Moral Distress: What Chaplains Can Do to Help Make All Things New

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Moral distress has gained pervasive momentum as a topic of concern especially for nurses in in-patient settings. (Weigland, Funk, 2012; Browning, 2011, Gallagher, 2012)

Multiple studies have focused upon the quantification of moral distress through the development of survey tools to measure the level of distress in specific populations. (Corley, Elwick, Gorman, 2001; Hamric, Borchers, Epstein, 2012; Wocial & Weaver, 2013)

We don’t know what type of interventions are effective in reducing moral distress. Leggett, Wasson, Sincore & Gamelli, 2013 reported an increase in moral distress on a burn unit after a 6 week intervention.
Nursing Challenges
Nurses need to respond to:

- Internal environmental shifting such as continually changing patient conditions and acuity levels (Casida & Pinto-Zipp, 2008)
- Life and death issues
- Introduction of new technology, medications and procedures
- Differing staffing models, nurse to patient ratios, work-force shortages. (Wagner, Merk, Kirsch, Hepworth & Williams, 2002)
- Appropriate care delivery processes to avoid errors and patient harm
Moral Distress

“The pain or anguish affecting the mind, body or relationships in response to a situation in which the person is...

- aware of a moral problem,
- acknowledges moral responsibility, and
- makes a moral judgment about the correct action yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing.” (ANA, 2008)
Sources of Moral Distress

Moral distress occurs when persons know (OR believe they know) the ethically appropriate course of action, but cannot carry out that action because of obstacles:

- Lack of time
- Lack of supervisory/administrative support
- Institutional or legal constraints
- Tremendous responsibility for patient care but little authority
- Physician power (Jameson, 1993)
Perceived Causes of Moral Distress

- Harm to patients – overly aggressive treatment
- Inadequate pain management
- Ineffective communication
- Unclear treatment goals
- Disrespecting, disregarding patient/family choices
- Incomplete or inaccurate disclosure
- Lack of informed consent
- Objectifying patients
- “Futile” treatment
- Authority imbalance & IDT conflict
- Inappropriate allocation of resources
Daily Sources of Diminished Resilience - Tugging at Heartstrings

- Emergent needs and fast pace
- Minimal (or lack of) extended interactions
- Belief that professionals must learn to control and hide feelings
- Unresolved unhappiness and emotional pain in personal and/or professional life
- Emotional burden of neutrality
- Jumping from crisis to crisis; needing to deny or minimize the emotional strain or pain
- Difficulty in setting realistic priorities and boundaries, and in asking for help
- Exposure to psycho-social-spiritual distress in addition to other stressors
- Decreased sensitivity to one’s own stressors
- Inability to bond or connect with those in one’s care
Empirical Evidence of the Implications of Moral Distress

Consequences in nurses’ lives:
- Stress, burnout, job dissatisfaction; departure from the work environment and from nursing (Hamric & Blackhall, 2007; Elpern, Covert, Kleinpell, 2005)

Immediate effects:
- Anger, cynicism, silent withdrawal and depression (hitting the wall and feeling nothing...“whatever”) (Wilkinson, 1988)

Long-term effects:
- Self worth is jeopardized; personal and professional relationships may be affected; psychological changes, behavioral manifestations and physical symptoms occur (Corley, 1995)
Moral Distress: Wounds and Scars

- 1 in 3 nurses have experienced moral distress (Redman & Fry, 2000)

- Almost 50% of nurses studied left their work unit or the profession due to moral distress (Millette, 1994)

- The intensity of moral distress was even greater than the frequency (Corey et al. 2001; 2005; Pauly et al; 2009; Rice et al. 2008)
Impact of Moral Distress: Painful Feelings and Psychological Disequilibrium

- **Reactive Symptoms:**
  Guilt, a sense of compromised integrity, becomes “Moral Residue”

- **Moral Residue**
  “that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves, or allowed ourselves to be compromised.” (Webster and Baylis, 2000)

- **“Crescendo Effect”**
  Cumulative moral distress + moral residue. (Epstein and Hamric, 2010)
A Model Linking Moral Distress and Moral Residue: the Crescendo Effect

(Moral distress)

(Moral residue)

(Moral residue crescendo)

(Time)

(Hamric, 2011)
Pre-Moral Distress Interventions

Spiritual Care & Employee Assistance Program

- Group and 1:1 Debrief Sessions facilitated by Spiritual Care Resources (SCR) and Employee Assistance Program (EAP)
  - Standard and proactive for any issue, not only Moral Distress
  - Rituals created from and embedded in organizational culture

- Schwartz Rounds implemented in 2012
  - Monthly, interdisciplinary forum to discuss emotional aspects of being a care provider
  - Co-facilitated by EAP Coordinator and Advanced Practice Chaplain
Research Study Purpose and Question

Purpose

- Gain understanding of existing hospital unit-based levels of moral distress.
- Determine if a defined intervention produces quantifiable results related to changes in distress levels.

Question

- Do nursing unit employees exposed to supportive interventions exhibit an improvement in moral distress?
Project Road Map

**Conduct MDS Survey**

**Quantitative**
- Launch survey
- Provide results to leadership
- Provide results to staff

**Qualitative**
- Develop an action plan including 3 prong intervention (Counseling, Ethics Committee Consult, & Cognitive Learning)
- Roll out education to staff

**Develop and Trial Implementation Plan**

**Develop & Implement Interventions**

**Qualitative**
- Begin offering Ethics Committee Consults, Counseling and Cognitive Interventions
- Conduct debriefings to validate effectiveness

**Quantitative**
- Compare pre and post survey responses
- Recognize situational challenges

**Repeat MDS Survey**

- Jan 2012
- April-July 2012
- Aug/Dec 2013
- Jan 2014
Survey Process

- Moral Distress was defined as occurring when professionals perceive that they cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints.

- The survey tool (MDS) measured the frequency that different situations have been experienced by staff and how disturbing the experience was for each individual.

- The survey had 20 questions and took approximately 15 minutes to complete.
Participation in Initial MDS Survey

- 474 respondents, which represented a 44% response rate
- 81.5% were staff nurses
- 88% were female with 68.5% of White/Caucasian background
- 62% were BSN
- Most frequently reported age group was 40 to 49 years
- Wide range of experience/tenure at the organization
1. **Counseling** - Provide support and counsel to the affected staff via Employee Assistance Program (EAP) and Pastoral Care using *The 4A’s*. The purpose of this support was to allow time for staff in a private setting to recall distressful events; to have time to vent about their experience and the experience of the patient and family.

2. **Ethics Committee Consult** – Provide ethical decision making and support.


(Source: RIC, Chicago, IL 2011)
## Delineated Interventions

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<thead>
<tr>
<th>Intervention</th>
<th>Control Group</th>
<th>Experimental Group</th>
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<tbody>
<tr>
<td>Counseling/Support</td>
<td>X</td>
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<tr>
<td>General Education presentation on Moral Distress</td>
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<td>X</td>
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<td>Ethics Consultation</td>
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<td>X</td>
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<td>Cognitive learning based on identified knowledge gaps</td>
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<td>X</td>
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<tr>
<td>Access to Moral Distress Hotline</td>
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<tr>
<td>Targeted rounding by Chaplain and/or EAP</td>
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<td>Formal debriefing sessions for Moral Distress</td>
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<tr>
<td>Educational flyers on Moral Distress posted on unit</td>
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Moral Distress Education

- June 2012: Initial discussions regarding specific training for Moral Distress with Chaplain, EAP Coordinator and Associate Chief Nursing Officer
- July 2012: Moral Distress Steering Committee formed
- October 2012 - November 2012: “Proactively Responding to Moral Distress” presented by Advanced Practice Chaplain and EAP Coordinator:
  - Defined Moral Distress
  - Identified signs and symptoms of Moral Distress and its impact
  - Introduced the 4 A’s Method to Proactively Respond to Moral Distress
  - Created awareness of organizational resources available when Moral Distress occurs
  - Presented 12 sessions to 167 participants
- November 2012: Schwartz Rounds Moral Distress Panel Presentation; 40 participants
Moral Distress Education

- January 2013 – May 2013 Clinical Group Presentations
  - Ethics Committee (16 participants)
  - Operational Leadership (18 participants)
  - Mother/Baby staff (50 participants)
  - Case Management Team (2 presentations, 43 participants)

- April 2013
  - Moral Distress Algorithm developed and distributed
  - Moral Distress Phone Hotline activated (monitored by Chaplain and EAP)
“So that’s what I’m feeling! Now what do I do???”

Proactively Responding to Moral Distress

Objectives:

- Define Moral Distress
- Identify the signs and symptoms of Moral Distress and its impact
- Utilize the 4 A’s method to proactively respond to Moral Distress (AACN toolkit: 4 A’s To Rise Above Moral Distress)
- Become more aware of the organizational resources available when Moral Distress occurs
The 4A’s to Rise Above Moral Distress

1. ASK

You may be unaware of the exact nature of the problem but are feeling distress.

Ask:

- Am I feeling distressed or showing signs of suffering?
- Is the source of my distress work related?
- Am I observing symptoms of distress within my team?

Goal: You become aware that Moral Distress is present.
The 4A’s to Rise Above Moral Distress

2. AFFIRM

- Affirm your distress and your commitment to take care of yourself.
- Validate your feelings and perceptions with others.
- Affirm your professional obligation to act.

Goal: You make a commitment to address Moral Distress
The 4A’s to Rise Above Moral Distress

3. ASSESS

Identify the sources of your distress.
- Personal
- Environment

Determine the severity of your distress.

Contemplate your readiness to act.
- You recognize there is an issue but may be ambivalent about taking action to change it.
- You analyze risks and benefits.

Goal: You are ready to make an action plan.
The 4A’s to Rise Above Moral Distress

4. ACT

Prepare to Act
➢ Prepare personally and professionally to take action.

Take Action
➢ Implement strategies to initiate the changes you desire.

Maintain Desired Change
➢ Anticipate and manage setbacks.
➢ Continue to implement the 4A’s to resolve Moral Distress.

Goal: You preserve your integrity and authenticity.
Moral Distress Decision Tree
(Gut Check)

Disruptive Patient
and/or Family

Test Question
- Patient / Family of disruptive or inappropriate behavior that has become challenging to manage

Follow Disruptive Patient Flow Diagram

Moral Distress

Test Questions
- Individual / Team feeling powerless to act according to one's personal and professional values

Call Moral Distress phone number (630) 533-6246

Spiritual Care / EAP Conducts a consultation

Confidential conversations individually (in person or by phone) to discuss concerns

Education (if needed)
- One to one support
- Inclusion of affected / involved staff
- Discussion of issues, reaction to strategies and how to work through the situation
- All situations are considered opportunities for the organization and are non punitive in nature

Consultation:

Ethics Committee Consult

Test Question
- Is there interference:
  - In an individual's right to choose
  - Promoting the well being of others
  - Doing no harm
  - Treating everyone equally

Contact Palliative Care RN for a consult (630) 533-4547

Northwestern Medicine
Clinical Interventions for Experimental Units

- Staff were encouraged by managers to contact either Spiritual Care and/or EAP directly for confidential support.

- Spiritual Care and/or EAP educated managers/leaders/CSC’s on how to support and provide periodic check-ins with staff.

- Educational flyers (“What is Moral Distress?” and “The 4A’s”) were posted and distributed on experimental units to reinforce learning and support resources available to staff.

- Attendees at monthly Schwartz Rounds sessions were reminded to contact either Spiritual Care and/or EAP for confidential support.
Clinical Interventions for Experimental Units

Consultation with Unit Managers around distressful situations resulted in supportive interventions by Spiritual Care and EAP:

- Spiritual Care rounded on the units and informally checked-in with individual staff.
- Spiritual Care provided 1:1 and small group support for affected staff.
- Spiritual Care and/or EAP conducted formal debriefing sessions during occurrences or shortly thereafter.
- Sessions were open to all staff and were voluntary.
Quantitative Findings

- Significant overall decrease in overall Total scores between Pre Intervention and Post Intervention groups for both the control and experimental units.

- Significant difference in this decline between Control and Experimental groups, with the Control group having lower overall change in Total scores when compared to the Experimental group.

- Average total scores for both the pre-intervention and post-intervention respondents were significantly higher for those who indicated they were currently considering leaving their position.
Total Score: Pre-Survey vs. Post Survey

![Chart showing Pre-Survey and Post Survey scores across different units: Mother Baby, 2nd Floor, 3A, 3B, 3C, 4th Floor, ICU, CCU. The chart displays the mean MDS-R Total scores for each unit with bars indicating Pre-Survey on the left and Post Survey on the right.](chart_image)
Total Score: Pre-Survey vs. Post Survey
Overall Total Score: Pediatric vs. Adult Nurses

![Bar chart showing the mean MDSRTOT scores for pediatric and adult nurses before and after a survey. The chart compares pre-survey and post-survey scores for pediatric and adult nurses.]
Overall Total Score: ICU vs. Non-ICU Nurses

Mean MDSRTOT

- ICU
- Non-ICU

Pre-Survey
Post Survey
Next Steps

- Provide additional education that grew out of the Moral Distress initiatives.

- Through the use of focus groups, determine the nature and source of the “distress” experienced by nurses.

- Based on analysis of focus group data (inpatient nursing):
  - define the dimensions of distress
  - select a quantitative tool to measure the prevalence of the phenomenon, which is suspected to be Moral Distress.

- Based on the results of the qualitative and quantitative phases of this study, propose strategies to assist in the management of the distress.
Additional Moral Distress Education

- November 2013 – May 2014:
  Practicing with Kindness, Compassion & Firmness:
  Setting Appropriate Boundaries with Patients and Families
  - Panel Presentations: Chaplain, EAP, Patient Relations, and Patient Satisfaction

- July 2014 - October 2014:
  Managing Challenging and Disruptive Patients and Families
  - Panel Presentations: Chaplain, EAP, Patient Relations, and Patient Satisfaction

- November 2015 – Present:
  Follow-up to Practicing with Kindness, Compassion & Firmness:
  Setting Appropriate Boundaries with Patients and Families
  - Panel Presentations: Chaplain, EAP, Patient Relations, and Patient Satisfaction
Can you tell me what interventions you recently received related to a Moral Distress situation?

Can you tell me what was most helpful with the interventions?

Is there anything that you recommend that we change about the interventions (think about the time, place or the type of interventions)?

Is there anything that you would have preferred to have happen that was not offered to you?

Can you comment on the overall effectiveness of the interventions?

Can you describe how you think that you have resolved your feelings as a result of the interventions?

Was there anything not resolved that you would like to share?
Qualitative Findings

Recurring Themes from Staff Nurses’ Focus Groups: January - September 2014

- “Being checked in on was wonderful, was able to talk with colleagues…”
- “Had flashbacks and panic attack upon coming back to work the next day...everyone was supportive and great.”
- “Still having mini flashbacks to that day...still have a sense of dread coming into work, bad dreams still happen...Biggest struggle is trying to honor patient’s memory without torturing myself.”
- “It’s that kind of support (from hospital resources/colleagues) that make a staff member want to stay....”
- “Having the opportunity to discuss with someone in the group who has been though a similar situation was helpful.”
- “Interventions helped to normalize my reaction.”
Qualitative Findings

Recurring Themes from Nurse Leaders Focus Groups: April – August 2014

- “Learning how to recognize it (Moral Distress) and give it a name. Hearing what others went through and learned; what they experienced.”
- “Having tools for early intervention. It’s almost like you need AA for Moral Distress. It takes some thinking and emotional inventory. I wish there was a ten question tool you could ask yourself.”
- “If you don’t reach closure, what’s the next step? It’s our job and we need to move on but you always wonder what happened in the time you were gone.”
- “Learning how to triage would be ideal. How do I deal with knowing if I should discuss it right away or let [staff] go home and bring it up again the next day? Knowing when to intervene and when not to is hard.”
- “Change the culture of thinking that ICU nurses should be tough and not need to talk and get away from certain situations. If I do that I don’t have the backup and it gives me an ethical dilemma.”
The study findings suggest that distress levels in nurses can be reduced with a three-pronged intervention bundle over time.

What are we learning?

What’s next...?
The Paradoxical Nature of Empathy & Compassion

- Neuroscience and Social Psychology Research are studying human responses to suffering related to empathy and compassion.

- When arousal in response to another’s suffering is not regulated, it can give rise to personal distress (Eisenberg, et al., 1994), which undermines the possibility for expressing compassion.

- Lack of self-regulation and hyper-arousal can result in self-focused behaviors such as avoidance or hyper activity aimed at relieving the distress.

- Lack of self regulation leading to empathic “over-arousal” may shift the focus from relieving the distress of another to relieving one’s own distress.
Therapeutic Intervention: Learnings from Neuroscience Research

Somatic therapies broaden traditional (cognitive) approaches to trauma treatment

- Trauma can result in:
  - Failure of the body, psyche and nervous system to process adverse events
  - Fragmented memories stored in parts of the brain with no access to speech or reasoning

- Repetitious recounting of distressful experiences has limited impact on healing

- Emotional support and connection with others can normalize distressful experiences, but also lead to:
  - Re-traumatization
  - Long-term emotional residue, even after initial “emotional distance” is achieved

- Cognitive thinking as a single resource can result in:
  - Powerlessness
  - Helplessness/hopelessness
  - Physiological overwhelm in nervous system, particularly amygdala
  - Inability to achieve deeper embodiment of the experience

*Dr. Bessel VanderKolk – The Body Keeps the Score (2014)*
Recommendations

Launch Phase III of Research Project

➢ Educate and support nurse leaders:
  - To identify Moral Distress in staff and provide “in the moment” support
  - To access additional resources (individual and/or staff debriefs) via a process that respects staff self-determination in self-care

➢ Provide educational seminars:
  - Emotional Intelligence
  - Resilience Theory
  - Somatic Regulation Interventions
Future Research

- Longitudinal studies within the nursing profession are needed to determine the sustainability of interventional methods.

- Comparing specialty units across larger organizations should be explored to understand the effectiveness of the interventions over time.

- Other sub-groups may benefit (e.g. ancillary support departments including surgical, radiological, and laboratory services).

- Intervention principles need to be practiced as they are not intuitive to most health care organizations.
  - Continual training and retraining of staff on interventions may provide insight into how best to improve these methods within hospital settings.
Questions?