and reflect on their experience. Twenty-six nurses completed the post-intervention survey, which was open for a period of 10 days; however, four did not meet the inclusion criteria described above

and were eliminated. This left 22 surveys that were combined with the pre-intervention surveys (*n*=20) for a total of 42 eligible for analysis. As mentioned above, demographic data were not collected in the post-intervention survey.

The MMD-HP included instructions for calculating each respondent's composite score after completion of the survey. The frequency score was obtained using a Likert scale that ranged from 0 (*never*) to 4 (*very frequently*). Similarly, the intensity score also used a Likert scale that ranged from 0 (*none*) to 4 (*very distressing*). The composite score for each respondent was computed by multiplying each item's frequency and intensity score, then adding those numbers together. The instrument developers noted that frequency and intensity should not be assessed separately as both contributed to moral distress (Epstein et al., 2019). Composite scores for each item could range from 0 to 16 and overall composite scores ranged from 0 to 432. The higher the score, the greater the moral distress (Epstein et al., 2019).

The survey responses were exported from Qualtrics to Excel for data analysis. Excel formulas were applied to calculate the composite scores using the formula described above. Descriptive analyses were performed including measures of central tendency and variability. Of the 42 survey respondents who met inclusion criteria, composite scores ranged from 39-271 with an average score of 141.4, representing a moderate level of moral distress among the sample (see Table 2).

Table 2

Averaged Composite Score for the Sample (Combined Pre/Post Surveys)

Descriptive Statistics	Averaged Composite Score
Mean	141.4286
Standard Error	8.584968
Median	141
Mode	168
Standard Deviation	55.63695
Sample Variance	3095.47
Kurtosis	-0.66538
Skewness	0.073137
Range	232
Minimum	39
Maximum	271
Sum	5940
Count	42
Largest(1)	271
Smallest(1)	39

Individual items on the MMD-HP were associated with different root causes of moral distress. Table 3 includes the root cause statements that had the five highest mean composite scores among the sample (ranging from 0 to 16). The complete data set for individual item composite scores can be found in Appendix M.

Table 3

Highest Rated Root Causes of Moral Distress

Root Cause Statement	Composite Score
Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient.	10.65
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.	9.9
Witness healthcare providers giving "false hope" to a patient or family.	7.15
Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.	6.78
Be required to work with abusive patients/family members who are compromising quality of care.	6.72

Analysis of these findings suggested the highest levels of moral distress among this sample were associated with aggressive care at end-of-life and the provision of care deemed to be futile. The ICU nurses in the sample reported the highest levels of moral distress when the patient's family insisted on aggressive care even when it conflicted with the nurses' professional opinions. These findings were consistent with those previously published by the MMD-HP authors (Epstein et al., 2019).

The MMD-HP also included two supplemental questions with nominal (yes/no) response options. The first question inquired whether respondents had ever left or considered leaving a clinical position in the past due to moral distress. Among this sample of practicing ICU nurses, 71% percent of participants answered 'yes' ($n = 30$). The second question addressed respondents' present intentions with 67% ($n = 28$) reporting they were not currently considering leaving their position due to moral distress while 33% ($n = 14$) reported they were. These data suggested that

although fewer nurses cited a current intention to leave their position due to moral distress, it remains a significant issue for many nurses.

Objective 3

O3 Evaluate the participation level of ICU nurses at the project site in the reflective debriefing intervention.

Recruitment efforts included posting eight signs throughout ICU breakrooms, verbal announcements at shift change huddles by the primary investigator, sending 200 individualized emails describing the project and listing the debriefing session dates and times, and informal verbal reminders from the primary investigator just prior to each session (see Appendix I for recruitment materials). Participation was encouraged by offering 10 debriefing sessions throughout a two-week intervention period scheduled at different times to accommodate both day and night shift nurses as well as on weekends and weekdays. All sessions were held in the fifth-floor ICU conference room, a private space that was easily accessible and utilized by staff from all ICUs. Due to the potentially beneficial aspects of reflective debriefing, all ICU nurses were invited to attend a session regardless of whether they met the project eligibility criteria or completed a survey. To encourage participation and maintain anonymity, personal information was not collected during these sessions. Light refreshments were provided during each session and were available to anyone in attendance. Financial support for the purchase of these light refreshments was obtained from the Sigma Theta Tau award mentioned above.

As displayed in Table 4, 15 ICU nurses attended a debriefing session. At the end of the first week of scheduled sessions, only three nurses had participated in the intervention. After a discussion between the project advisor and the primary investigator, the decision was made to hold additional sessions during the second week at varying times to allow for increased attendance. Ten sessions were held over the two-week intervention period with attendance

ranging from zero to three participants per session. At times, multiple debriefing sessions were held on the same day as needed. For example, on 6/20/2023, a nurse arrived just as the night shift debriefing session was wrapping up at 0800 and expressed a desire to participate, which the primary investigator accommodated. Two additional sessions were held that same day to target day shift nurses at 0930 and 1930. The goal was to offer sessions at varying times to allow nurses to participate given the often-unpredictable fluctuations in patient care responsibilities and staffing.

Basic analysis of attendance patterns revealed that nurses were more likely to attend a session immediately following the end of their shift regardless of whether it was a day shift or night shift. This was evidenced by the two sessions with three attendees occurring at 0730 and 1930. The lowest participation occurred in sessions held mid-shift during the day. Potential reasons for this overall low participation rate are discussed under the Limitations and Recommendations for Future Research sections in Chapter V of this written document.

Table 4

Debriefing Session Schedule and Attendance

Session Date	Time (Military)	Attendance (Registered Nurses)
Sunday, 6/11/2023	0730	1
Sunday, 6/11/2023	2200	2
Monday, 6/12/2023	1700	0
Sunday, 6/18/2023	1700	1
Tuesday, 6/20/2023	0730	3
Tuesday, 6/20/2023	0800	1
Tuesday, 6/20/2023	0930	1
Tuesday, 6/20/2023	1930	3
Wednesday, 6/21/2023	0730	1
Wednesday, 6/21/2023	1700	2

Objective 4

O4 Perform additional descriptive and inferential analyses of the project findings and disseminate all results to the project site including making recommendations to leadership about the feasibility of implementing reflective debriefing as a future intervention.

Additional Analyses of Survey Results

To thoroughly explore all available data, several additional statistical tests were performed using the raw data exported from Qualtrics to Excel. First, the MMD-HP composite scores of the pre-intervention and post-intervention survey respondents were calculated based on the formula provided by the survey developers and described above. Then, descriptive statistical

analyses were performed to determine mean composite scores among the pre-intervention (*n* = 20, mean score of 145.6) and post-intervention (*n* = 22, mean score of 137.6) groups. It is important to note that due to low attendance rates at the debriefing sessions, all survey responses were included in this analysis regardless of whether the respondents participated in a session or not. To compare these two survey groups using inferential statistics, an *F* test two sample for variances test was performed in Excel. As shown in Table 5, the calculated *F* value (1.11) was less than the *F* critical value (2.1) with a *p* value of .40. These findings suggested the difference between the two groups might be due to chance and we could, therefore, assume equal variance (Kim et al., 2022). Next, an independent two-sample *t*-test was performed in Excel (see Table 6), which demonstrated no statistically significant difference between the two groups (p =.32, $t(40)$=0.46).

Table 5

F-Test Two-Sample for Variances: Pre- and Post-Intervention Surveys

	Pre-Intervention	Post-Intervention
Mean	145.65	137.5909
Variance	3335.292	2993.491
Observations	20	22
Df	19	21
F	1.114181	
P(F<=f) one-tail	0.40279	
F Critical one-tail	2.108979	

Table 6

Independent Two-Sample t -Test: Pre- and Post-Intervention Surveys

	Pre-Intervention	Post-Intervention
Mean	145.65	137.5909
Variance	3335.292	2993.491
Observations	20	22
Pooled Variance	3155.847	
Hypothesized Mean Difference	0	
Df	40	
t Stat	0.464333	
P(T<=t) one-tail	0.322463	
t Critical one-tail	1.683851	
P(T<=t) two-tail	0.644926	
t Critical two-tail	2.021075	

Finally, the MMD-HP mean composite score of the post-intervention surveys (118.3) from the nine respondents who attended a debriefing session was compared to the mean composite score (150.5) of the remainder of the control cohort ($n = 31$) using an independent two-sample *t*-test. The pre-intervention surveys from the two respondents who attended a debriefing session were excluded since they were considered part of the "intervention" cohort and therefore could not be part of both groups in an independent *t*-test analysis. Results from this analysis indicated no statistically significant difference between the two groups (see Table 7; $p = 0.06$, $t(38) = -1.65$). In addition, another *F*-test two-sample for variances analysis was completed to compare variance between the intervention and control groups. The results indicated the

calculated *F* value (0.75) was greater than the *F* critical value (0.32); therefore, equal variances could not be assumed (see Table 8).

Table 7

Independent Two-Sample t-Test: Intervention and Control Groups

	Intervention Group	Control Group
Mean	118.3333	150.4839
Variance	2441.25	3245.658
Observations	9	31
Hypothesized Mean Difference	0	
Df	15	
t Stat	-1.65815	
P(T<=t) one-tail	0.059023	
t Critical one-tail	1.75305	
P(T<=t) two-tail	0.118047	
t Critical two-tail	2.13145	

Table 8

F-Test Two-Sample for Variances: Intervention and Control Groups

	Intervention Group	Control Group
Mean	118.3333	150.4839
Variance	2441.25	3245.658
Observations	9	31
Df	8	30
F	0.752159	
P(F<=f) one-tail	0.353911	
F Critical one-tail	0.324738	

It is important to consider the limitations of these tests given the overall small sample size and the differing sizes of the two groups. A small sample size could result in reduced statistical power, meaning the results of this study are unlikely to be generalizable to ICU nurses as a whole. In addition, the difference in the size of the two groups and the unequal variance demonstrated that these results are less reliable (Kim et al., 2022). A full discussion of these limitations can be found in Chapter V.

Dissemination of Results and Recommendations to the Project Site

A dissemination plan and recommendations to leadership at the project site about the feasibility of implementing reflective debriefing as an intervention to reduce moral distress and identify the root causes among ICU nurses are detailed in Chapter V.

Summary of Findings

This study aimed to assess the intensity, frequency, and root causes of moral distress among registered nurses in the ICU at the project site and to explore their interest in reflective debriefing as a potential intervention. The mean composite score for the MMD-HP among the sample was 141.4, which indicated at least a moderate level of moral distress. Individual composite scores were as high as 271 within the sample, suggesting that elevated levels of moral distress existed among a small number of nurses. In addition, 33% of the nurses surveyed reported they were actively considering leaving their current position due to moral distress, further emphasizing the need to address this phenomenon at the project site. This figure was alarming as a significant loss of nursing staff would have devasting patient safety and financial consequences for the organization. When examining the potential impact of reflective debriefing as an intervention to reduce moral distress, there was no statistically significant difference between the MMD-HP composite scores of those who attended a debriefing session and those who did not (p = .06). However, the small and unevenly distributed sample sizes precluded any conclusions regarding the debriefing intervention's effectiveness. The limitations and future implications of reflective debriefing as a potential intervention are discussed in Chapter V along with recommendations for leadership at the project site.

Analysis and Summary of the Research Questions

The first research question guiding this DNP scholarly project was as follows:

Q1 What are the intensity, frequency, and root causes of moral distress among ICU nurses at the project site?

This question was answered by analyzing the results of the MMD-HP survey administered to a sample of ICU nurses at the project site. Higher scores on the MMD-HP indicated increased levels of moral distress (Epstein et al., 2019). A mean composite score of

141.4 suggested at least a moderate level of moral distress among the sample. Over one-third of the ICU nurses surveyed in the MMD-HP reported they were currently considering leaving their position due to moral distress. The data analysis also identified the root causes associated with the highest levels of moral distress among the sample were largely associated with providing aggressive care at end-of-life. Recognizing this as a major contributing factor for moral distress among this sample should inform future interventions aimed at reducing moral distress. Chapter V provides further recommendations for the project site.

The second research question was:

Q2 What is the feasibility of reflective debriefing as a potential intervention for decreasing the impact of moral distress among ICU nurses at the project site?

This question was answered through analysis of the development and delivery of reflective debriefing sessions to ICU nurses at the project site as a potential intervention for decreasing moral distress. The development and implementation of the reflective debriefing guide required a comprehensive synthesis of the literature and formal training on the part of the primary investigator as the debriefer. Recruitment of the sample followed standard research procedures and included signage on the unit, announcements in shift change huddles, informative emails, participation incentives, and light refreshments at each debriefing session. Overall low participation rates in this project prohibited any conclusions about the efficacy of reflective debriefing but the overall level of moral distress and root causes among the sample were identified using the survey instrument as described above.

Additional analysis demonstrated a reduction in moral distress composite scores among the participants (n = 9) who attended a debriefing session compared to the composite scores of the rest of the sample (n = 31); however, these results were not statistically significant, likely due to the small and unevenly distributed sample sizes. Based on an analysis of the attendance

patterns at the debriefing sessions, it appeared that immediately following shift change might be the best time for nurses to attend a session. While these findings suggested that reflective debriefing might be feasible, additional research with larger sample sizes is needed to fully investigate the effectiveness of debriefing as an intervention to reduce moral distress among ICU nurses. Chapter V explores the limitations of this project along with the implications of these findings for both research and clinical practice.

CHAPTER V

DISCUSSION

This chapter provides a summary of the results of this scholarly project including the conclusions, limitations, and recommendations for the project site. A reflection on how this project met the American Association of Colleges of Nursing's (AACN, 2021) *The Essentials: Core Competencies for Professional Nursing Education* is also included in this chapter. The purpose of this DNP scholarly project was to explore the intensity, frequency, and root causes of moral distress among registered nurses in an adult intensive care unit (ICU) setting and the feasibility of reflective debriefing as a potential intervention.

Summary of the Project

After synthesizing the literature, debriefing appeared most frequently as a promising intervention to reduce moral distress (Browning & Cruz, 2018; Hickey, 2022; Reilly & Jurchak, 2017). Using these results, an evidence-based debriefing guide was designed as guided by the AACN (2004) 4A's model and the Recognize and Address Moral Distress Tool (AACN, 2020). The primary investigator completed additional training from a national organization on facilitating debriefing sessions. Ten sessions were held over a two-week period with a total of 15 ICU nurses in attendance.

Next, a reliable and validated survey, the MMD-HP (Epstein et al., 2019), was distributed to ICU nurses at the project site both before and after deployment of the debriefing sessions and the results were analyzed using descriptive and inferential statistics as described in Chapter IV.

The knowledge-to-action (KTA; Graham et al., 2006) framework underpinned the project throughout. The KTA framework uses action phases that guide knowledge translation. For example, moral distress was identified as an issue in the literature and informally among nurses and leadership at the project site. The project site did not have a standard process for addressing moral distress so the evidence-based reflective debriefing intervention, considered a product/tool in the framework, was designed with the local context in mind. The KTA framework was also used to identify barriers to project implementation that included a limited ability of ICU nurses to attend debriefing sessions during or after a busy shift. Adjustments to the process were made such as offering sessions at varying times and days, reflecting the tailoring aspect of the framework. Evaluation of knowledge creation and the action cycle are cyclical and ongoing in the KTA framework as reflected throughout this chapter.

Finally, data for this project were collected using the MMD-HP, a 27-item survey designed to measure the intensity, frequency, and root causes of moral distress among healthcare providers (Epstein et al., 2019). Of the approximately 200 ICU nurses working at the project site, 42 pre- and post-intervention surveys were completed and eligible for analysis. The MMD-HP mean composite score suggested a moderate level of moral distress among the sample. The MMD-HP composite scores for nurses who attended a debriefing session were lower when compared to those who did not attend a session; however, these findings were not statistically significant.

Conclusions

In this exploratory study, the sample of ICU nurses at the project site reported a moderate level of moral distress based on analysis of MMD-HP composite scores. Nurses identified aggressive care at end-of-life as among the most significant root causes of moral distress. This

was consistent with several published studies that reported similar root causes of moral distress among nurses, physicians, and other healthcare professionals (Epstein et al., 2019; Hickey, 2022).

This project also aimed to explore the feasibility of reflective debriefing as a potential future intervention at the project site. Participation in the reflective debriefing sessions remained low despite efforts by the primary investigator to increase attendance. This was likely multi-factorial but at least somewhat attributed to the challenges associated with stepping off the unit during a shift to attend a debriefing, which is discussed in more detail in the Limitations section below. There is also a need to foster a culture of self-care in the nursing profession as it is largely focused on the care of others. As demonstrated in the literature review, moral distress could have negative impacts not only on nurses but also on patients and healthcare systems (Hickey, 2022). Finding solutions to reduce moral distress is imperative for both organizations and the nursing profession.

Limitations

The limitations of this scholarly project included low participation among the ICU nurses in the debriefing sessions. In addition, just 42 nurses fully completed the MMD-HP surveys, resulting in a low completion rate of 21% (nine nurses completed both the pre- and post-intervention surveys). Recruitment efforts included emails, announcements at shift change huddles, and signage around the units. Completion of the surveys was incentivized with the option to enter a raffle for an electronic Amazon gift card. Despite these efforts, there was an overall small sample size in this scholarly project, which limited generalizability.

Six debriefing sessions were initially scheduled over the two-week intervention period. After low attendance was noted in the first week, the primary investigator opted to increase the

number of sessions offered in the second week without changing incentives to increase participation. Ten sessions allowed for 15 nurses to attend. Anecdotally, many nurses expressed interest in attending debriefing sessions to the primary investigator during the data collection period; however, due to patient care needs, they were unable to step away from their duties during their shifts. Several nurses also expressed that they wanted to get home to their families or to sleep so they were reluctant to stay after their shift to attend a debriefing.

In addition, several unusual circumstances occurred at the project site during project implementation that might have contributed to the low participation rates. First, there was a Coronavirus-19 outbreak in the ICU around the time the pre-intervention survey was distributed, which led to the ICUs being understaffed due to quarantine protocols. This outbreak created additional burdens on staff such as being required to wear N-95 masks and undergoing frequent COVID-19 testing for source control. In addition to short staffing, several nurses and nurse managers mentioned to the primary investigator that the acuity of the patients in the ICU was notably higher than was typical during the data collection period. These factors led to nurses not being able to take work breaks, feeling more fatigued at the end of their shifts, and not having time to prioritize self-care. One nurse shared with the primary investigator that morale in the ICUs was low so it was not an ideal time to participate in a scholarly project even though the staff saw the value and importance of addressing moral distress.

Recommendations

Recommendations to the Project Site

The survey results suggested that nurses at the project site were experiencing a moderate level of moral distress and 33% of those surveyed were currently considering leaving their position due to this issue. These findings warrant efforts to further explore moral distress and

design interventions to improve the wellbeing, job satisfaction, and retention of these highly skilled ICU nurses within the organization. Future efforts to facilitate attendance at debriefing sessions could include offering supplemental staff support so nurses are able to step away and attend a debriefing session knowing their patients are safely cared for. Another suggestion proposed by the nurses at the project site was to offer education pay for staying after a shift to attend a debriefing session. The evidence was clear that moral distress could have negative impacts on nurses, patients, and organizations. Offering creative solutions to prioritize addressing this phenomenon might enhance support of critical care nurses, reduce turnover, and improve patient outcomes. This information was compiled into an executive summary by the primary investigator and will be disseminated via email to the ICU leadership at the project site upon completion of the DNP project (see Appendix N). Leadership will be invited to share the summary with the nursing staff at their discretion.

Recommendations for Future Research

While this scholarly project was underpowered and the primary investigator was unable to determine if reflective debriefing reduced moral distress among those nurses who participated in the intervention, the findings contributed to a growing body of evidence suggesting this was a potentially effective and feasible strategy. The literature indicated that moral distress is an issue affecting a large percentage of ICU nurses but large-scale RCTs investigating the impact of a variety of interventions aimed at reducing moral distress were lacking. While reflective debriefing might be one of several effective strategies for reducing moral distress, adequately powered studies are needed to determine efficacy as well as to evaluate other types of interventions such as journaling and mindfulness training.

Reflection

In 2021, the American Association of Colleges of Nursing updated *The Essentials: Core Competencies for Professional Nursing Education*, which include 10 domains guiding nursing scholarship and practice. Throughout this paper, the abbreviation AACN has been used in reference to the American Association of Critical Care Nurses. In this section alone, it is used in reference to the American Association of Colleges of Nursing. The following section explores how this DNP scholarly project addressed each of those 10 domains and met the competencies for advanced-level nursing education required by the AACN.

Domain 1: Knowledge for Nursing Practice

This domain encompasses the integration of nursing knowledge into practice (AACN, 2021). This scholarly project included a comprehensive literature review and synthesis of the root causes of moral distress among ICU nurses as well as potential interventions to reduce moral distress. While moral distress is not unique to the nursing discipline, ICU nurses are particularly impacted by morally distressing situations due to their proximity to high acuity patient care and the dying process (Hickey, 2022). The literature suggested that reflective debriefing was a potentially beneficial intervention to reduce moral distress among ICU nurses (Browning & Cruz, 2018; Reilly & Jurchak, 2017); thus, it was selected as the focus of this scholarly project. The findings from this project had direct implications for nursing practice in the critical care setting as well as more broadly.

Domain 2: Person-Centered Care

The person-centered domain was particularly relevant to this scholarly project as it focused on enhancing compassion for nurses as caregivers. Moral distress occurs when one knows the right course of action but is unable to take it due to environmental or systems

constraints (Jameton, as cited in Morley et al., 2019). As nurses provide compassionate care to their patients, they must also care for themselves and honor the American Nurses Association code of ethics. Domain 2 in the *Essentials* specifically addressed self-care for nurses (AACN, 2021). Acknowledging moral distress and developing evidence-based resources and interventions to reduce it is an example of enhancing self-care for nurses, which in turn improves the delivery of patient care.

Domain 3: Population Health

This domain was addressed by considering the systems-level factors that contribute to moral distress among the ICU nurse population. As described in the literature review, these factors could include being understaffed, a lack of resources, the provision of aggressive yet futile care, and negative team dynamics (Browning & Cruz, 2018; Giannetta et al., 2022). This project incorporated these factors by involving leadership and other stakeholders in the planning phase as well as providing recommendations for future initiatives to the project site. This project also addressed the socioeconomic impact of moral distress. As discussed in the literature review, moral distress could lead to nurse turnover and the cost of replacing a single ICU nurse has been estimated as high as $64,000 (Hickey, 2022). Given that over one-third of the nurses surveyed at the project site reported they were considering leaving their current position due to moral distress, it is imperative that this issue be addressed from both a clinical and financial standpoint. Debriefing is a potentially cost-effective method to reduce moral distress as it might only require low-cost or free facilitator training and providing staffing coverage or educational pay to allow nurses to attend a 30-minute session.

Domain 4: Scholarship for the Nursing Discipline

This scholarly project demonstrated the synthesis, translation, and dissemination of nursing knowledge. This was accomplished through a synthesis of the current literature, translation of the evidence into an evidence-based project, and dissemination of the results to a project committee and stakeholders from the project site. The expertise of a doctorate-prepared nurse practitioner who served on the project committee and had experience with debriefing was also incorporated into the project. This project was designed with consideration of ethical principles and according to Institutional Review Board guidelines, both key facets of nursing scholarship. In addition, while moral distress could impact a wide range of professionals, this project focused on the phenomenon experienced by ICU nurses, which contributed to our disciplinary knowledge base.

Domain 5: Quality and Safety

This domain was addressed through efforts to reduce moral distress among ICU nurses and to create a psychologically safe work environment through implementation of reflective debriefing. As demonstrated in the literature review, moral distress in nurses could negatively impact patient care due to multiple factors including nurse burnout and detachment from care duties as well as increased nurse turnover (Hickey, 2022). By measuring moral distress levels among the sample of ICU nurses at the project site and exploring the feasibility of a reflective debriefing intervention, this project aimed to promote a work environment supportive of staff wellbeing and resiliency (AACN, 2021).

Domain 6: Interprofessional Partnerships

This scholarly project highlighted the impact positive team dynamics could have on moral distress among ICU nurses. In the MMD-HP survey findings, the sample reported that negative team dynamics were the least prevalent among the possible root causes of moral distress (see Appendix M). This indicated that participants felt interdisciplinary team dynamics were mostly positive and not a significant source of moral distress—a positive sign for the project site. In addition, another level-two competency in this domain suggested that advanced practice nurses should direct interprofessional activities and initiatives in the clinical setting. Future moral distress initiatives at the project site could be led by an advanced practice nurse and include team members from different professions such as medicine, respiratory therapy, and social work to foster team building and collaboration.

Domain 7: Systems-Based Practice

Moral distress arises from personal, team, and systems-based contributing factors. This scholarly project addressed all three categories of triggers using the MMD-HP. Systems-based factors might include understaffing, poor access to care resources, and pressure to cut costs (Epstein et al., 2019). While this project did not aim to resolve these systems-level problems, it did recognize them as factors that could increase moral distress among ICU nurses. The primary investigator also provided recommendations to ICU leadership on ways to address moral distress and the needs of the workforce (AACN, 2021; see Appendix N). In addition, as healthcare systems aim to improve cost-effectiveness, reducing moral distress might reduce costs by preventing nurse turnover and the costs associated with replacing highly skilled nurses (Hickey, 2022).

Domain 8: Information and Healthcare Technologies

While not one of the highest-ranked root causes for moral distress among the sample in this project, excessive electronic documentation was noted in the literature as a potential contributor to moral distress among ICU nurses (Epstein et al., 2019). As the use of technology increases in healthcare, it has the potential to reduce the amount and quality of direct patient interaction many nurses find fulfilling. To maintain face-to-face interaction and foster team building, the primary investigator of this project opted to host debriefing sessions in person. When considering future interventions to reduce moral distress at the project site, offering debriefing sessions using video technology could be considered as it might increase opportunities for more nurses and other staff to participate.

Domain 9: Professionalism

Moral distress can stem from threats to professional integrity and the nursing code of ethics (Epstein et al., 2019). This could include continuing aggressive care at end-of-life that conflicts with patient preferences or nurse expertise. These types of ethical dilemmas threaten the ethical principle of patient autonomy and nurses' ability to advocate for their patients and practice within our professional scope. This scholarly project aimed to address this discrepancy by acknowledging that morally distressing incidents occur regularly in nursing and by offering an evidence-based solution to promote compassionate, patient-centered care (AACN, 2021). Findings from this project could be used to promote a workplace environment that supports nursing ethics and professional values while also improving patient outcomes.

Domain 10: Personal, Professional, and Leadership Development

This scholarly project highlighted the potential benefits of a reflective debriefing intervention on moral distress among ICU nurses. During the development and implementation of this DNP scholarly project, the primary investigator utilized her personal and professional skills to promote a culture of self-care and support the wellbeing of the ICU nurses at the project site (AACN, 2021). The primary investigator was also able to collaborate with the ICU leadership team, acquire debriefing facilitator skills, and execute a doctoral-level scholarly project. These activities contributed to her development as a future leader in nursing and have set the foundation for a pattern of lifelong learning (AACN, 2021).

Summary

Moral distress is a phenomenon that affects up to 80% of ICU nurses at least once during their careers (Hickey, 2022). Unresolved moral distress negatively impacts nurses, teams, patients, and organizations. This project assessed moral distress among ICU nurses at the project site and explored the feasibility of reflective debriefing as a potential future intervention. Results suggested that ICU nurses at the project site reported moderate levels of moral distress based on MMD-HP composite scores. While this project was unable to determine the impact of reflective debriefing on the moral distress of nurses who participated in the intervention, the literature supported this as one of several promising strategies to address this issue. The success of future efforts to reduce moral distress at the project site will require ongoing support from leadership to allow nurses to prioritize addressing moral distress and its consequences without compromising patient care duties. The KTA framework was utilized throughout the project to translate known and emergent evidence into practice. This project also reflected the AACN

(2021) *Essentials* that include 10 domains and numerous competencies guiding advanced level nursing scholarship.

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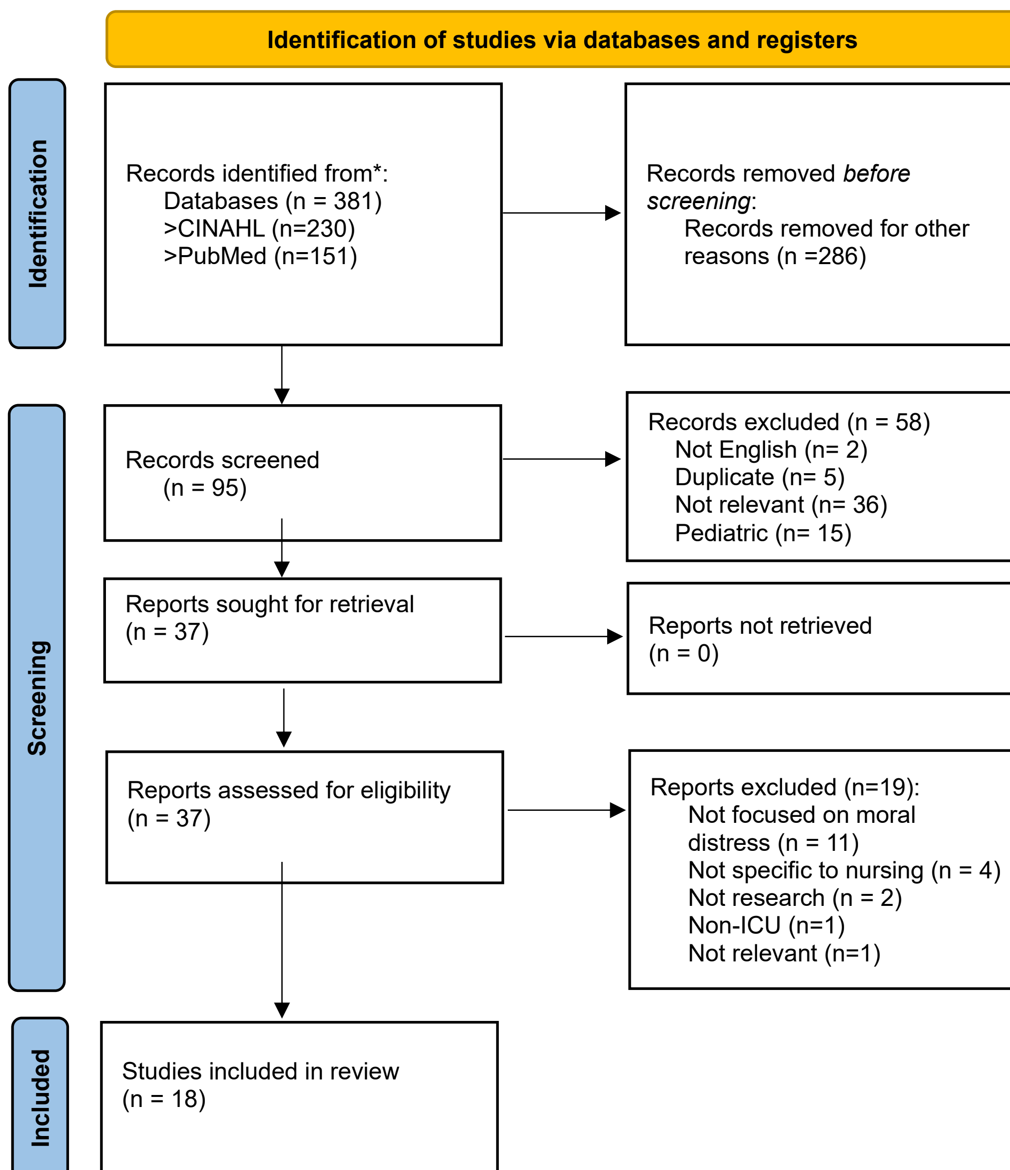
APPENDIX A

PREFERRED REPORTING ITEMS FOR SYSTEMATIC REVIEWS AND META-ANALYSES DIAGRAM



*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).

**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

APPENDIX B

TABLE OF EVIDENCE

Table B1

Table of Evidence

Author	Purpose	Theory or Framework	Design	-Setting -Sample	-Survey -Analysis	Findings	+Implications -Limitations	Grade Level
Abbasi et al., 2019	To reduce moral distress in nurses through empowerment training	Theory of Moral Reckoning in Nursing	Randomized control trial (RCT) Pre/post-test	-Adult intensive care unit (ICU) in Iran -60 ICU nurses	-Hamric's Moral Distress Scale -SPSS, ANOVA	Significant ($p<0.05$) improvement in moral distress scores for intervention group 1 month after intervention (but not at 2 weeks after)	+Moral distress exists in ICU nurses and teaching coping mechanisms can reduce it -2-day workshop is not feasible for this project -Short follow up period -Cultural implications may vary between Iran and US	II
Andersson et al., 2022	Describe the impact of COVID on ICU nurses' moral distress	None listed	Descriptive Cross-sectional	-ICUs in Sweden -71 critical care nurses	-Moral Distress Scale – revised (MDS-R) -The Checklist for Reporting Results of Internet E-Surveys (CHERRIES) -Qualitative analysis based on Elo and Kyngas (2008)	Moral distress occurred during the pandemic mostly due to the provision of futile care and poor teamwork. Moral distress led to 39% of respondents considering leaving their job.	+Communication is a key element in reducing moral distress in ICU nurses -Descriptive, does not include interventions to reduce -Swedish study may have limited generalizability to US -Small sub-group (71 out of a pool of over 30,000)	VI
Browning & Cruz, 2018	To reduce moral distress among ICU nurses using reflective debriefing	None listed	Pre/post test design with control group	-ICU in Philadelphia -43 ICU nurses	-MDS-R survey before and 6 months later -Reflective Debriefing model -SPSS used for descriptive statistics	Moral distress was often the result of provision of futile care Reduction in moral distress occurred when nurses felt empowered to speak up	+The reflective debriefing model they developed may be useful for this project -45-60 minute sessions is a long time for nurses to leave the bedside during their shift	IV

Table B1 Continued

Author	Purpose	Theory or Framework	Design	-Setting -Sample	-Survey -Analysis	Findings	+Implications -Limitations	Grade Level
Giannetta et al., 2022	To explore moral distress of ICU nurses using Corley's scale in terms of intensity and frequency.	Corley's Moral Distress Theory	Systematic review	-CINAHL, PubMed, PsycINFO -17 studies focused on ICU nurses included	-Corley's instruments (MDS, MDS-R) -PRISMA guidelines, Newcastle-Ottawa scale	ICU nurses experience a moderate level of moral distress. Higher levels are seen in younger nurses as well as those with less experience. Moral distress is reduced when nurses feel empowered, supported, and autonomous. -Triggers include futile care, unsafe staffing	+Validates the occurrence of moral distress in ICU nurses and identifies several triggers that could be addressed with interventions -Included older articles (8 of 17 articles were more than 5 years old) -No intervention	V
Hickey, 2022	Assess the impact of interventions to address moral distress in ICU nurses	Mealer and Moss's Categories of Interventions to Address Moral Distress	Integrative review	-PubMed, APA Psycnet, CINAHL -6 studies included	-PRISMA -Analysis tools not listed	Educational interventions can reduce moral distress. Addressing perceived powerlessness can reduce moral distress (MD). The development of coping skills using the American Association of Critical Care Nurses' (AACN) 4A's decreased MD. Culture of addressing ethical dilemmas Fix the workplace> individuals	+Applied similar limits to literature search as this review (adult ICU, interventions). +Saw benefit of AACN's 4A's -Only 6 studies, small sample sizes, heterogenous interventions and results	V (not all RCTs)

Table B1 Continued

Author	Purpose	Theory or Framework	Design	-Setting -Sample	-Survey -Analysis	Findings	+Implications -Limitations	Grade Level
Jarden et al., 2018	Assess ICU nurses' perception of workplace improvement efforts	None listed	Descriptive Qualitative	-New Zealand critical care nurses (via social media and professional org) -65 ICU nurses	-Free text response to 2 questions -Applied thematic analysis	Workplace well-being is enhanced with: -Individual: prioritize self-care and work-life balance including sick leave, prayer -Team: collaboration, appreciation, formal debriefing -Organization: less pressure to work overtime, formal debriefing, staffing, team building	+Debriefing mentioned as effective -Low quality study -No intervention tested	VI
Jarden et al., 2020	Identify factors that promote ICU nurses' well-being	Grounded Theory	Systematic review	-Ovid, PsycINFO, EBSCO, Scopus, PubMed, Web of Science Core collection -4 studies included, 387 nurses total	-PRISMA for the search -NVivo qualitative data analysis	Challenge to find high quality research studies focused on well-being rather than ill-being -Mindfulness and spirituality can enhance well-being, team commitment promotes collaboration	+Focus on well-being rather than ill-being, a more positive approach to addressing moral distress -Only 4 articles, heterogenous interventions, not high-quality studies	V

Table B1 Continued

Author	Purpose	Theory or Framework	Design	-Setting -Sample	-Survey -Analysis	Findings	+Implications -Limitations	Grade Level
Kang et al., 2021	Explore the experience of moral distress among nurses and physicians in acute care	Grounded Theory	Qualitative descriptive	-South Korea hospitals -22 clinicians	-Semi-structured interviews -MAXQDA	Identified themes that led to moral distress: family dominance, hierarchy, avoiding discussing death, intensive workload, lack of support for clinicians Moral distress led to stress, guilt, depression	+Identified triggers for moral distress that can be addressed with interventions -No interventions offered -Not limited to ICU -While some themes are similar between US and Korea, the cultural differences may not translate to this population	VI
Lamiani et al., 2017	To validate the MDS-R	None listed	Descriptive Survey	-Italy, 8 ICUs -184 clinicians (physician, nurse, residents)	-Administered MDS-R and Beck Depression Inventory -Exploratory and confirmatory factor analysis	Confirmed the validity and reliability of the MDS-R. Seven items were removed. Nurses and physicians had similar moral distress scores. Nurses reported higher rates with futile care, physicians with deceptive communication	+Again, this may be a useful tool for this project -Eliminated several items on the MDS-R, but still called it reliable	IV
Lusignani et al., 2017	To examine moral distress in nurses, specifically frequency and intensity	None listed	Descriptive Survey	-Italy, 46 acute care units -283 nurses, convenience sample	-MDS-R survey -Excel 2008 and statistical software R	High levels of moral distress are often related to providing futile care. The highest levels were amongst nurses with less experience and those planning to quit.	+Consistent with other studies that futile care is a huge driver of moral distress, perceived powerlessness -Did not test interventions -Italy vs US may not be generalizable	IV

Table B1 Continued

Author	Purpose	Theory or Framework	Design	-Setting -Sample	-Survey -Analysis	Findings	+Implications -Limitations	Grade Level
McAndrew & Hardin, 2020	To explore ethical dilemmas amongst ICU nurses and organizational support	“The theory of nurse-promoted engagement with families” (p.1640)	Qualitative descriptive	-ICUs at a midwestern academic medical center -111 nurses responded	-Two open ended questions - Erlingsson and Brysiewicz’s content analysis	Three themes: lack of voice in ethical conflicts (perceived powerlessness), ICU can cause patient suffering, there is potential for organizational support to reduce moral distress such as more training from ethics and involvement with palliative	+Similar themes to other studies +Provides potential interventions at organizational level including debriefing -Did not test interventions	VI
Morley et al., 2022	To better understand contributing factors of moral distress	Feminist Empirical Bioethics	Interpretive (Descriptive)	-UK National Health System hospitals -21 ICU nurses	-Face to face interviews, recorded for transcription -COREQ guidelines -van Manen’s six activities for interpretive phenomenology	Developed the Moral Distress Model -Five factors contribute to moral distress: >Feeling unvalued as a professional >Provider variability in patient management >Incongruent values (personal vs professional) >Duty to protect >Powerlessness and team dynamics	+These 5 factors should be the focus of interventions -Does not test interventions	VI

Table B1 Continued

Author	Purpose	Theory or Framework	Design	-Setting -Sample	-Survey -Analysis	Findings	+Implications -Limitations	Grade Level
Piscitello et al., 2022	Assess impact of intervention on nurse moral distress and patient outcomes	None listed	Prospective cohort study, pre/post test	-Urban academic Medical ICU (Chicago) -48 nurses pre-intervention, 33 post -49 patients	-Measure of Moral Distress for Healthcare Professionals Scale (MMD-HP) -GraphPad Prism version 8.0 for statistical analysis	Interventions did not reduce moral distress. Patients in intervention group were more likely to transition to do not resuscitate earlier, higher discharge rates, lower length of stay and costs	-Disappointing that this did not improve moral distress in nurses, but patient outcomes are reassuring -Conducted during COVID, may have impacted -Authors do not specify if nurses were involved in family meetings	IV
Reilly & Jurchak, 2017	Assess the impact of reflective practice on practice and the unit	Kim's Method of Critical Reflective Inquiry	Qualitative descriptive	-Cardiac ICU, urban academic medical center -9 nurses participated in focus groups	-Interview guide used during focus group, open-ended questions -Manual content analysis to deduce and codify themes	Reflective practice and ethics rounds led to improved sense of value, reduced moral distress, increased empathy, improved understanding of ethics	+Reflective practice is a component of this project, seeing the benefit of this intervention is helpful. Especially the impact including nursing leadership had -Small group -Found value with addition of nurse ethicist, our facility is currently in transition	VI
Rhéaume et al., 2022	Explore moral distress in ICU nurses during COVID	None listed	Qualitative descriptive	-Canadian ICUs -Convenience sample, 111 incidents identified by 108 nurses	-Free text writing about a critical incident -Braun and Clarke thematic analysis using Dedoose software	Four themes: >Managing pandemic >Family grief >Staff safety >Futile care Also mention of lack of institutional support	+Similar themes of family distress and futility -Staff safety more specific to COVID -Interventions not tested	VI

Table B1 Continued

Author	Purpose	Theory or Framework	Design	-Setting -Sample	-Survey -Analysis	Findings	+Implications -Limitations	Grade Level
Rushton et al., 2021	Examine the impact of educational intervention on resilience and dealing with ethical challenges	Social Learning Theory	Prospective repeated-measures, before/after intervention	-2 large academic hospitals -192 intervention, 223 control	-Mindful ethical practice and resilience academy training -11 survey instruments using Qualtrics -Multiple statistical analyses mentioned but no one tool identified	Increase in mindfulness, engagement, resilience; reduced burnout and turnover, reduced depression	+Comprehensive intervention improved nursing resilience -Education curriculum unrealistic for this project	III
Sirilla et al., 2017	Assess moral distress across nursing specialties including nursing demographics and experience	None listed	Cross-sectional survey	-Academic medical center -329 surveys of nurses in various specialties	-MDS-R -descriptive statistics, one-way ANOVA, Spearman correlations, regression model	Overall MDS-R score was low to moderate. Highest in critical care, periop, and procedural areas. Weak correlation with increased scores and years of experience, no correlation with age. >Themes of futile care, communication negatively impacting care, false hope to families	+Critical care nurses are particularly susceptible to moral distress -Low response rate, very large hospital system- may not translate to this setting -They found more experienced nurses had higher levels of MD	VI

Table B1 Continued

Author	Purpose	Theory or Framework	Design	-Setting -Sample	-Survey -Analysis	Findings	+Implications -Limitations	Grade Level
Vincent et al., 2020	Perception of moral distress among interdisciplinary healthcare team members	None listed	Qualitative descriptive	-Staff of 4 ICUs in the southwest -28 survey participants (nurses, nurse practitioners, physicians, respiratory, social workers, dietitians, clergy)	-MDS-R, free text questions -Coded and analyzed responses using systematic text condensation	Moral distress was present among all participants, associated with distress over care decisions along with organizational and team issues. Themes included: >Futile care >Communication >Lack of collaboration >Lack of support by leadership >Bullying	+Powerful statements from respondees accentuating scope of moral distress in ICU -Free text responses were not required for the survey so likely led to sampling bias -No intervention	VI

APPENDIX C

WOLTERS KLUWER PERMISSION

WOLTERS KLUWER HEALTH, INC. LICENSE
TERMS AND CONDITIONS
Mar 09, 2023

This Agreement between UNC -- Tegan Jones ("You") and Wolters Kluwer Health, Inc. ("Wolters Kluwer Health, Inc.") consists of your license details and the terms and conditions provided by Wolters Kluwer Health, Inc. and Copyright Clearance Center.

License Number	5492110093263
License date	Feb 18, 2023
Licensed Content Publisher	Wolters Kluwer Health, Inc.
Licensed Content Publication	Journal of Continuing Education in the Health Professions
Licensed Content Title	Lost in knowledge translation: Time for a map?
Licensed Content Author	Ian Graham, Jo Logan, Margaret Harrison, et al
Licensed Content Date	Jan 1, 2006
Licensed Content Volume	26
Licensed Content Issue	1
Type of Use	Dissertation/Thesis
Requestor type	University/College
Sponsorship	No Sponsorship
Format	Print and electronic
Will this be posted online?	Yes, on an unrestricted website
Portion	Figures/tables/illustrations
Number of figures/tables/illustrations	1
Author of this Wolters Kluwer article	No
Will you be translating?	No
Intend to modify/change the content	No
Title	Reducing moral distress in ICU nurses
Institution name	University of Northern Colorado
Expected presentation date	Sep 2023
Order reference number	787878
Portions	Figure 1 on page 19

APPENDIX D

SAINT JOSEPH MEDICAL CENTER
LETTER OF SUPPORT

From: **Teresa Montoya WA-Tacoma** <teresa.montoya@vmfh.org>
Date: Wed, Mar 15, 2023 at 4:12 PM
Subject: Re: DNP Project in ICU
To: Tegan Jones WA-Tacoma

Hi Tegan,
Thank you for reaching out. This is very much needed and I am very excited to have you do this work in our department. Do you have a timeline when you would like to do this? Please let me know how else I can help support this project.

Teresa

Teresa Montoya, RN, BSN
Director Critical Care, Respiratory Care
St. Joseph Medical Center
1717 South J Street, Tacoma, WA 98405 | (MS 01-20)
P 253-426-6687 | **I** 127-6687 |
vmfh.org

APPENDIX E

EVIDENCE-BASED REFLECTIVE DEBRIEFING GUIDE

Topic	**Time Allotted**
INTRODUCTION • Statement of voluntary participation, verbal implied consent reminder: “Participation in this project is completely voluntary and you may withdraw at any time. The risks of participation are minimal and include the time commitment of approximately 30 minutes for attending this debriefing session, along with the potential for emotional distress through reflection on this difficult topic. The aim is to reduce moral distress through group debriefing; however, should you need further support, all SJMC employees have access to CHI via Lyra Health. Your presence at this session constitutes implied consent to participate.” • Expectation of privacy statement: “Thank you all for attending this debriefing session. We are here to acknowledge and discuss the impact moral distress may have on us as nurses. We want everyone to feel safe to share so that we can learn from and support each other. Please keep in mind that anything said in this session should remain confidential. Leadership is interested in the potential impact of this project so I will likely share general survey results and recommendations based on the results, but it will be anonymous” • Moral Distress: when you know the right thing to do, but constraints make it impossible to pursue the right course of action. It can lead to physical and emotional symptoms if not addressed. • Burnout: physical, mental, and emotional exhaustion caused by workplace stress leading to depersonalization, disengagement • Compassion fatigue: physical, mental, and emotional weariness r/t caring for those in significant pain or emotional distress • Goal: reflect and acknowledge the work we do, create a healthy work environment where you feel safe and supported to act and maintain the professional moral code • Expectations: This is an opportunity to discuss moral distress and create a structure for addressing it using the AACN 4A’s model. It is beyond the scope of the project to solve staffing issues, etc. In order to stay on schedule I may prompt us to move on. • Any questions?	5 minutes
ASK • Can you think of a time when you felt morally distressed? I will give you a minute to write this down (pause) • What about the situation was morally distressing? Does anyone want to share their thoughts/emotions. • Goal: recognize when you are experiencing moral distress	5 minutes
AFFIRM • You are not alone, your experiences and feelings are valid (normalize emotional reaction to the work) • Nurses have a professional obligation to act to uphold our professional code of ethics. We also must make difficult decisions regularly. • Goal: commit to addressing morally distressing situations	3 minutes

ASSESS
• What factors contribute to your moral distress? (personal, team, environmental, organizational) Suggestions to guide discussion:
  o Self: non-beneficial care, unnecessary treatments, end-of-life care, needless patient suffering, false hope
  o Unit: inadequate staffing, ineffective communication, incompetent colleagues, bullying
  o Organization: inadequate staffing, lack of resources, pressure to decrease costs, hospital policies, hierarchy/powerlessness, ineffective communication, financial limitations
• What methods to you use to cope? What helped? Suggestions to guide discussion:
	7 minutes

○ Self: recognize distress, talk to a trusted colleague, connect with others for support, identify parties that could help, participate in professional development, seek help from employee assistance ○ Unit: pause after patient deaths, mentor new staff, identify ethics champions, recognize situations that frequently cause distress, establish a committee to address these issues ○ Organization: promote a healthy work environment, offer palliative and ethics consultations, provide training on debriefing, resilience, communication; zero-tolerance on bullying, promote well-being of team • Goal: Ready to make action plan	
ACT • Determine what steps can be taken to change the situation • Which of the methods that we discussed seem like they could work for you? • Consider actions you can take on your own and which ones need to be addressed by others within the unit or organization? • What barriers and risks do you anticipate? How can you address them? • What support resources are available? • Make a plan to act: what is one action you can take the next time you encounter a morally distressing situation? • Goal: preserve your professional integrity	7 minutes
WRAP-UP • Debriefing gives a voice to recognize the difficult nature of the work you do every day. This has given us an opportunity to recognize how supportive you are to each other! • 4A's model can be used to process and act on moral distress • If anyone feels that they need more support, resources are available through the employee assistance program • Please fill out the follow up survey!***	3 minutes

CAPC Course Pointers

- Goals: self-awareness, barriers/solution, communication, self-reflection, finding meaning, educational, reflect, acknowledge, learn from each other, understand, give voice to the impact of the work on us, decrease isolation

APPENDIX F

AMERICAN ASSOCIATION OF CRITICAL CARE NURSES PERMISSION

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

February 9, 2023

Tegan Jones, ADN, BSN, MSN, AGACNP
3312 6th Avenue, Apt. 4
Tacoma WA 98406

Dear Tegan Jones:

Thank you for your reuse request. We hereby grant permission for your reuse of the AACN copyrighted content below, free of charge, subject to the following conditions:

1. Content (including items 1 and 2 in bullet No. 2 below) will be used as a framework in the development of an intervention to reduce moral distress among ICU nurses at St. Joseph Medical Center in Tacoma, Washington, as part of a project in partial fulfillment of the requirements for the DNP degree at the University of Northern Colorado.

2. Suitable acknowledgment to the original sources must be made, preferably as follows: (1) American Association of Critical-Care Nurses. *Recognize & Address Moral Distress.* Aliso Viejo, CA: American Association of Critical-Care Nurses; 2020. Available at: https://www.aacn.org/~/media/aacn-website/clincial-resources/moral-distress/recognizing-addressing-moral-distress-quick-reference-guide.pdf. ©2020 by AACN. All rights reserved. Used with permission. (2) American Association of Critical-Care Nurses. *The 4 A's to Rise Above Moral Distress.* Aliso Viejo, CA: American Association of Critical-Care Nurses. ©2004 by AACN. All rights reserved. Used with permission.

3. Permission is granted for the following use case, which applies to both pieces of content itemized in bullet No. 2 above: chart/graph/table/figure, individual academic, print and electronic, United States, original language, up to 199 circulation, current edition and up to 5 years (until February 9, 2028).

4. In the event the material for which permission is granted herein includes third-party materials (such as graphs, figures, and similar materials) that are identified in such material as having been used or adapted with permission or one-time use (or a similar indicator), requester is responsible for identifying and seeking separate permissions for any such materials. Without such a separate permission, AACN does not grant the requester rights to use any such third-party materials.

Thank you for your interest in the American Association of Critical-Care Nurses.

Sincerely,

Michael Muscat
AACN Publishing Manager

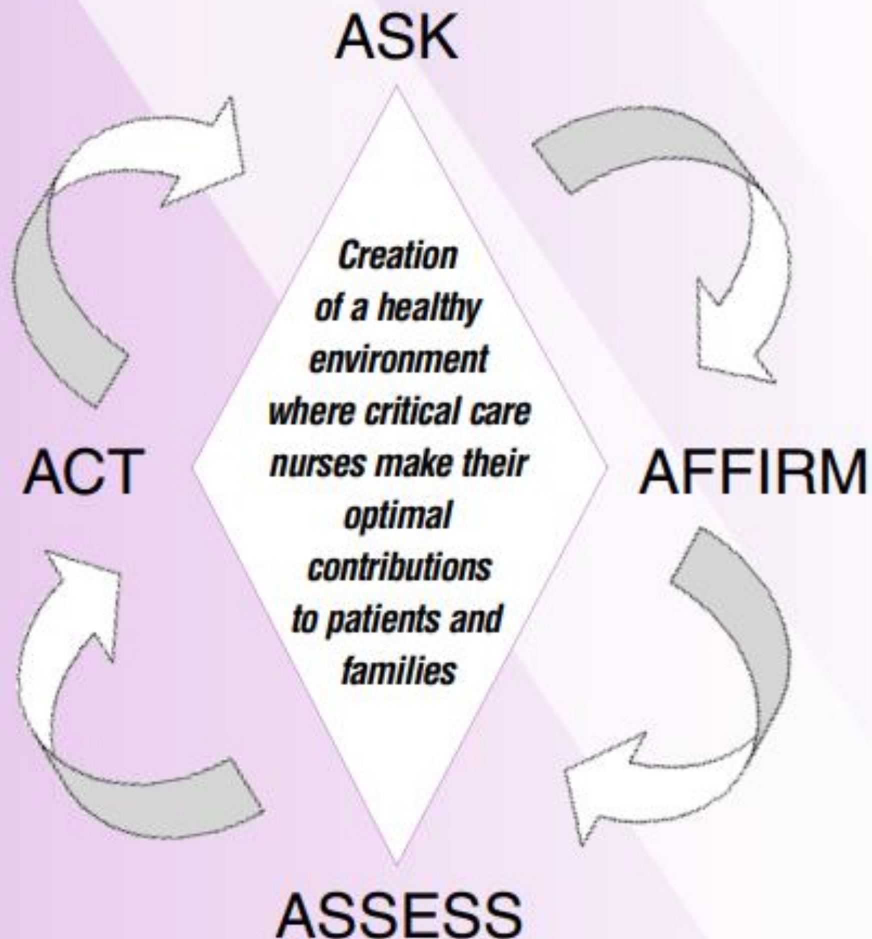
Accepted:

ARNP 2/10/2023

TITLE DATE

APPENDIX G

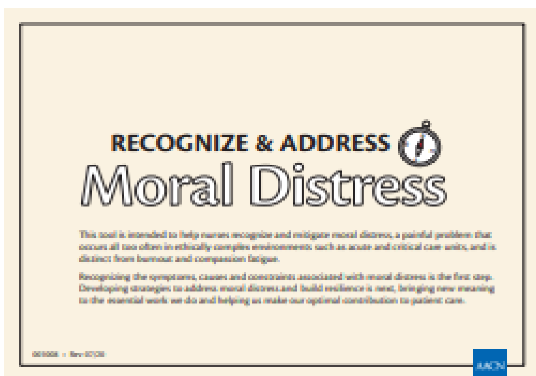
AMERICAN ASSOCIATION OF CRITICAL CARE NURSES
4A’S TO RISE ABOVE MORAL DISTRESS

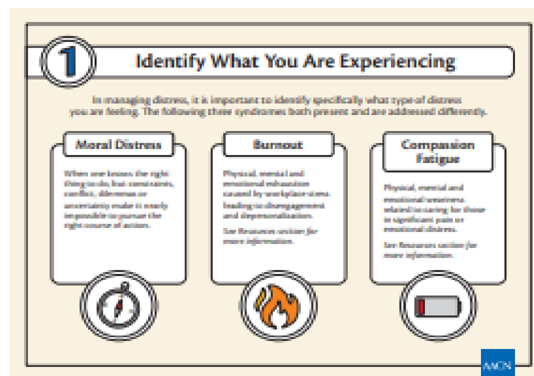


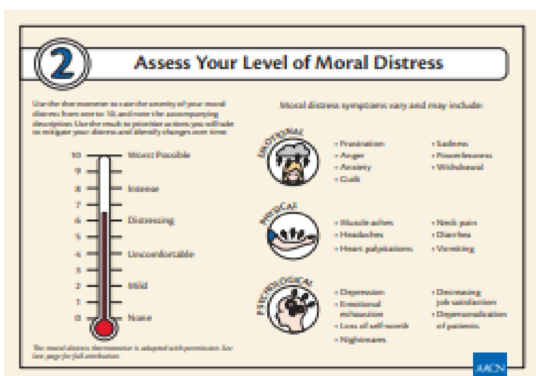
American Association of Critical-Care Nurses. The 4 A's to Rise Above Moral Distress. Aliso Viejo, CA: American Association of Critical-Care Nurses. ©2004 by AACN. All rights reserved. Used with permission.

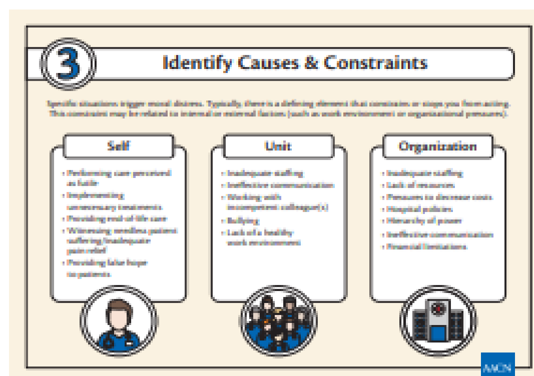
APPENDIX H

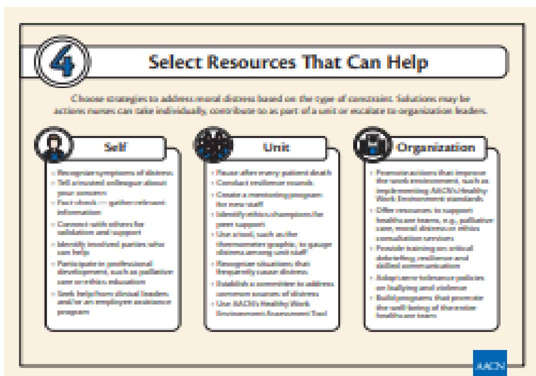
AMERICAN ASSOCIATION OF CRITICAL CARE NURSES
RECOGNIZE AND ADDRESS MORAL DISTRESS

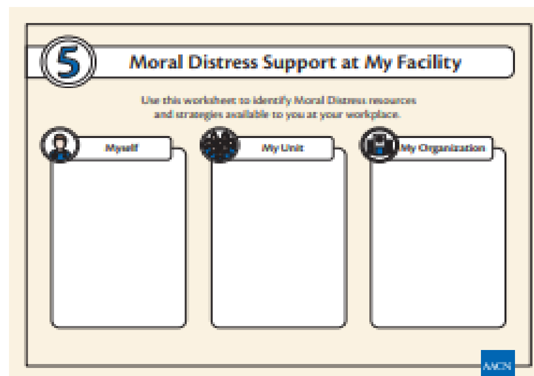












American Association of Critical-Care Nurses. Recognize & Address Moral Distress. Aliso Viejo, CA: American Association of Critical-Care Nurses; 2020. Available at: https://www.aacn.org/~/media/aacnwebsite/clincial-resources/moral-distress/recognizing-addressing-moral-distress-quick-reference-guide.pdf. ©2020 by AACN. All rights reserved. Used with permission.

APPENDIX I

RECRUITMENT MATERIAL

DNP Project Survey on Moral Distress

Dear Nurse Colleagues,

My name is Tegan Jones, I am one of the Nurse Practitioners with the Pulmonary Critical Care Team. As many of you know, I am implementing a Doctor of Nursing Practice (DNP) scholarly project in partial fulfillment toward a DNP degree from the University of Northern Colorado.

My DNP project aims to reduce moral distress among ICU nurses using a reflective debriefing intervention. Moral distress is recognized as a significant problem for nurses working in the ICU and can lead to physical and psychological symptoms, contributing to burnout, attrition, and poor-quality patient care. The evidence suggests that reflective debriefing may reduce moral distress among ICU nurses.

All ICU nurses are invited to voluntarily participate in this project by completing a pre- and post-intervention survey with optional attendance at one of six 30-minute debriefing sessions in between surveys, which will be held on the following dates in the 5th floor conference room:

- Session 1 Sunday June 11 at 0730
- Sunday 2 Sunday June 11 at 2200
- Session 3 Monday June 12 at 1700
- Session 4 Sunday June 18 at 1700
- Session 5 Tuesday June 20 at 1930
- Session 6 Wednesday June 21 at 0730

Important: You are encouraged to complete the surveys even if you are unable to attend a debriefing session. Your responses will be kept completely confidential and only analyzed as a group. After completion of each survey, you will be given the opportunity to enter a raffle to win one of six $50 Amazon gift cards.

If you would like to complete the pre-intervention survey, please click on the following link between May 31 and June 9 and enter your unique code: XXXX

https://unco.co1.qualtrics.com/jfe/form/SV_aWXj5mmIOnsdFUq

Please feel free to reach out with any questions via email at jone1645@bears.unco.edu. Thank you for considering participating in my scholarly project.

Sincerely,

Tegan Jones
DNP Candidate
MSN, AGACNP-BC, RN

ATTENTION CRITICAL CARE NURSES

FEELING DISTRESSED?

PARTICIPATE IN A REFLECTIVE DEBRIEFING SESSION AS PART OF A DNP PROJECT

SUNDAY 6/11 @ 0730 AND 2200

MONDAY 6/12 @ 1700

SUNDAY 6/18 @ 1700

TUESDAY 6/20 @ 1930

WEDNESDAY 6/21 @ 0730

5th FLOOR CONFERENCE ROOM

Up to 80% of ICU nurses report experiencing moral distress! Moral distress occurs when you know the correct course of action, but are unable to take it due to personal, team, or organizational constraints. Common triggers include staffing issues, poor team communication, and providing futile or end-of-life care. Reflective debriefing has been shown to reduce moral distress and improve nurse wellbeing.

All part- and full-time ICU nurses are invited to attend a ~30 minute guided debriefing session at shift change

Please follow the link in your SJMC email to complete a before and after survey even if you are not able to attend a session. You can be entered to win one of six $50 Amazon gift cards for each survey you complete!

Participation is voluntary. Reach out to Tegan Jones (NP with PCCM) if you have any questions! Jone1645@bears.unco.edu

APPENDIX J

PERMISSION TO USE MEASURE OF MORAL DISTRESS FOR HEALTHCARE PROFESSIONALS

To: Jones, Tegan

Save all attachments

Measure of Moral Distress for...
1.14 MB

MMD-HP.doc
90.5 KB

Tegan,

Thanks so much for your email. We've recently updated and revised the scale and I'm delighted for you to use it. I've attached it here, along with the paper describing the revision and update.

Please feel free to reach out any time if questions arise.

Beth

Beth Epstein
Professor
Associate Dean for Academic Programs
Professor, UVA Center for Health Humanities and Ethics
E meg4u@virginia.edu
P 434.924.0106
M 434.242.5927

University of Virginia
School of Nursing
CMNEB 3107
225 Jeanette Lancaster Way
Charlottesville, VA 22903

APPENDIX K

THE PRE-INTERVENTION SURVEY

REDUCING MORAL DISTRESS IN ICU NURSES THROUGH REFLECTIVE DEBRIEFING: PRE-INTERVENTION SURVEY

Introduction

Thank you for your interest in this Doctor of Nursing Practice (DNP) scholarly project. You are invited to complete this survey even if you do not plan on or are unable to attend a reflective debriefing session. This project has been approved by the Institutional Review Board of the University of Northern Colorado (phone: 970-351-1907; email: orsp@unco.edu). Should you have any questions or technical difficulties with this survey, the Primary Investigator, Tegan Jones, can be reached at jone1645@bears.unco.edu. The project advisor is Dr. Natalie Pool, PhD, RN (natalie.pool@unco.edu) should you have additional concerns.

Implied Consent:

Participation in this project is completely voluntary and you may withdraw at any time. The risks of participation are minimal and include the time commitment (approximately 10 minutes) of completing a survey and/or attending a debriefing session (approximately 30 minutes), along with the potential for emotional distress through reflection on this difficult topic. The aim is to reduce moral distress through group debriefing; however, should you need further support, all SJMC employees have access to CHI via Lyra Health. Completion of this survey constitutes implied consent to participate. Thank you for your participation!

I have read the above statement and agree to participate Yes ___ No__

Please answer the following questions to determine your eligibility to participate in this project:

1. I am currently employed by SJMC as a bedside/clinical RN in one or more of the ICUs at least half-time (0.5 FTE): Yes__ No __
2. I am currently on ICU Orientation: Yes__ No_ (If Yes, survey closes)
3. I am a travel or agency nurse: Yes__ No_ (If Yes, survey closes)
4. Total years of experience as a Registered Nurse: <1_ 1-2__ 3-5_ 6-9__ >10__
5. Total years of experience in the ICU: <1_ 1-2__ 3-5_ 6-9__ >10__

Instructions: 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*.

	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 Very distressing				
	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? Yes__ No__

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

If you would like to be entered in an optional raffle for a chance to win a $50 Amazon electronic giftcard, please enter your email address here **(emails will not be linked with any survey responses**): ________________

APPENDIX L

INSTITUTIONAL REVIEW BOARD APPROVAL

Date:	05/09/2023
Principal Investigator:	Tegan Jones
Committee Action:	**IRB EXEMPT DETERMINATION – New Protocol**
Action Date:	05/09/2023
Protocol Number:	2304049163
Protocol Title:	REDUCING MORAL DISTRESS IN INTENSIVE CARE UNIT NURSES THROUGH REFLECTIVE DEBRIEFING
Expiration Date:	

2304049163

The University of Northern Colorado Institutional Review Board has reviewed your protocol and determined your project to be exempt under 45 CFR 46.104(d)(702) (703) for research involving

Category 2 (2018): EDUCATIONAL TESTS, SURVEYS, INTERVIEWS, OR OBSERVATIONS OF PUBLIC BEHAVIOR. Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 45 CFR 46.111(a)(7).

Category 3 (2018): BENIGN BEHAVIORAL INTERVENTIONS IN CONJUNCTION WITH THE COLLECTION OF INFORMATION FROM ADULT SUBJECTS through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met: (A) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (B) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement,

or reputation; or (C) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 45 CFR 46.111(a)(7). For the purpose of this provision, benign behavioral interventions are brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Provided all such criteria are met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else. If the research involves deceiving the subjects regarding the nature or purposes of the research, this exemption is not applicable unless the subject authorizes the deception through a prospective agreement to participate in such research.

2304149163

You may begin conducting your research as outlined in your protocol. Your study does not require further review from the IRB, unless changes need to be made to your approved protocol.

As the Principal Investigator (PI), you are still responsible for contacting the UNC IRB office if and when:

- You wish to deviate from the described protocol and would like to formally submit a modification request. Prior IRB approval must be obtained before any changes can be implemented (except to eliminate an immediate hazard to research participants).
- You make changes to the research personnel working on this study (add or drop research staff on this protocol).
- At the end of the study or before you leave The University of Northern Colorado and are no longer a student or employee, to request your protocol be closed. *You cannot continue to reference UNC on any documents (including the informed consent form) or conduct the study under the auspices of UNC if you are no longer a student/employee of this university.
- You have received or have been made aware of any complaints, problems, or adverse events that are related or possibly related to participation in the research.

If you have any questions, please contact the Interim IRB Administrator, Chris Saxton, at 970-702-5427 or via e-mail at chris.saxton@unco.edu. Additional information concerning the requirements for the protection of human subjects may be found at the Office of Human Research Protection website - http://hhs.gov/ohrp/ and https://www.unco.edu/research/research-integrity-and-compliance/institutional-review-board/.

Sincerely,

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

Nicole Morse
Interim IRB Administrator

University of Northern Colorado: FWA00000784

230404163

Carter Hall 2008 | Campus Box 143 | Greeley, CO 80639 | Office 970-702-5427

APPENDIX M

INDIVIDUAL ITEM COMPOSITE SCORES FROM MEASURE OF MORAL DISTRESS FOR HEALTHCARE PROFESSIONALS

Statement	Composite Score
Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient.	10.65
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.	9.9
Witness healthcare providers giving "false hope" to a patient or family.	7.15
Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.	6.78
Be required to work with abusive patients/family members who are compromising quality of care.	6.72
Watch patient care suffer because of a lack of provider continuity.	6.67
Experience compromised patient care due to lack of resources/equipment/bed capacity.	6.48
Have excessive documentation requirements that compromise patient care.	6.26
Be required to care for patients who have unclear or inconsistent treatment plans or who lack goals of care.	6.22
Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments.	6.18
Be required to work with other healthcare team members who are not as competent as patient care requires.	5.76
Experience lack of administrative action or support for a problem that is compromising patient care.	5.14
Be unable to provide optimal care due to pressures from administrators or insurers to reduce costs.	4.47
Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.	4.4
Witness low quality of patient care due to poor team communication.	4.26
Participate on a team that gives inconsistent messages to a patient/family.	4.1
Work with team members who do not treat vulnerable or stigmatized patients with dignity and respect.	2.9
Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.	2.54
Follow a physician's or family member's request not to discuss the patient's prognosis with the patient/family.	2.46
Participate in care that I do not agree with, but do so because of fears of litigation.	2.22
Be required to care for patients whom I do not feel qualified to care for.	2.17
Work within power hierarchies in teams, units, and my institution that compromise patient care.	1.92
Fear retribution if I speak up.	1.79
Be required to care for more patients than I can safely care for.	1.73
Feel unsafe/bullied amongst my own colleagues.	0.93
Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.	0.89
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.	0.87

APPENDIX N

DRAFT EXECUTIVE SUMMARY TO INTENSIVE CARE UNIT LEADERSHIP

Dear Saint Joseph's ICU Leadership,

Thank you for allowing me to implement my Doctor of Nursing Practice (DNP) scholarly project in the ICUs at SJMC. Your support has been greatly appreciated. As you may recall, the purpose of this project was to explore moral distress among ICU nurses and whether reflective debriefing may be a feasible intervention for reducing the negative impact of this issue on nursing staff.

<u>Project Findings</u>

Below are some highlights from the project:

- Approximately 21% of the ICU nurses at SJMC completed moral distress surveys. Only nurses employed by SJMC and working at least .5 FTE were included in the analysis.
- The results of the survey indicated that the ICU nurses have a moderate level of moral distress (average score of 144 on a scale of 0-432).
- One third (33%) of the nurses surveyed reported that they are considering leaving their current position due to moral distress.
- Nurses identified providing aggressive care at end-of-life to be among the highest rated root causes of their moral distress. It was also noted that team-based root causes were among the lowest contributors to moral distress, suggesting a supportive team culture at SJMC.
- Despite offering 10 debriefing sessions at various times/days over a 2-week period, only 15 ICU nurses were able to attend. Therefore, it was not possible to draw conclusions about whether this intervention reduced moral distress among the those who attended.
- The highest attendance was at sessions offered immediately after a shift (0730 and 1930). Many nurses expressed interest in attending a session but noted the inability to step away from the bedside as a barrier during their shift.

<u>Recommendations</u>

If the ICU leadership team remains interested in pursuing reflective debriefing as an intervention for reducing moral distress in the future, the following recommendations may be helpful:

- Offering sessions immediately after a shift appears to be the best time for nurses to attend. If offering sessions during the shift, providing additional staff coverage on the unit may be required to maintain patient safety.
- Given the support in the literature for reflective debriefing being an effective strategy, offering an incentive to participate (such as education pay) is recommended.
- Offering reflective debriefing virtually and including colleagues from other disciplines (e.g., medicine, social work, etc.) may be an option for increasing participation and fostering team building.

In conclusion, the ICU nurses at SJMC identified that they are experiencing at least a moderate level of moral distress. Given the potential consequences of unresolved moral distress, including nurse attrition and burnout, ICU leadership may be interested in potential interventions. I would be happy to assist with future efforts to address moral distress at SJMC. Please feel free to contact me with any questions or concerns.

Thank you again for your support and assistance,

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DNP Candidate

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