

# **Moral Distress to Moral Success: Strategies to Decrease Moral Distress in the Critical Care Nurse**

Lindsay R. Semler

**Background:** Moral distress, originally defined in 1984 as knowing the correct action to take, but being unable to pursue that action due to internal or external constraints, affects up to 70% of critical care nurses. Effects of moral distress include burnout, physical and psychological stress, turnover, a decrease in quality patient care, and even nurses leaving the profession.

**Purpose:** This paper discusses a pilot workshop implemented in a single intensive care unit, and aims utilize an evidence-based intervention to 1) Determine willingness of critical care nurses to engage in the moral distress forum; 2) Decrease nurses' experienced levels of moral distress; and 3) Increase nurses' perceived comfort and confidence in ethical decision making.

**Methods:** The study used a mixed quantitative and qualitative design. The setting was an academic, urban tertiary care center in the Heart and Vascular Intensive Care Unit. The intervention consisted of a four-hour interactive workshop, followed by two individual self-reflection activities at 2-3 weeks and 5-6 weeks after the workshop. Attendance rosters were used to ascertain the willingness of nurses to engage in the moral distress forum. Moral distress levels and ethical confidence were measured pre and 5-6 weeks post the intervention. The Moral Distress Thermometer was used to measure the levels of moral distress, and the Perceived Ethical Confidence Scale was used to measure four areas of ethical confidence. Qualitative data were collected on participants' causes of moral distress, ethical challenges they experienced, and their response to those ethical challenges.

**Results: Quantitative results:** Eighteen nurses out of 139 (12.9%) elected to participate in the moral distress workshop. The most frequent causes of moral distress (selected from a list in the demographics survey) were: disproportionate suffering of patients/families (83.3%), unclear goals of care (83.3%), patients' decision-making capacity (72.2%), and communication with team (55.6%). Nurses experienced a significant ( $p=0.001$ ) decrease in moral distress, with an average decrease score on the MDT of -3.329. The participants' average ethical confidence increased in all in four areas (ability to identify the conflicting values at stake, knowing role expectations, feeling prepared to resolved ethical conflict, and being able to do the right thing), with knowledge of role expectations and feeling prepared to resolve ethical conflict yielding a statistically significant increase ( $p=0.034$  and  $0.020$ , respectively).

**Qualitative results:** Nurses had the option of citing their causes of moral distress that were not already listed on a demographics survey; these included *Values of Nurses' Input Not Recognized*, *Lack of Palliative Care*, and *Families Not Receiving Transparent Communication*.

Themes that emerged from nurses' experienced ethical challenges were *Futile Care/Unclear Goals of Care*, *Patient Unable to Communicate Wishes*, *Lack of or Mixed Communication From the Healthcare Team to Family*, and *Patient Suffering*. In response to the ethical challenges participants experienced, the themes of their responses were *Used Communication Strategies to Discuss with Interdisciplinary Team Members*, *Assessing/Reflecting on Situation Using the 4 As*, *Self-Care*, *Discussed with Fellow Nurses*, *Considered All Viewpoints*, and *Advocated for Patient*.

**Implications:** This pilot study demonstrates the effectiveness of an evidence-based intervention for decreasing critical care nurses' moral distress and increasing their ethical confidence. The strategies described in this paper can be replicated by nursing leaders who wish to effect change at their local level. This intervention can also be adapted and expanded to other professions and clinical care units.

