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

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Background

- Moral distress was originally defined in 1984 as knowing the correct action to take, but being unable to pursue that action due to internal or external constraints
- Effects of moral distress include burnout, physical and psychological stress, turnover, a decrease in quality patient care, and even nurses leaving the profession
- Moral distress affects up to 70% of critical care nurses in the literature
- 60% of H&V ICU nurses reported "having to do things that compromise my values" on a 2017 Engagement Survey
- High levels of moral distress in H&V ICU via Moral Distress Scale- Revised 91.04(40.7) in 2014
- Anecdotal reports of moral distress by H&V ICU nurses

Project Aims

- **Aim 1:** Determine willingness of critical care nurses to engage in the moral distress forum
- **Aim 2:** Decrease nurses' experienced levels of moral distress
- **Aim 3:** Increase nurses' perceived comfort and confidence in ethical decision making
- **Secondary qualitative aims**: Describe causes of moral distress, ethical challenges experienced, and responses to ethical challenges by nurses in the H&V ICU

Methods

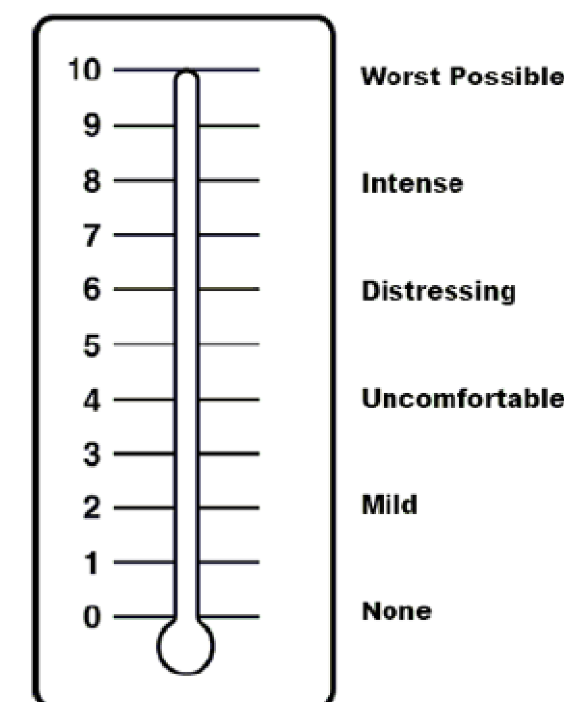
- Setting: A large urban academic medical center in the Heart and Vascular Intensive Care Unit in Philadelphia, Pennsylvania
- Target population: all critical nurses working in the H&V ICU
- Pre/post measurement of moral distress and perceived ethical confidence using the Moral Distress Thermometer (MDT) and Perceived Ethical Confidence Scale (PECS)
- Intervention: A four-hour interactive workshop that included didactic, case studies, group discussion, and action plan development
  - Followed by two self-reflection exercises at two time points

Sample Characteristics (n = 37)

Characteristic	n=18
Age, mean(SD)	30.61(7.039)
Gender, n(%)	
Female	n=14 (77.8%)
Male	n=4 (22.2%)
Years as RN, mean(SD)	6.61(5.45)
Years as RN on unit, mean(SD)	3.53(3.64)
Primary shift worked, n(%)	
Day	5 (27.8%)
Night	3 (16.7%)
Rotate	10 (55.6%)
Contributes to moral distress, n(%)	
Communication with team	10 (55.6%)
Disproportionate suffering of patients/families	15 (83.3%)
Unclear goals of care	15 (83.3%)
Patients' decision-making capacity	13 (72.2%)
Resource allocation	7 (38.9%)
Other*	7 (38.9%)

Intervention

- Four-hour interactive workshop developed by the PI based on current literature
- Intervention included information on moral distress, moral resilience, mindfulness, nursing ethics, ethical decision making, communication strategies, case studies, creation of action plans, and facilitated group discussion.
- Two self-reflection exercises at 2-3 weeks and 5-6 weeks post intervention
  - Gathered quantitative and qualitative data about experienced ethical challenges and the nurses' reaction/response
- Pre and post measurement of moral distress using the Moral Distress Thermometer (MDT)
- Pre and post measurement of ethical confidence using the Perceived Ethical Confidence Scale (PECS)



Participants' Causes of Moral Distress

- Disproportionate suffering of patients/families (83.3%)
- Unclear goals of care (83.3%)
- Patients' decision-making capacity (72.2%)
- Communication with the care team (55.6%)
- 38.9% of RNs reported other causes of moral distress. Themes were:
  - *Values of Nurses' Input Not Recognized*
  - *Lack of Palliative Care*
  - *Families Not Receiving Transparent Communication*

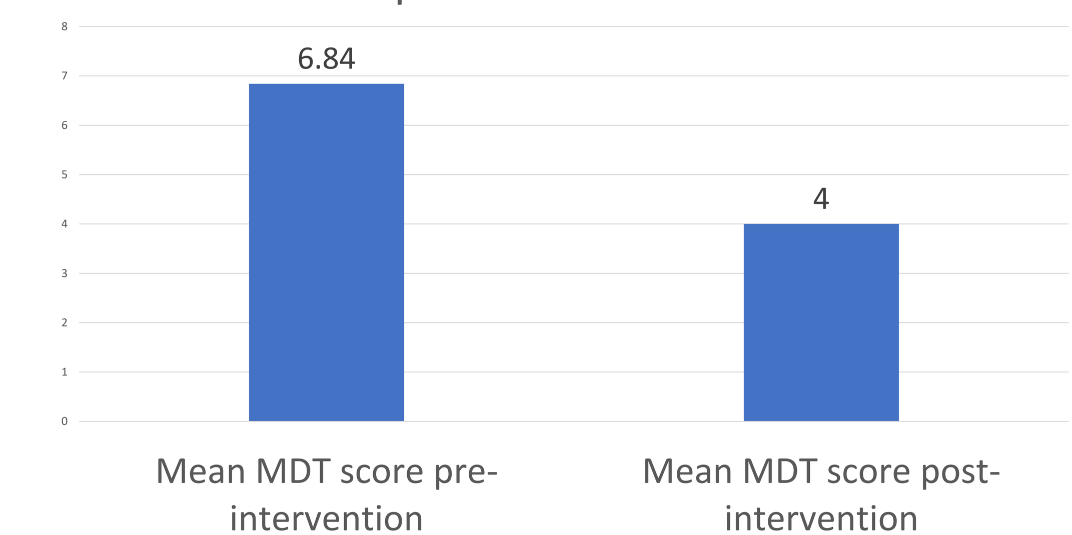
Qualitative Results

- Thematic analysis of the ethical challenges described in participants' self-reflections:
  - *Futile Care/Unclear Goals of Care*
  - *Patient Unable to Communicate Wishes*
  - *Lack of or Mixed Communication From the Healthcare Team to Family*
  - *Patient Suffering.*
- Thematic analysis and quantitative data showed that nurses used several tools to cope with ethical challenges
  - *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*
  - *Advocated for Patient.*

Quantitative Results

- **Aim 1:** Eighteen nurses out of 139 (12.9%) elected to participate in the moral distress workshop
- **Aim 2:** The mean MDT pre score was 6.83 (SD 1.654), and post score was 4 (SD 2.474). A Wilcoxon signed rank test was run, and the mean change on the MDT was -3.329, a statically significant change (p= 0.001).
- **Aim 3:** A Wilcoxon signed rank tests was conducted for each of the four questions on the PECS. The participants' average ethical confidence increased in all four areas (ability to resolve conflicting values at stake, knowing role expectations*, feeling prepared to resolved ethical conflict**, and being able to do the right thing).

Denotes a statistically significant increase (p=0.034* and 0.020)*



Conclusions

- This project demonstrated a statistically significant decrease in nurses' levels of moral distress over a 6-week period
- Participants experienced an overall increase in their ethical confidence, with statistically significant increases in 2/4 areas
- Participants found this intervention to be beneficial, and used strategies from the workshop in dealing with ethical challenges

Limitations

- Conducted on a single intensive care unit with a small sample size (n=18)
- Convenience sampling was used
- Total study time frame was limited to 6 weeks; no data on how moral distress and ethical confidence increased or decreased after this time frame
- Reliability and validity of Perceived Ethical Confidence Scale not firmly established

Future Directions

- Moral distress workshops such as these can be implemented at the unit level, and expanded to service line or organizational levels
- This educational intervention can be adapted to be used for other settings (medical surgical wards, oncology units, etc) and clinicians (Advanced Practice Providers, physicians, respiratory therapy, etc)
- Longer-term studies will be beneficial to evaluate sustained decrease in moral distress and increase in moral resilience and ethical confidence