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EXPLORING THE PRESENCE OF
MORAL DISTRESS IN CRITICAL CARE NURSES

by

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A Major Paper Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

With healthcare moving toward greater outpatient and preventative approaches, hospitalizations are increasingly intended for those who are critically ill. Frequently this requires the need for highly specialized nursing as well as resource utilization.

Technological advances have aided in providing this type of intensive care but they have also compelled practitioners to make treatment decisions that did not previously exist.

The conflict of maintaining one's life without ascertaining whether there will be quality of life is just one example of a difficult situation that can lead to moral distress. The purpose of this study was to explore the effects of moral distress on critical care nurses.

The project employed a survey design. After obtaining IRB approval, a convenience sample of 28 nurses was obtained from a small community hospital's ICU and CCU.

Each participant completed the Moral Distress Scale-Revised (MDS-R) measure and some demographic questions. Results confirmed that moral distress was present among

the participants at low to moderate levels: 18 nurses (64%) scored low with seven nurses (25%) scoring in the moderate range. The most morally distressing experiences were

related to end of life care. The most morally distressing and frequent event was that of

"follow the family's wishes to continue life support even though I believe it is not in the

best interest of the patient". There was no correlation between nurses' age, level of

experience and moral distress. Limitations included a small sample size and lack of

diversity in age and experience. It is possible that the researcher's affiliation with the unit

could have affected participants' responses regarding leaving their current position. The

findings suggest that more research should be done on exploring the ethical climate and

other factors that effect moral distress.

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Exploring the Presence of Moral Distress in Critical Care Nurses

Background/Statement of the Problem

The American Association of Critical-Care Nurses (AACN, 2008) describes the critical care setting as one where patients require complex assessments, high-intensity therapies and interventions and continuous nursing vigilance. The Center for Disease Control and Prevention (CDC, 2017) recently determined that out of 136 million emergency department visits, 2.1 million resulted in a critical care admission. However, even with advances in medicine, the mortality rate in the critical care unit exceeds 50% (CDC). With a high proportion of patients dying before leaving the hospital, providing high quality end of life care and patient advocacy is a key-nursing role in the care of the critically ill.

Brilli et al. (2001) concluded that a multidisciplinary approach, specifically intensive care unit (ICU) dedicated personnel, such as nurses, respiratory therapists, pharmacists and intensivists, is the basis for any well-functioning critical care model. Intensive care unit nurses in particular “improve the ICU experience for both patients and their families, and through their critical thinking skills, experienced nurses readily recognize clinical changes to prevent further deterioration in these patients” (p. 2011), ultimately aiding in preventing complications and improving long-term outcomes.

With healthcare moving towards an increased outpatient and preventative approach, hospitalizations are intended for those progressively and acutely ill, often requiring an increased need for critical care nursing. Medical advances have provided today’s practitioners with treatment decisions that did not exist previously. This potentially leads to more difficult situations and decisions, including life saving interventions such as the use of ventilators, continuous renal replacement therapy

(CRRT) and intra-aortic balloon pumps (IABPs), to mention a few. In utilizing such life-saving interventions, one begins to wonder about the quality of life someone might have after their initiation. The conflict of maintaining one's life without ascertaining whether there will be quality of life is just one example of a difficult situation that can lead to moral distress.

Moral distress is defined by AACN in *Public Policy Position Statement: Moral Distress* (2008) as occurring when “you know the ethically appropriate action to take, but are unable to act upon it and you act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity” (2008, p.1). The purpose of this project was to explore the effects of moral distress on nurses in the critical care environment.

Next, a review of literature relevant to moral distress is presented.

Literature Review

An extensive literature search was performed utilizing CINAHL, PubMed, Google Scholar, and web searches of related websites. The search terms included "moral distress" and "burnout". Adding the terms "critical care" and "nursing" narrowed the search results further. Publications in English only, dated 2001 to the present, were reviewed.

Healthcare professionals are placed close to significant events in human existence such as birth, death, pain, suffering and everything in between, and while being in this position is a privilege, it also presents challenges. This role involves participation in decisions that are life changing and deeply effects everyone involved. Due to the nature of critical care units, moral distress exists in everyday practice. Moral distress can occur as advances in technology allow people to live longer than before, often when it isn't in the patients' best interest. This is compounded by inadequate communication among healthcare providers, patients, and families, as well as inappropriate staffing, and false hope given to patients and families (Savel & Munro, 2015).

Moral Distress Defined

In order to minimize moral distress, one must understand what moral distress is, be able to acknowledge it as a current issue in practice and be cognizant of literature that creates pathways to managing the issue. Andrew Jameton first explored the concept of moral distress in 1984 in his book *Nursing Practice: The Ethical Issues*. Jameton (1984) defined moral distress as "knowing the right thing, but constraints make it impossible to pursue the right course" (p.6). Since Jameton's research, many have developed various definitions of moral distress based on the most recent literature. Elpern et al. (2005) stated moral distress is a psychological disequilibrium that occurs when the ethically right

course of action is known but cannot be acted upon. Moral distress is defined by AACN in *Public Policy Position Statement: Moral Distress* as occurring when “you know the ethically appropriate action to take, but are unable to act upon it and you act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity” (2008, p.1). For this study, moral distress was defined according to the AACN definition, based on its’ national recognition as a highly respected resource for critical care nurses.

Moral Distress Measurements

Several scales are available to measure moral distress. The most notable include the Moral Distress Scale (Corley, 2001), the Moral Distress Scale-Revised (Hamric, Borchers, & Epstein, 2012) and the Moral Distress Thermometer (Wocial & Weaver, 2013). The frequency of ICU interactions causing moral distress will increase, causing a potential health hazard for health care professionals, particularly nurses providing direct clinical care (Morris & Dracup, 2008). Utilizing tools to measure moral distress would provide evidence supporting the need for resources for healthcare professionals overcoming moral distress. Morris and Dracup (2008) note that "the critical care community needs the equivalent of "stress-barrier precautions" that prevent harm to staff but allow care to continue in a positive, professional manner consistent with the promotion of dignity and respect for patients and families" (p. 400).

Corley’s Moral Distress Scale (MDS) (Corley et al., 2001) focuses on patient care situations that evoke moral distress. It is a 38-item scale that assesses the frequency and intensity at which moral distress occurs, ranging from 0 to 6 for each category. There is a total score as well as scores for the three subscales which measures *individual*

responsibility, not in patient's best interest and deception. The MDS is highly reliable as evidenced by Cronbach alpha ranging from 0.82 to 0.98. Lerkiatbundit and Borry (2009) noted that the MDS was reviewed by three experts to assess each item for validity in measuring moral distress. The content validity index was 100% (Lerkiatbundit & Borry).

The Moral Distress Scale-Revised (MDS-R) (Hamric, Borchers, & Epstein, 2012) is a Likert scale, ranging from 0-4, comprised of 21 items. *Intensity* is defined as the level of disturbance of each situation, while *frequency* is how often the situation arises (Hamric). The Likert scale 0 means, " items that have never been experienced or are not seen as distressing [and] do not contribute to an individual's level of moral distress" (p. 9). The MDS-R allows for separate analysis of *intensity* and *frequency*, and creates a composite score for each individual item (frequency multiplied by intensity). The composite score ranges from 0-16 for each item and 0-336 total for the 21-item scale. The system allows for items marked as not distressing or not experienced to be eliminated, thus giving a more accurate reflection of moral distress when compared to the original MDS. The validity of the MDS-R has been reported as adequate. It's highly reliable as evidenced by Cronbach alpha greater than 0.95 (Hamric).

The Moral Distress Thermometer (MDT) is a single item scale depicted as a mercury thermometer with an 11-point scale from 0–10 (Wocial & Weaver, 2013). Located near the scale are verbal descriptors to help describe a degree of distress. The authors provide a definition of Moral Distress with the scale and ask respondents to reflect on their clinical practice in the last two weeks, including the day the scale is utilized, and to identify on the thermometer their level of Moral Distress. The Moral Distress Thermometer did show a low to moderate convergent validity when compared to

the Moral Distress Scale. Wocial and Weaver (2013) concluded that the MDT might prove to be beneficial as a screening tool for moral distress and that the single item scale may be beneficial in tracking changes in moral distress over time.

Effects of Moral Distress on Healthcare Costs

Background. The focus on registered nurse retention and frequent job turnover has heightened due to rising nursing shortages and the increased costs related to organizations. According to the *Nursing Shortage Fact Sheet* published by the American Association of College of Nurses (AACN, 2014), increasing patient admissions combined with the projected increasing shortage of Registered Nurses (RNs), increasing health care needs, and inability for schools to expand in order to meet the demand, means keeping as many nurses as possible in the profession is crucial. The AACN stated that insufficient staffing in hospitals is raising stress levels of nurses, impacting job satisfaction, and driving many nurses to leave the profession.

Saving valuable time and money is a focus that many organizations are working to improve. This includes improving staff satisfaction and improving patient satisfaction (Jones, 2008). Monetary savings are valued, but by saving in staff turnover costs, there are also other improvements systems' wide that cannot be quantified. Decreasing moral distress is a foundational step in keeping experienced nursing staff in the critical care units where they are able to foster the growth and knowledge of inexperienced staff, allowing for a positive impact on patient care (Rushton, 2006).

Impact of Moral Distress on Healthcare Costs. Voluntary Hospitals of America Inc. (2002) noted that organizations with low turnover rates, between 4% and 12%, had lower risk-adjusted mortality and lower patient lengths of stay than did organizations

with moderate (12% to 22%) or high (22% to 44%) turnover rates. High turnover is associated with significant financial costs (Jones, 2008) and results in the loss of experienced nurses, leading to an impact on patient care (O'Brien-Pallas, 2010).

O'Brien-Pallas (2010) conducted a study utilizing a repeated cross-sectional and longitudinal design staggering over seven to eight months and consisting of a data collection period of three months. The nurse sample consisted of 8325 participants representing several specialties, including the ICU, medical, pediatric, obstetrics, psychiatric, rehabilitation and surgical units. Site research coordinators collected data on turnover and costs. The overall mean annual turnover rate was 19.9%, with the ICU having the largest average turnover rate at 26.7%. The SF-12 Mental Health Status survey was utilized to measure the mental health of participants. When compared to the average mental health score (<48.43), 44.4% of nurses scored lower than the average (47.9) and were considered mentally unhealthy. Higher turnover rates were associated with deterioration in nurse's mental health. O'Brien-Pallas found that when staffing patterns were unstable it lead nurses to experience job stress. As literature has pointed out (Aiken et al., 2011; Roche & Duffield, 2013), increased turnover can then lead to understaffing, which has been directly linked to a cause of moral distress.

Jones (2008) conducted a study that gathered data retrospectively from turnover costs from fiscal year 2002 involving data from a large acute care hospital combined with data from nurse executives of three service lines. The Nursing Turnover Cost Calculation Methodology was utilized, which subdivides costs into pre hire and post hire costs and into further subcategories. The largest cost categories were vacancy costs (pre hire), orientation and training costs (post hire), newly hired RN productivity costs (post hire),

and advertising and recruiting costs (pre hire), representing more than 90% of costs (Jones, 2008). The author found that RN turnover costs ranged from \$82,000 to \$88,000 per RN. This does not include the costs associated with use of temporary nurses, staff overtime, closed bed, and patient deferrals. Higher organizational costs (due to loss of productivity and organizational inefficiencies from staff instability) occur when high-performing nurses leave and have to be replaced (Jones).

Roche and Duffield (2013) conducted a prospective longitudinal study conducted in two waves, one-year apart spanning three states and 11 hospitals. Among those hospitals, 1673 nurse surveys were sent out and 44% (n=736) were returned. The researchers focused on several factors that turnover costs affect, including patient, nurse and system outcomes. Costs were divided into four categories including termination, temporary replacement, hiring and startup. The mean turnover rate was 16.4% with the maximum turnover rate being 76.7%. The mean cost excluding temporary replacement was \$26,464 (ranging from \$9,755 to \$55,677), with the mean costs including temporary replacement being \$48,342 (ranging from \$17,519 to \$104,532). Parallel to research done by O'Brien-Pallas (2010), Roche and Duffield found that an increase in turnover lead to a decrease in quality of care, job satisfaction, and nurses' mental health.

Effects of Moral Distress on the Healthcare Professions

Background. Sauerland et al. (2014) identified that there is an inverse relationship between moral distress and ethical climate. Ethical climate is described as the organizational conditions and practices in which problems with ethical implications are identified, discussed and decided, embodying the character of the organization. This is a variable that can be changed to improve the work environment (Sauerland). Moral

distress has been found to be an influential factor in teamwork erosion, decreased quality of care and poor patient outcomes (Rushton, Caldwell, & Kurtz, 2016). Removing some of these barriers, along with a trusting and open workplace environment, can empower nurses when handling moral distress (Rushton et al.). Rushton (2016) pointed out barriers preventing nurses from acting as moral agents include excessive workloads, intra-team conflict and contentious power dynamics.

Evidence of Moral Distress on the Healthcare Professions. Moral distress affects every level of the healthcare system and everyone involved, spanning across specialties. Working closely with critical care nurses, respiratory care therapists are also affected by moral distress. Schwenzer and Wang (2006) surveyed 57 respiratory care practitioners at a 552-bed tertiary care hospital. The Moral Distress Scale-Revised by Hamric et al. (2012) was utilized in the study. The items on the scales were ordered by their means, with the higher mean corresponded to an increased amount of moral distress. The highest values were related to: “continue to participate in care for a hopelessly injured person who is being sustained on a respirator” (3.78); “follow the physician’s request not to discuss code status with the patient” (3.77); “follow the family’s wishes for patient care when I do not agree with them” (3.76); and “follow the family’s wishes to continue life support even when it is not in the best interest of the patient” (3.69). The highest mean was 3.78, while the lowest was 1.11. Because they are involved in moral decisions, such as withdrawal of ventilators, respiratory therapists often experienced moral distress due to factors similar to their nursing counterparts.

A study performed by Austin, Kagan, Rankel, and Bergum (2008) explored psychologists’ experiences where they had described dealing with moral distress in

psychiatric and mental health settings. The authors used the interpretive inquiry method hermeneutic phenomenology that focuses on uncovering a human experience through description (Austin et al.). Each participant was asked to describe situations that stimulated feelings of moral distress. The authors found that moral distress was strongly influenced by societal expectations of their profession, such that they should be responsible for dealing with societal issues and interpersonal violence for those who reject medical advice. Psychologists also reported much of their moral distress came from attempts at keeping specific patients on their caseload.

Effects of Moral Distress on Nursing Practice

In the AACN (2008) position statement, it was noted that moral distress results in significant physical and emotional stress, which contributes to nurses' feelings of loss of integrity and dissatisfaction with their work environment. Chronic stress, hypertension, and headaches, identified as stress-related disorders, can attribute to 54% of all job-related absenteeism (Caine & Ter-Bagdasarian, 2003). Nurses often seem unaware of the moral distress they experience, and they tend to label their feelings as stress, burnout, emotional exhaustion and job dissatisfaction, when it may actually be symptomatic moral distress (Pendry, 2007).

Effects of moral distress in the acute care setting. Cummings (2010) conducted a descriptive study that surveyed 168 acute care nurses. Of those nurses, 40 provided examples of morally distressing situations they had experienced in their careers. This includes emotional outpourings by family members, combined with feeling burnt out by events, and the pressure of critical decision-making causes stress to staff.

A study by Aiken et al. (2011) suggested that a healthier work environment might

decrease nurses' reports of moral distress. These authors conducted a survey of 1406 hospitals in nine countries between 1999 and 2009. When nurses reported having higher quality work environments, there were significant decreases in reports of job dissatisfaction (in eight out of nine countries) and decreased reports of high burnout ($P < 0.05$). For example, nurses working in "better" work environments had 27.5% of nurses report high burnout and 15.7% of nurses report job dissatisfaction in hospitals in the USA. In hospitals considered to have "poor" work environments in the United States, 39.6% of nurses reported high burnout and 30.4% of nurses reported job dissatisfaction. The researchers found that acute care nurses showed lower burnout and dissatisfaction with one's job when they worked in better environments. Burnout and moral distress have equally been linked to similar causative factors, with job dissatisfaction contributing to both. Those same hospitals were also associated with better quality of care outcomes for patients. The authors noted that in all countries, hospitals where nurses reported having better work environment reported a smaller percentage of nurses reporting negative outcomes.

In a similar study, Cimiotti, Aiken, Sloane and Wu (2012) found an association between hospital-acquired infections (HAIs), specifically urinary tract infections and surgical site infections, with burnout and moral distress. Secondary data and surveys sent to 7,076 nurses working in 161 hospitals in Pennsylvania were analyzed and found a significant correlation between nurse burnout and the increased frequency of HAIs. When burnout was reduced by 30% in hospitals, there were noted to be 6,239 fewer infections, saving up to \$68 million. Because frequent incidences of moral distress can lead to burnout, reducing onset of moral distress can lead to an overall decline of burnout

amongst staff (Dalmoloin, Lunardi, Barlem, & Silveira, 2012).

Moral distress affects nurses personally, as well as their ability to work and continue working on the same unit. Borhani, Abbaszadeh, Nakhaee, and Roshanzadeh (2015) conducted a cross-sectional study of 220 nurses analyzing the relationship between moral distress, professional stress and the desire to stay in the profession. The data were collected from nurses in two teaching hospitals in Iran. Nurses identified working in a broad spectrum of clinical settings including critical care, medical, surgical, pediatrics, emergency and psycho-medicine specialties. Of these specialties, the largest responses came from critical care (36.8%; n=81), surgical (29.5%; n=65) and medical (15%; n=33) areas. The researchers utilized Corley's MDS, along with Wolfgang's Health Professions Stress Inventory and the Nedd Questionnaire on Intent to Stay in the Profession. The mean moral distress intensity was 2.25 and the mean moral distress frequency was 2.11 on a scale from 0 to 5. The mean intensity for professional stress was 2.21 and professional stress frequency was 2.26 on a scale from 0 to 5. Results were significant for correlations between moral distress and professional stress ($P < 0.05$).

Effects of Moral Distress on Critical Care Nurses

Overly aggressive treatment is described as treatment that increases the burden of suffering for the patient. This includes procedures that may prolong death such as dialysis and intra-aortic balloon pumps. Gutierrez (2005) utilized qualitative, descriptive methodology in order to focus on collecting a large quantity of descriptive data in an interview format. The authors recruited 12 critical care nurses with greater than one-year experience in critical care working in a large teaching hospital. Use of measures perpetuating death was reported by 92% (n=11) of the nurses. The author also found that

50% (n=6) of nurses believed that the most significant professional effect of moral distress was reluctance to go to work. Gutierrez concluded that the top reason for moral distress in critical care was that of overly aggressive treatment.

Wiegand and Funk (2012) examined nurses' experiences related to moral distress in a descriptive study utilizing open-ended surveys. Surveys were distributed to 204 critical care nurses working at a university medical center, with 37 responses received. The surveys focused on situations that cause moral distress, consequences of the situation, and changes nurses would make when faced with a similar situation were used. Their findings were similar to other literature on moral distress, with the majority (73%; n=27) of nurses reporting moral distress as related to end of life care. Nurses reported crying, losing their appetite and experiencing nightmares as well as physical symptoms such as diarrhea, headaches, heart palpitations and vomiting. An array of emotions, including anxiety, depression, hopelessness and powerlessness were also associated. These effects led to an increased need for personal days, utilization of sick time and the potential for leaves of absences, leading to a potential for understaffing. The affects of moral distress on nurses can affect job performance and their ability to take care of patients and their families. Because they felt at times that their communication seemed to repeatedly be ignored, nurses described having to provide a lower standard of care to their patients (Wiegand & Funk).

Burston and Tuckett (2013) conducted a literature review spanning the years 1982-2011 across several databases focusing on moral distress within and outside the context of nursing practice. The researchers reviewed contributing factors, outcomes, and interventions regarding moral distress. Moral distress in the individual comes from

within, meaning who they are and how they perceive events. Characteristics of the individual were noted to effect moral distress. These included the nurses' perception of their role, their life and previous experiences and their relationships with other nurses and physicians. The nurses' worldview and perspective regarding values were identified as contributing factors. Worldview in particular was associated with expectations of standard care, moral sensitivity and individual ethical perspectives. Site-specific considerations affecting moral distress included resourcing, staffing and care.

Availability of resources, as well as an organizations' allocation of resources, contributed to moral distress. Unsafe staffing, inadequately trained staff and staffing patterns limiting access to patient care were identified as other contributing factors. When the researchers referred to care, they were actually referring to gaps in care, such as a lack of beds for patient care, inappropriate environments for palliative care and a general lack in knowledge and information (Burston and Tuckett). Burston and Tuckett identified that moral distress effects nurses by having consequences for oneself, others and for the system. These are identified as feeling towards oneself ("I would feel..."), towards others ("I would act...") and toward the system ("I would do..."). The review corroborated that moral distress can lead nurses to avoid a patient, a conflict situation and end delivery of care altogether. This ultimately contributes to decrease in quality of care, physical and emotional illness, burnout, staff turnover and decreased workplace satisfaction.

Burston and Tackett (2013) noted that there are two ways to intervene: an individualistic approach and a collaborative approach. The individualistic approach is based on education, focusing on improving understanding and coping strategies to effectively manage moral distress. Likewise, a collaborative approach utilizes education

to focus on an inter-professional agenda. Improved collaboration communication and an increase in ethical education is a worthwhile strategy against moral distress.

Reports of moral distress in critical care nurses are not exclusive to the United States (US). Karanikola et al. (2014) surveyed 566 Italian nurses. The authors utilized the Moral Distress Scale (MDS) to explore the associations in the intensive care units between moral distress and nurse-physician collaboration, autonomy, professional satisfaction, intention to resign and workload. A self-reported questionnaire was utilized in this descriptive cross-sectional survey. The authors found that the most morally and frequently distressing situation to be that of initiating extensive life saving measures when it was only prolonging death. This was evidenced by 'initiating extensive life saving actions when they only prolonged death' being the most frequent response with a mean of 2.8 on a scale of 0 to 4. Distress was reported to have a mean of 9.2 on a scale of 0-16 according to the modified Corley's Moral Distress Scale.

According to the American Association of Colleges of Nursing (2014), the shortage of nurses is expected to continue to intensify due to increasing need for healthcare combined with aging of the Baby Boomers. One significant factor noted to contribute to the shortage is that of insufficient staffing. Recognizing moral distress is an initial step in keeping nurses in their current positions and in their profession. It is also crucial in improving quality of care and protecting patients from the negative consequences that result from moral distress on nurses and supporting staff throughout the healthcare system.

Moral Distress Interventions

The American Association of Critical-Care Nurses (AACN; 2004) highlighted

several barriers that are of concern when dealing with moral distress. These include internal barriers such as lack of awareness, fear, and lack of confidence and external barriers including lack of administrative support, power imbalances and lack of time. Increasing awareness and ongoing difficulties with moral distress in nursing have led to increased exploration in developing solutions for the problem; one includes *The 4 A's to Rise Above Moral Distress* and the SUPPORT model.

Moral distress and the four A's. The AACN published *The 4 A's to Rise Above Moral Distress*. The 4 A's represent a processing tool designed to encourage positive change in complex situations; they stand for *Ask, Affirm, Assess, and Act*.

The initial step in the process, *Ask*, is determining whether the nurse is experiencing moral distress. Rushton (2006) noted that initially, anger and anxiety toward obstacles or conflict with others about important values is how moral distress can begin. Some key phrases that are reflective of moral distress include "Why are we doing this?" "There's nothing more we can do"; "I can't stand to watch the patient's response"; and "They don't get it" (Rushton).

The second step, *Affirm*, is committing to address moral distress. This involves having the professional responsibility to contribute to maintaining a healthy work environment, validating one's feelings with others and declaring one's professional responsibility to act (AACN). The American Nursing Association (ANA) Code of Ethics (2015), *Provision 5* makes distinguishable points regarding moral distress and affirmation: (1) moral respect accords with moral worth and dignity, extending to oneself and includes health promotion and safety; (2) nurses should promote and maintain their own health and well-being, just as they do for their patients, and nurse leaders should

foster this within organizations; (3) as moral agents, nurses should foster moral discourse and express one's moral point of view as a duty to self; (4) preservation of integrity is a self-regarding duty; nurses must be treated with respect and need never tolerate abuse; (5) nurses must maintain competence and strive for excellence in practice by routinely evaluating their own performance (p.19-22).

Assess is next in the cycle of change. This part of the cycle entails identifying sources of stress and their severity of moral distress. Some sources are specific patient care situations, unit policies or practices and lack of collaboration. The *4 A's to Rise Above Moral Distress* provides the tools that aid in assessing risks and benefits in regards to moral distress. Diminishing or removing the risks is the best way to recognize and manage change (AACN, 2004).

The fourth point in minimizing moral distress requires the nurse to address and initiate actions. Preparing to *Act* requires developing a self-care plan, identifying appropriate sources of support and investigating outside resources for guidance. The AACN (2004) lists specific actions that are applicable to distress regarding a current patient care situation, a pattern of care within a unit and lack of interdisciplinary collaboration. The final piece after initiating action is to maintain desired change. With any initiation of change, setbacks can be anticipated and managed. The cycle of the 4 A's is a process that allows for continuous re-evaluation at every level of the process. Distressful situations will constantly occur, but utilization of the *4A's to Rise Above Moral Distress* provides the tools and guidance to stand by the *ANA Code of Ethics, Provision 5*, to benefit everyone involved in ethically challenging healthcare environments.

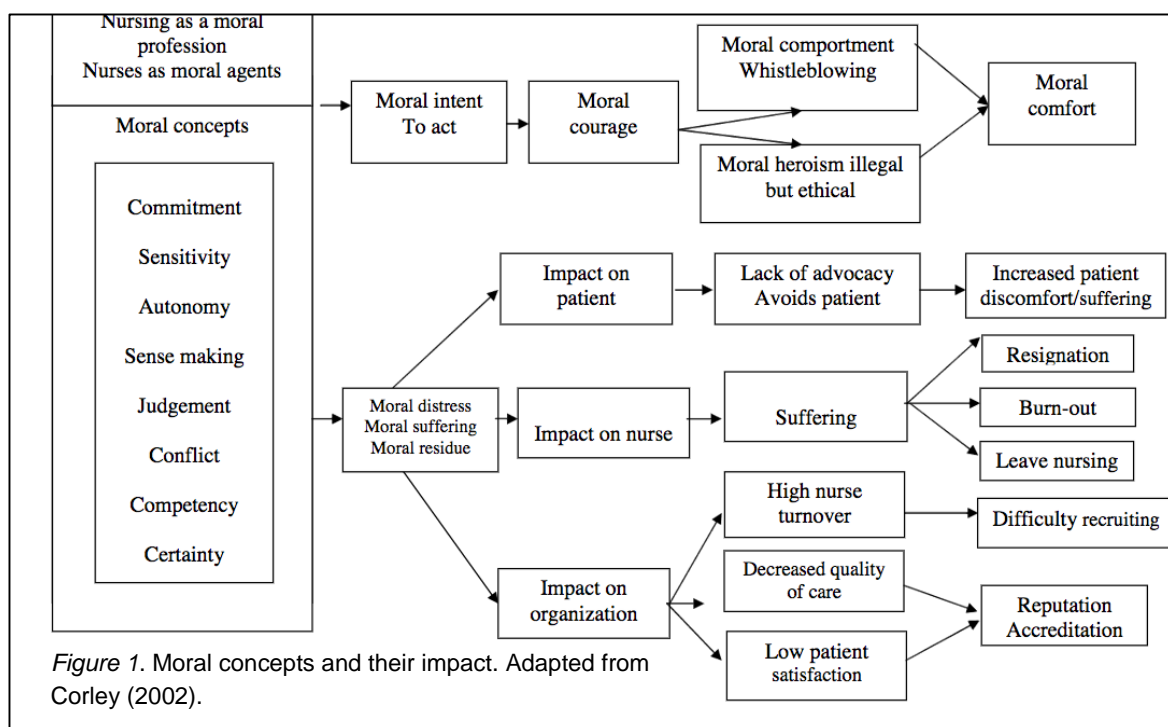
Moral distress and the SUPPORT model. Prottas (2013) supported past literature in concluding that trusted leaders that are effective and hold a high standard of integrity model an example for employees. This can be influential in leading them to be increasingly engaging in constructive and productive behaviors. With nurse leaders' focused attention on creating a culture of high ethical standards, prompt action can make a profound difference on moral distress.

A recent study done by Pavlish, Brown-Saltzman, So, and Wong (2016) focused on targeting nurse leaders' experiences with moral distress. The end result was the development of the *SUPPORT* model for addressing moral distress. The framework highlighted individual, collective and leadership actions directed at moral distress. *SUPPORT* is a pneumonic used to identify key pieces of the framework: (1) See it/Seek it out; (2) Understand it; (3) Pay attention: Assess workplace climate; (4) Promote receptive environment and engagement; (5) Open opportunities for dialogue; (6) Reflect, evaluate, revise; and (7) Transform environment. Nurse leaders are challenged to be increasingly mindful of moral complexities that occur in their settings. This model encourages a team-based dialogue focused on ethics-related conversations open to patients, families, and members of the healthcare team. Pavlish et al. (2016) notes that the *SUPPORT* model aids in creating policies adhering to the ANA Code of Ethics by providing strategies for nurse leaders enabling them to improve nurses' ethical skills

Next, the theoretical framework that was used to guide this study will be presented.

Theoretical Framework

The theory of nurse moral distress by Corley (2002) was used to guide the development and implementation of this project. This theory considers internal and external contexts contributing to moral distress. Internal contexts consist of the nurses' psychological response, while external context refers to the work environment. Six moral concepts are identified in the theory including *moral commitment*, *moral sensitivity*, *moral autonomy*, *moral sense making*, *moral judgment*, *moral conflict*, *moral competency*, and *moral certainty* (Corley). These concepts are depicted in *Figure 1*.



Moral commitment refers to adhering to moral values (*moral integrity*). Corley (2002) identified that all nurses who have a strong sense of moral integrity, but lack requisite moral competency, experience more moral distress as an outcome. *Moral competency* is the ability to make moral sense of situations, use good moral judgment, and engage in moral behavior. *Moral integrity* is the adherence to moral values and ties to

one's sense of self-respect. *Moral sensitivity* is defined as the ability to recognize a moral conflict, show contextual and intuitive understanding of the patient's vulnerable situation, and have insight into the ethical consequences of decision on behalf of the person). A key point regarding moral sensitivity is that nurses who have a high level of moral sensitivity experience less moral distress. Nurses with moral sensitivity who lack moral competency are more likely to experience moral distress (Corley).

Moral commitment is apparent before moral certainty can be developed (Corley, 2002). It is described as the willingness to take risks after engagement with a moral issue. Low levels of moral distress are associated with nurses who have high levels of moral commitment, leading to increased moral competency, demonstrating exemplary moral behavior. *Moral competency* is the ability to use moral sense of a situation in order to have good judgment and intention, leading to morally appropriate behavior. Even with strong moral commitment, a lack of competency increases one's chance of experiencing moral distress (Corley).

Corley (2002) identified *moral autonomy* as the freedom, right and responsibility to make choices in regard to patients. *Moral certainty* is confidently using autonomy with conviction, leading to risk of personal and professional self in order to act on righteousness (Corley). By having moral commitment and moral competence, nurses are less likely to experience moral distress. The proposed theory identifies that nurses who have a high level of moral commitment, moral competence, and moral autonomy are more likely to feel moral certainty and experience less moral distress.

Moral judgment is utilizing ethical considerations to determine a course of action (Corley, 2002). Appropriate moral judgment, when exercised, leads to less moral distress

When moral values clash, moral conflict is present and can lead to moral outrage over a situation. When prompted by a moral or ethical conflict, and the nurse chooses to act, moral courage is the end product, leading to less moral distress.

All of the concepts are related in complex ways and highlight that moral distress for nurses is a multifaceted phenomenon. From the organizational standpoint, the physical and psychological support systems within healthcare systems are referred to as constitutional restraints (Corley, 2002). Constitutional restraints have been theorized as the foremost underlying factor to moral distress. Corley theorized several points, one being that nurses who work in supportive environments and organizations that recognize moral distress are less likely to experience the consequences of moral distress.

Organizational encouragements of collaboration with physicians, access to practice policies and supportive environments have positive effects on nurses and their ethical management of moral conflict (Corley). An organization that fosters respectful relationships between peers, management, administration and providers and can decrease moral distress. Both the individual and organizational perspectives give direction as to what and where interventions can be implemented to decrease moral distress and maintain supportive environments. Corley's moral distress theory provides a structure to identify and manage moral distress in acute care settings.

Next, the methods used to carry out this project will be presented.

Method

Purpose

The purpose of this project was to explore the effects of moral distress on nurses in the critical care environment.

Design

The proposed project was carried out as a self-report survey project describing nurses' moral distress in the acute care setting utilizing a survey method. The survey used was Hamric's Moral Distress Scale-Revised (MDS-R)(Hamric, Borchers, & Epstein, 2012). Corley's original Moral Distress Scale guided the survey and focused on patient care situations that evoked moral distress. The MDS-R was designed with three objectives in mind. These included more root causes of moral distress, expanding its use in non-ICU settings, and making it appropriate for use by multiple healthcare disciplines (Hamric, Borchers, & Epstein, 2012).

Setting

The survey was completed by critical care nurses working in a small community hospital in SE Massachusetts that consists of 8 mixed Medical/Surgical ICU beds and 8 mixed ICU/Cardiac Critical Care beds. The nurse to patient ratio in both units is on average one nurse caring for two acute care patients.

Sample

A convenience sample included all registered nurses on two Critical Care Units. There were a total of 28 participants that met the criteria for inclusion in the study.

Measurement

The scale that was used for this project was the Moral Distress Scale-Revised (Hamric, Borchers, & Epstein, 2012). The initial scale was shortened and items were

added and removed based on current literature. Of the items that were kept, clarification and broadening of items allowed for the scale to be translated beyond critical care. In order to have an applicable scale to multiple disciplines, six parallel versions were created. The one that will be used for this study is the *Moral Distress Scale- Revised, Nurse Adult Questionnaire*. The scale is based on a Likert system, ranging from 0-4, for each of the 21 items listed. Intensity is defined as the level of disturbance of each situation, while frequency is how often the situation arises (Hamric, Borchers, & Epstein, 2012). Beginning the Likert scale at 0 means " items that have never been experienced or are not seen as distressing do not contribute to an individual's level of moral distress" (Hamric, Borchers, & Epstein, 2012). The MDS-R allows for separate analysis of intensity and frequency, but also can create a composite score for each individual item (frequency multiplied by intensity [fxi]). The composite score thus ranges from 0-16 for each item and 0-336 total for the 21 items scale. The system allows for items marked as not distressing or not experienced to be eliminated, thus giving a more accurate reflection of moral distress. Hamric, Borchers, and Epstein (2012) note the reliability of the instrument tested by calculating the Cronbach's alpha for the nurse is 0.89.

Procedure

Ethical Considerations. Data collection began after International Review Board (IRB) approval was obtained from the Rhode Island College IRB and administrative approval was obtained from Charlton Memorial Hospital.

Data Collection. Data collection began following approval, and lasted one week. Demographic information that was gathered from participants included their average hours worked per week, average years in the critical care setting, average years as a

nurse, and level of education (including CCRN certification specifically). Nurses were informed of the study first through their system-based email addresses. In an email addressed from this investigator, they received a copy of the informational letter detailing the study, its purpose, and the use of the findings, as well as contact information for this investigator and the primary investigator. The surveys were accessible to all staff that wished to participate in nursing common areas. These included bulletin boards located behind the nurses' stations. Surveys were located in a manila envelope, with a copy of the cover letter attached to the outside. Each survey was filled out anonymously. Each survey had a consent letter attached notifying participants that a returned survey signified consent of inclusion in the quality project. Staff were encouraged to participate via raffle offering of a \$25 gift card to Amazon at the conclusion of the study. Corresponding tickets were attached to each survey, allowing each participant to submit a survey and a matching ticket to a sealed box located on each unit. This allowed for anyone simply entering a ticket into the raffle to be excluded if a matching survey was not present. A ticket was drawn at random at the conclusion of data gathering.

Data Analysis. Data was analyzed using Excel software. Project findings were presented in poster format at the School of Nursing Colloquium in May 2017 at Rhode Island College. The poster will also be on display at Charlton Memorial Hospital in the Critical Care area, allowing for participants to appreciate the results. Author will arrange a meeting with the critical care leadership and staff to report and discuss the project findings.

Next, the results will be presented.

Results

A total of 28 nurses completed the survey. Demographic data is illustrated in Table 1 on the next page.

The age ranges for the majority of participants were between the 25-35 years old. This age group totaled 16 (57%) of nurses. Of the sample of 28 nurses, there were eight (29%) nurses that had been working in the field of nursing for one to five years and eight (29%) participants for five to 10 years. Eighteen (70%) participants reported having less than five years critical care experience. Twenty-two (78%) participants were working full-time in critical care at the time of the survey. Only three (8%) nurses reported having Critical Care Registered Nurse certification. Of the 28 participants, 19 (68%) have a bachelor's degree in nursing, accounting for the majority of nurses.

Table 1

Demographic Data

Demographic Data (N=28)	
Age (years)	
Under 25	4 (14%)
25-35	16 (57%)
Over 35	8 (29%)
Years of experience as a nurse	
Less than 1 year	1 (3%)
1-5	8 (29%)
5-10	8 (29%)
10-15	7 (25%)
Greater than 15 years	4 (14%)
Years of experience in Critical Care	
Less than 5 years	18 (70%)
5-10	4 (14%)
10-15	4 (14%)
Greater than 15 years	1 (2%)
Level of Employment	
Full-time Position (>36 hours)	22 (84%)
Part-time Position	3 (8%)
Per Diem	3 (8%)
Level of Education	
Associate's degree	6 (16%)
Bachelor's degree	19 (68%)
Diploma	3 (8%)
CCRN certification	3 (8%)
Other degrees (not nursing related)	4 (12%)

The MDS-R allows for separate analysis of intensity and frequency. Each individual item can create a composite score (frequency multiplied by intensity [fxi]) allowing for a total composite score to be determined by adding each items composite score (fxi + fxi). The composite score thus ranges from 0-336 total for the 21 items scale. The system allows for items marked as not distressing or not experienced to be

eliminated, thus giving a more accurate reflection of moral distress.

The MDS-R is based on a Likert system, ranging from 0-4, for each of the 21 items listed. The mean scores for moral distress frequency and intensity (level of disturbance) were calculated separately for each question and are summarized in Table 2 on the next page. Depicted are the average scores for each item based on the 0-4 Likert scale that was provided by participants' answers. Moral distress frequency and moral distress level of disturbance scores that ranged from 0-1.33 are considered low, scores that range from 1.34 to 1.67 are considered moderate, and scores that range of 1.68 are considered high.

Mean frequency scores ranged from 0.53 to 3.17 based on the 0-4 Likert scale. There were 4 items that scored highest for moral distress frequency. The highest scoring item was "follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient" with a mean frequency of 3.17. The second highest scoring item was "witness medical students perform painful procedures on patients solely to increase their skill" with a mean frequency of 3.11. The two items that tied for third highest scores were "initiate extensive life saving actions when I think they only prolong death" (mean frequency of 2.60), and "continue to participate in care for a hopelessly ill patient...when no one will make a decision to withdraw support" (mean frequency of 2.60). The lowest-scoring items for moral distress frequency were "avoid taking action when I learn that a physician or nurse colleague has made an error and does not report it" (mean 0.53) and "assist a physician who, in my opinion, is providing incompetent care" (mean 0.53).

Table 2

MDS-R Scores

Moral distress item	Mean frequency	Mean intensity
1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.	1.85	2.50
2. Witness healthcare providers giving “false hope” to a patient or family.	1.92	2.14
3. Follow the family’s wishes to continue life support even though I believe it is not in the best interest of the patient.	3.17	3.33
4. Initiate extensive life-saving actions when I think they only prolong death.	2.60	3.21
5. Follow the family’s request not to discuss death with a dying patient who asks about dying.	1.39	2.64
6. Carry out the physician’s orders for what I consider to be unnecessary tests and treatments.	1.78	1.50
7. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.	2.60	3.21
8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.	0.53	2.29
9. Assist a physician who, in my opinion, is providing incompetent care.	0.53	2.95
10. Be required to care for patients I don’t feel qualified to care for.	1.07	2.46
11. Witness medical students perform painful procedures on patients solely to increase their skill.	3.11	1.78
12. Provide care that does not relieve the patient’s suffering because the physician fears that increasing the dose of pain medication will cause death.	1.03	2.21
13. Follow the physician’s request not to discuss the patient’s prognosis with the patient or family.	0.78	1.89
14. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient’s death.	0.85	1.89
15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	0.28	2.71
16. Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit.	0.75	2.39
17. Work with nurses or other healthcare providers who are not as competent as the patient care requires.	1.00	2.21
18. Witness diminished patient care quality due to poor team communication	1.35	2.46
19. Ignore situations in which patients have not been given adequate information to insure informed consent.	0.85	2.03
20. Watch patient care suffer because of a lack of provider continuity.	1.46	2.96
21. Work with levels of nurse or other care provider staffing that I consider unsafe.	1.28	3.00

Mean level of disturbance scores ranged from 1.5 to 3.33 (Table 2). Depicted are the average scores for each item based on the 0-4 Likert scales. There were three items that scored the highest for level of disturbance. The item that scored the highest was “follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient” with a mean of 3.33. The second highest scoring item was “initiate extensive life saving actions when I think they only prolong death” (mean 3.21). The third highest scoring item for level of disturbance was “continue to participate in care for a hopelessly ill patient...when no one will make a decision to withdraw support” with a mean of 3.21. The lowest-scoring item for moral distress level of disturbance was “carry out the physician’s orders for what I consider to be unnecessary tests and treatments” (mean 1.5).

Total composite scores for the scale can then be broken down into three categories with low levels of moral distress ranging from zero to 84, moderate levels of moral distress ranging from 85 to 168, and high levels of moral distress ranging from 169 to 336. The majority of the participants had composite scores that were considered to be in the low range. This accounted for 18 nurses (64%) who were considered to be in the low range. Another six (22%) nurses scored within the moderate range, and four (14%) participating nurses were considered to be in the high range in regards to overall moral distress.

The final questions on the MDS-R are not scored. These questions inquired about the participants’ work history in regards to moral distress. The MDS-R specifically inquires if one has ever considered leaving a position due to moral distress, left a previous position, or if they had considered leaving a previous position. It also inquires if

the participant is considering leaving their current position due to moral distress. There were two (7%) participants who chose not to answer the question. Of the nurses who participated, 13 nurses (46%) would not have considered leaving a position. Nine (32%) of the participants had considered leaving a position and six (21%) nurses left a position in the past due to moral distress. At the time of the survey, 22 (82%) of the participants would not leave their current position. In opposition to those 22 nurses, four (14%) would consider leaving their current position.

Next, the summary and conclusions will be discussed.

Summary and Conclusion

Mortality rates in critical care units exceed 50%, and providing quality end of life care to these patients is key for critical care nurses. Many staff nurses report leaving jobs in ICU and CCU because of constant exposure to a high stress environment, feeling burnt out and not being able to tolerate or control poor end of life care. Moral distress, or the conflict one feels when maintaining life which might not have quality, may be one reason that experienced nurses choose to leave critical care practice.

Moral distress (MD) is defined by the AACN as occurring when “you know the ethically appropriate action to take, but are unable to act upon it and you act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity” (2008, p.1). Moral distress is often mislabeled as stress, burnout, emotional exhaustion and job dissatisfaction, when it may actually be symptomatic moral distress. Moral distress leads to increased need for personal days, utilization of sick time and the potential for leaves of absences, leading to a potential for understaffing (Pendry, 2007). Literature points to end of life care as a major factor contributing to MD in critical care nurses (Gutierrez, 2005).

The purpose of this project was to explore the effects of moral distress on nurses in the critical care environment. A descriptive, exploratory design utilizing a self-report survey was the approach taken. Responses on Hamric’s Moral Distress Scale-Revised (MDS-R)(2012) were collected. The Moral Distress Scale-Revised (Hamric, Borchers, & Epstein, 2012) is a 21-item likert scale ranging from 0-4 and measures for separate analysis of intensity and frequency, as well as a composite score. A convenience sample of 28 critical care nurses working in a small community hospital with an 8 bed ICU and

an 8 bed CCU participated. Demographic data was collected, including age, highest level of education, years of experience as a registered nurse, years of experience as a critical care nurse, additional certifications and degrees and employment status (full time, part time, or per diem). Data were analyzed using descriptive statistics for means and percentages. Additionally correlations were analyzed between demographics and moral distress.

The majority of nurses (n=18; 64%) were identified as being in the low range for overall moral distress. Another six (22%) nurses scored within the moderate range and four (14%) participating nurses had high levels of moral distress. The literature points out several components that could explain why moral distress was relatively low in the sample. Aiken et al. (2011) suggested that a healthier work environment might decrease nurses' reports of moral distress. Corley (2002) also theorized several points, one being that nurses who work in supportive environments and organizations that recognize moral distress are less likely to experience the consequences of moral distress. In this study, ethical climate was not explored amongst participants.

Moral distress level of disturbance was moderate among this sample of critical care nurses, whereas moral distress frequency was low to moderate. This implies that moderately disturbing experiences occurred at a low to moderate frequency. Because frequent incidences of moral distress can lead to burnout, reducing onset of moral distress can lead to an overall decline of burnout amongst staff (Dalmoloin, Lunardi, Barlem, & Silveira, 2012). In this sample, infrequent morally distressing situations could be a significant factor in the reason behind participants having lower levels of moral distress.

The most morally distressing experiences, in terms of frequency and level of disturbance, were “follow the family’s wishes to continue life support even though I believe it is not in the best interest of the patient” and “initiate extensive life saving actions when I think they only prolong death”. This corresponds with findings by Gutierrez (2005) who concluded that the top reason for moral distress in critical care was that of overly aggressive treatment. Wiegand and Funk (2012) also found that the majority (73%; n=27) of nurses reporting moral distress were related to end of life care.

A lack of relationship between years of service and moral distress contradicts what current literature has explored. Borhani, Abbaszadeh, Nakhaee, and Roshanzadeh (2015) noted an inverse relationship between increasing age and years of service and the effects of moral distress. Their study identified that as nurses gain more experience facing moral challenges, they develop effective coping mechanisms, leaving moral distress to effect them less (Borhani et al., 2015). The lack of a relationship in this study was potentially due to the small sample size. Other limitations included a lack of diversity in age and experience amongst participants. The low participant rate was perhaps due to the limit on the amount time allowed for data collection (one week). A small percentage of nurses who participated in the study chose not to answer the final question regarding their consideration about leaving their current position. The researcher’s relationship to the participants, as a peer staff nurse, may have impacted responses to this and other questions.

Overall study findings indicated that critical care nurses experienced low levels of moral distress. However, four nurses were considering leaving their current position, two of which had scored in the high range for moral distress. With end of life care being the

main source of moral distress amongst critical care nurses, it is crucial to maintain staff that have developed the skills needed in dealing with this phenomenon. Sustaining a skilled and experienced staff allows those to mentor newcomers into being resilient leaders regarding moral distress in the future.

Next, recommendations and implications for advanced practice registered nurses will be discussed.

Recommendations and Implications for Advanced Nursing Practice

The study's findings are beneficial to Advanced Practice Registered Nurses (APRNs). Advanced Practice Registered Nurses are leading the way for nursing in clinical practice, education, and research. They are key players when it comes to change, often discovering and putting into practice the newest evidence-based practice principles and contributing to policy changes. Because of their influential presence, APRNs become monumental in decreasing moral distress.

Due to the complexities of the critical care area, APRNs work closely with registered nurses and other interdisciplinary staff. In having close working relationships with colleagues, APRNs are in a pivotal position to recognize moral distress amongst staff. As Pendry (2007) noted, nurses often seem unaware of the moral distress they experience and they tend to label their feelings as stress, burnout, emotional exhaustion and job dissatisfaction, when it may actually be symptomatic moral distress. The opportunity exists for APRNs to provide support for nurses and fellow APRNs and advocate for their well-being. This may in turn benefit patients, allowing nurses to be better advocates and deliverers of care. As noted in the literature, increased moral distress can lead to an array of physical symptoms for staff, leading to increased use of sick time, and understaffing, eventually causing poor outcomes for patients. Advanced practice nurses have the opportunity to intercept the potential cascade of events, improving patient care, patient outcomes and staff retention in their workplace and in the nursing profession.

An increase in ethical education is a worthwhile strategy against moral distress

(Burstion & Tackett, 2013). Advanced Practice Registered Nurses can continue to educate themselves on the most recent evidence--based practices regarding moral distress; this includes interventions such as the SUPPORT model. This model encourages a team-based dialogue focused on ethics-related conversations open to patients, families, and members of the healthcare team. It aims at highlighting individual, collective and leadership actions directed at moral distress. The AACN's *The 4 A's to Rise Above Moral Distress* is another tool that can aid in identifying and decreasing moral distress. By educating oneself, one is able to educate others on these concepts, empowering individuals to act as a positive agent when it comes to decreasing moral distress in the work environment.

Advanced Practice Registered Nurses are advocates for policy changes and enhance clinical practice by utilizing the latest evidence based practices. Prottas (2013) supported past literature in concluding that trusted leaders that are effective and hold a high standard of integrity model an example for employees. Advanced Practice Registered Nurses, as leaders, are held to a high standard regarding modeling a high standard of behavior. The ability to identify moral distress in practice is a crucial step towards policy change. Recognizing the problem and utilizing ethical education in practice creates an argument for change needed. As nursing leaders, APRNs can voice a need for recognition of moral distress in nursing and identify a need for policy change in an effort to keep nurses in the profession, improve ethical climate and decrease moral distress on an organizational level.

Advanced Practice Registered Nurses are trained to apply evidence-based practices into the clinical setting. Future research could focus on the effectiveness of

selected interventions. These include use of the SUPPORT model and the AACN's *The 4 A's to Rise Above Moral Distress*, allowing for improvement of current models or development of new strategies. As technology continues to advance, APRNs will be faced with new ethical dilemmas. As these dilemmas become more evident, there will be a gap in knowledge as to how to effectively cope with the moral distress within those situations. In addressing this gap, APRNs will need to update assessment strategies, implement effective, evidence-based interventions and evaluate impact in order to face new and emerging dilemmas in practice.

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Appendix A

Permission for use of Moral Distress Scale – Revised

Dear Ms. Gonzalez,

Please forgive my delay in responding to your request. Thank you for your interest in the Moral Distress Scale – Revised (MDS-R). There are six versions of this scale: nurse, physician and other healthcare professional versions for adult settings (including ICUs and other inpatient units), and parallel versions for healthcare providers in pediatric settings. The MDS-R is designed for providers who deliver direct patient care in inpatient settings. The instrument shows evidence of reliability and validity, published in the *American Journal of Bioethics: Primary Research*:

Hamric, A.B., Borchers, C.T., & Epstein, E.G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Primary Research*, 3(2), pp. 1-9.

You should read this article before deciding whether the MDS-R will be appropriate for your project; let me know if you need me to send you a copy.

The MDS-R has a unique scoring scheme, designed to give a measure of current level of moral distress. Conceptually, items that have never been experienced or are not seen as distressing do not contribute to an individual's level of moral distress. As noted, the Likert scales for each item have been adjusted to 0-4 from Corley's original 1-7 scoring range. To generate a composite score, the frequency score and intensity (named "level of disturbance") score for each item should be multiplied; note that this results in eliminating items never experienced or not distressing from the composite score. In addition, items rarely experienced or minimally distressing have low scores and items experienced frequently and as most distressing have higher scores. Each item product of frequency and intensity will range from 0 to 16. To obtain a composite score of moral distress, these individual item products should be added together. Using this scoring scheme allows all items marked as never experienced or not distressing to be eliminated from the score, giving a more accurate reflection of actual moral distress. The resulting score based on 21 items will have a range of 0 – 336.

I am happy to give you permission to use the MDS-R. I have attached the adult nurse version. I do request that you let me know your findings from using the MDS-R. If you decide to change items for particular specialty purposes or for different settings or outside the USA, I request that you keep me informed of the changes you make and the results

you obtain.

Best wishes,

Ann Hamric

Ann B. Hamric, PhD, RN, FAAN

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Virginia Commonwealth University

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[illegible]

If there are other situations in which you have felt moral distress, please write them and score them here:										

Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

No, I've never considered quitting or left a position _____

Yes, I considered quitting but did not leave _____

Yes, I left a position _____

Are you considering leaving your position now? Yes No

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Appendix C

Demographic Data

Please provide the following information. As with your answers to other portions of this survey, your responses will be kept confidential.

1. Age:

____ <25

____ 26-35

____ >35

2. Highest level of education:

____ Associate degree in nursing

____ MSN

____ Diploma degree in nursing

____ Doctorate

____ Bachelor's/BSN

____ Degree in field other than nursing. Indicate field _____

3. How many years have you worked as an RN?

____ <1 year

____ 1-5 years

____ 5-10 years

____ 10-15 years

____ >20 years

4. How many years have you worked as an RN in a critical care setting, if any:

____ < 1 year

_____1-5 years

_____5-10 years

_____10-15 years

_____>20 years

5. What certifications, if any, do you currently hold? (I.e. CCRN)

6. Is your current position:

_____Full time (36+ hours/week)

_____Part time

_____Per Diem