Can Interventions Reduce Moral Distress?
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History of Central DuPage Hospital

1958: Citizens movement to open a local hospital
1964: CDH opens its doors with 113 beds and 66 physicians
Today: CDH is a 347 bed, nationally recognized regional destination medical center

Hospital Operations

Inpatient Beds: 347
- Adult ICU
- Cardiac ICU
- Med/Stepdown
- Obstetrics (MCU)
- Pediatrics (Level 1)
- Behavioral Health

Average Daily Census: 275

Outpatient Sites of Services
- 40+ Cadence Physician Group (CPG) Sites: Primary Care and Specialty Care
- 7 Convenient Care Sites: 1 Express Care Site
- 2 Cancer Centers, CDH Proton Center & Breast Health Center
- Behavioral Health Services
- Outpatient Surgical Services
- Pain Clinic
- Rehabilitation Services
- Home Health and Hospice Services*
- Not under hospital license

*Not under hospital license
While we do not manage for awards, we are always honored to receive them.

Leapfrog Top Hospital Award
- CDH was listed for the 3rd location in the last nine years (2006-2010)
- CDH was awarded the Leapfrog Group Top Hospital Award in 2014

CDH's Orthopaedics program was ranked #28 in the nation (2014)

National Recognition
- CDH is an ANCC‐recognized Magnet hospital
- <6% of hospitals are Magnet recognized

HealthGrades Awards
- CDH received the Outstanding Patient Experience Award 2012, 2013, and 2014

Nursing Challenges
Nurses need to respond to:

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

Current Perspective
- Moral distress has gained pervasive momentum as a topic of concern especially in the in‐patient hospital settings (Leggett, Wasson, Searce & Carroll, 2010).
- 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, Elswick, Hamric, & Gorman 2001; Henrich, Scherken, Spinet, 2012; Wood & Weaver, 2015).
- We don't know what type of interventions are effective in reducing moral distress. Leggett, Wasson, Searce & Carroll (2010) reported an increase in moral distress on a burn unit after a 6 week intervention.
Moral Distress Interest

- Seen as a key factor negatively affecting health care providers (Jameton, 1984).
- Experienced by those such as nurses who feel caught in the middle between the needs of the patient and the demands of hospital. Strong tension between power and powerlessness (1995).
- Further a person in such a position has a tremendous amount of responsibility in caring for patients but little authority (1993).

Moral Distress Linkages

- People experiencing moral distress act in a manner contrary to their personal and professional values. There is a psychological disequilibrium that occurs when the ethically right course of action is known but cannot be acted upon:
  - Not just emotional distress - perception that values are being violated
  - Occurs when the person raising the question is not in charge
  - Professional or personal risks for raising a question (Iomdin & Hamric 2006).

Further Empirical Evidence

- Moral distress has been associated with consequences:
  - Stress, burnout, job dissatisfaction, departure from environment an nursing (Hamric & Blackhall, 2007; Elpern, Covert, Kleinpell, 2005)
  - Immediate effects
    - Anger, cynicism, silent withdrawal (Hitting the wall and will not feel anything: "whatever") and depression (Wilkinson, 1988)
  - Long term effects
    - Self worth is jeopardized, personal and professional relationships may be affected, changes psychologically, behavioral manifestations and physical symptoms (Corley, 1995).
Moral Distress Definition

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 support
- Institutional or legal constraints
- Physician power (Jameton, 1993)

Moral Distress Characteristics

Painful feelings and psychological disequilibrium

- Initial: frustration, anger, anxiety
- Reactive: guilt, compromised integrity, moral residue
  - 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 & Bayliss, 2000)


[Note: Diagram and reference to Harris, 2011]
Strong Evidence

- Nursing profession finds value in studying moral distress.
- Moral distress has significant consequences.
- Lack empirical evidence to support best practices
  - No intervention studies target time identification or mediation of moral distress over prolonged periods of time.

Moral Distress Study at CDH - Original Design (Phase 1)

- 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 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.

Phase I - Outcomes

- Determined prevalence of moral distress versus compassion fatigue as a priority through focus group feedback.
- Reviewed multiple moral distress survey tools and identified preferred tool for CDH.
- Changed project leadership.
**Study Purpose and Question**

**Purpose**
- Gain understanding of existing hospital unit based level of moral distress.
- Determine if defined intervention produces quantifiable results related to change in distress levels.

**Question**
- Do nursing unit employees exposed to supportive interventions exhibit an improvement in moral distress?

**Eligibility Criteria**

**Inpatient Nursing Units**

**Target** - Inpatient nurses

**Control Units:**
- Pediatrics, PICU, NICU, Mother Baby, Labor and Delivery, 2 Adult Surgical units, Cardiology and a Step Down unit

**Experimental Units:**
- 3 Medicine units, Neuro unit and 2 Adult ICU's

**Phase II - Research Design**

- Mixed methodology approach.
- Sequential exploratory strategy - quantitative methods followed by qualitative methodology.
- Through a field study multiple units are being investigated using multiple data collection procedures over a 24 month period of time.
Project Road Map

24 Month Road Map

- Develop and implement interventions
- Review & revise interventions
- Qualitative
  - Beeg in offering Ethics Committee Consults, Counseling & Cognitive Learning & Roll out education to staff
- Quantitative
  - Launch survey
  - Provide results to leadership
  - Provide results to staff

Presentation Steps

- Story Behind the Development of the Interventions
- Results
  - Demographics
  - Quantitative
  - Qualitative
- Findings
- Conclusions
- Limitations
- Recommendations

Delineated Interventions

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<tr>
<th>Intervention</th>
<th>Control Group</th>
<th>Experimental Group</th>
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<tr>
<td>Teaching Support</td>
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<td>Modified Education presentation on Moral Distress</td>
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<td>Ethics Consultation</td>
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Pre-Moral Distress Interventions

Spiritual Care & Employee Assistance Program

- Group and 1:1 Debrief Sessions facilitated by Employee Assistance Program (EAP) and Spiritual Care Resources (SCR)
  - 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

Pre-Moral Distress Education

Pediatric Education Days

- Presented by EAP Coordinator
- 3 days in 2012; 4 hours each day
- Topics
  - Professional Boundaries
  - Moral Distress
  - Compassion Fatigue

Moral Distress Education

Timeline - Exploring New Ground

- June 2012
  - Initial discussions re specific training for Moral Distress with Chaplain, EAP Coordinator and Chief Nursing Officer
- October 2012 – November 2012
  - Educational program presented by Chaplain and EAP Coordinator
    - Define moral dilemma
    - Identify the signs and symptoms of moral dilemma and its impact
    - Utilize the EAP method to assistively respond to moral dilemma
    - AACN toolkit: 4 A’s To Rise Above Moral Distress
  - 12 live sessions offered with 167 total participants
- December 2012
  - Moral Distress Panel discussion at Schwartz Rounds with 40 participants
Moral Distress Education
Timeline – Exploring New Ground

- January 2013 – May 2013
  - Clinical Group Presentations
  - Ethics Committee (16 participants)
  - Operational Leadership (18 participants)
  - Case Management (two presentations, 43 participants)

- April 2013
  - Moral Distress Algorithm developed and distributed
  - Moral Distress Phone Hotline activated

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 is to allow time for staff in a private setting to recall the event and time to vent about their experience and the experience of the patient and family which is ultimately intended to promote healing.

Ethics Committee Consult: Provide ethical decision making and support.

Cognitive Learning: Offer education by physician and nursing leadership related to assessment and treatment. (Source: RCC, Chicago, IL 2011)

Clinical Interventions for Experimental Units
Consultation with Unit Managers around distressful situations resulted in supportive interventions by EAP and Spiritual Care:

- 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.
- EAP and/or Spiritual Care conducted formal debriefing sessions during occurrences or shortly thereafter. Sessions were open to all staff and were voluntary.
Clinical Interventions for Experimental Units

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

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Survey Process

**Definition:** Moral Distress was defined as occurring when professionals 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.
Results

- 474 respondents which represented a 44% response rate
- 83.5% 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

Overall MDS-R Total Score
Pre Survey vs. Post Survey

Figure 2. Overall MDS-R Total Score: Controls vs. Experimental
Figure 3. Overall MDS-R Total Score: Pediatric vs. Adult Nurses

Figure 4. Overall MDS-R Total Score: ICU vs. Non-ICU Nurses

MDS-R Total by Unit Data
Findings

- Significant overall decrease in overall MDS-R Total scores between Pre Intervention and Post Intervention groups (t=6.712, p<.001; see Figure 1) for both the control and experimental units.
- Two-Way ANOVA revealed that there was a significant difference in this decline between Control and Experimental groups (F=4.413, p<.05), with the Control group having lower overall change in MDS-R Total scores when compared to the Experimental group.

Debriefing Script

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)?

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?

Focus Groups for Staff

January – September 2014
- 8 Sessions offered (2 attendees)
- Medical Oncology (6 attendees)

Qualitative Comments:
- "Being checked in on was wonderful, able to talk with colleagues..."
- "Wasn't thrilled at first,但 was great." (same for the rest)
- "Saw what you did, but it didn't make the problem go away..."
- "In the same situation, would you do the same?"
- "Making the opportunity to discuss with someone in the group who has been through a similar situation was helpful..."
- "Interventions helped to normalize my reaction..."
Focus Groups for Unit Leaders

April – August 2014
- 2 Medical Oncology sessions (5 participants)
- ICU Clinical Staff Coordinators (12 participants)

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<th>Themes</th>
<th>Description</th>
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<td>Recognizing and Framing</td>
<td>Early Intervention</td>
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<tr>
<td>Leadership</td>
<td>Change</td>
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Qualitative Comments

- “Learning how to recognize it 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 8 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 [I should discuss it right away] or will I go home and bring it up against the next shift? Knowing when to intervene and when not to be a barrier.”
- “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.”

Conclusions

The study findings suggest that distress levels in nurses can be reduced with a three-pronged intervention bundle over time.

Limitations

- Study was conducted in one community hospital which may not be generalizable to other health care settings or academic facilities.
- Controls were not established to ensure that the interventions were carried out effectively, reinforced, embedded or evaluated.
- Changes that occurred within the organization during the study period may have had an impact on the results.
Therapeutic Intervention Learnings

Recommendations 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
  - Repetitive recounting of distressful experiences has limited impact on healing

- Emotional support and connection with others, while normalizing distressful experiences, can lead to:
  - Emotional distance

- Cognitive thinking as a single resource can result in:
  - Powerlessness
  - Helplessness/hopelessness
  - Inability to achieve deeper embodiment of the experience

- The body keeps the score.

Experiential Interventions

- Somatic Experiencing (SE) — using the whole body, psychologically and physiologically, to build capacity to expand and regulate psychological and emotional experiences.
  - Supports de-sensitization and re-regulation of the nervous system, particularly amygdala
  - Inability to achieve deeper embodiment of the experience

- Dr. Bessel Van der Kolk – The Body Keeps the Score (2014)

CDH Code Grays 2012-Current

Consistent need for education and training across CDH clinical departments

*2012 data only includes August to December
MDS-R Total by Unit Data

Code Gray Reduction
Through focused BHS initiative, code grays continue to trend downward

Extending BHS Hospital Initiatives

Supporting other clinical areas that treat patients with behavioral health needs

- Designing dedicated spaces in the Emergency Department to accommodate behavioral health patients with safety modifications
- Continuing patient observations in the ED
- Providing specialty training to the social medicine teams to treat patients with significant mental health co-morbidities through a partnership of the hospital, psychiatrists and nursing
- Training inpatient hospitalists in detecting and managing behavioral patients
- Sharing ongoing education for the expert care needed for managing difficult medical patients with psychiatric needs including medication management and de-escalation techniques
- Launching a Consult Liaison Service in July
Recommendations

Launch Phase III of Research Project

- Educate and support of nurse leaders:
  - To identify moral distress in staff and provide “in the moment” support
  - To access additional resources (individual and/or staff deidentifiy) as a process that requests staff self determination in self-care
- Provide educational sessions:
  - 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 be understood the effectiveness of the interventions over time.
- Other subgroups 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.
  - Continuing training and retaining of staff on interventions may provide insight into how best to improve these methods within hospital settings.

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