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Can Interventions Reduce Moral Distress?

Session #

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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

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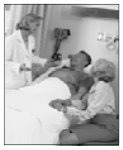
Hospital Operations



Inpatient Beds: 347

- Adult ICU
- Cardiac ICU
- Med/Surg
- OB/Gyn
- Pediatrics/PICU
- Neonatal (Level III)
- 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

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National Recognition

While we do not manage for awards, we are always honored to receive them

Truven 100 Top Hospitals Award
- CDH has been on the list eight of the last nine years (2006-2010, 2012-2015)

US News and World Report
- CDH was ranked the #9 hospital in Chicagoland and #9 in Illinois (2014)
- CDH's Orthopaedics program was ranked #28 in the nation (2014)

Leapfrog Top Hospital
- CDH was awarded the LeapFrog Group Top Hospital award in 2014
- CDH was one of only 94 hospitals from around the country to receive this distinction

Cancer Program
- CDH is ACS Commission on Cancer accredited with commendations
- CDH Breast Health Center is accredited by NAPBC

Magnet Status
- 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
- CDH has 11 5-Star Ratings

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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.

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Current Perspective

- Moral distress has gained pervasive momentum as a topic of concern especially in the in-patient hospital settings (Weigand, Funk ,2012; Browning, 2011, Gallagher, 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, 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, Sinacore & Gamelli (2013) reported an increase in moral distress on a burn unit after a 6 week intervention.

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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).

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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 (Gordon & Hamric 2006).

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Further Empirical Evidence

- Moral distress has been associated with consequences:
  - Stress, burnout, Job dissatisfaction, departure from environment and 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 maybe affected, changes psychologically, behavioral manifestations and physical symptoms (Corley, 1995).

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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)

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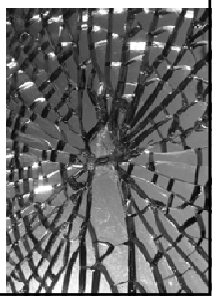
Moral Distress *Characteristics*

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)



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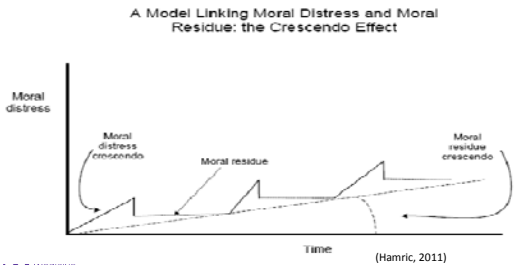

(Hamric, 2011)

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 targeting identification or mediation of moral distress over prolonged periods of time

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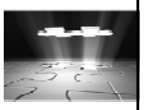
Moral Distress Study at CDH - Original Design (Phase 1)

- 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.



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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.

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Study Purpose and Question

Purpose

- Gain understanding of ***existing*** hospital unit based level of moral distress.
- Determine if a 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?

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Eligibility Criteria

Inpatient Nursing Units

Target – Inpatient nurses

Control Units:
Pediatrics, PICU, NICU, Mother Baby, Labor and Delivery, 3 Adult Surgical units, Cardiology and a Step Down unit

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

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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.

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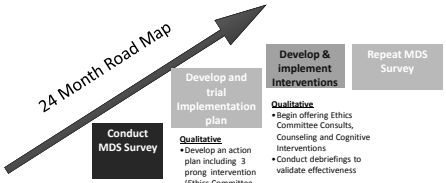
Project Road Map



Conduct MDS Survey

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

Develop and trial Implementation plan

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

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 12 | April- July 12 | Aug/Dec 13 | Jan 14

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Presentation Steps

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

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Delineated Interventions

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

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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

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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

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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 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
  - 12 live sessions offered with 167 total participants
- December 2012
  - Moral Distress Panel discussion at Schwartz Rounds with 40 participants

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Moral Distress Education

Timeline – Exploring New Ground

- January 2013 – May 2013
  - Clinical Group Presentations
    - Ethics Committee (16 participants)
    - Operational Leadership (18 participants)
    - Mother/Baby (50 participants)
    - Case Management Team (two presentations, 43 participants)
- April 2013
  - Moral Distress Algorithm developed and distributed
  - Moral Distress Phone Hotline activated

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Breakthrough Interventions for Experimental Group 3 Pronged Approach

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 to have 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: RIC, Chicago, Il 2011)

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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.

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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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Delineated Interventions

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

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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.

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Results

- 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

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

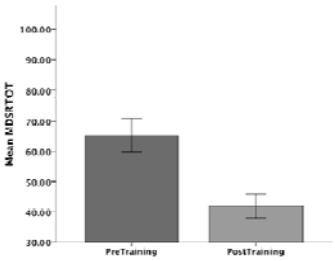

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Figure 2. Overall MDS-R Total Score:
Controls vs. Experimental

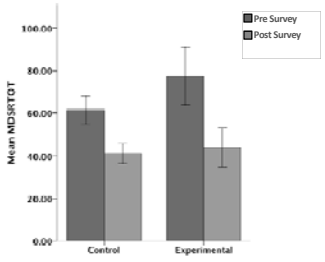

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Figure 3. Overall MDS-R Total Score: Pediatric vs. Adult Nurses

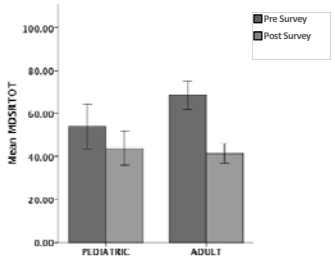

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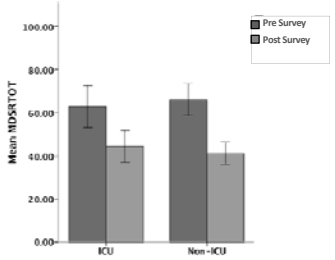
Figure 4. Overall MDS-R Total Score: ICU vs. Non-ICU Nurses



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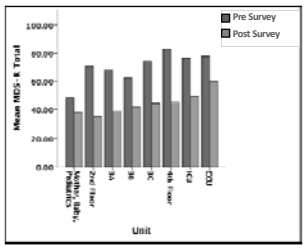
MDS-R Total by Unit Data



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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.
- The **average MDS-R 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.**

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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?)

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?

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Focus Groups for Staff

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

Themes

Simple Check-ins | Timing in Response to the Issue | Trauma Reactions; Flashbacks | Support from Co-workers | Staff Retention

Qualitative Comments

- *"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 self."*
- *"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."*

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Focus Groups for Unit Leaders

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

Themes

Recognizing and Naming | Early Intervention | Closure and Moving On | Leadership Triage | Culture

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 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."*

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Conclusions

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

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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 upon the results.

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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
  - Fragmented memories stored in parts of the brain that don't have access to speech or reasoning
- Repetitious recounting of distressful experiences has limited impact on healing
- Emotional support and connection with others, while normalizing distressful experiences, can 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
  - Helpless/hopelessness
  - Physiological overwhelm in nervous system, particularly amygdala
  - Inability to achieve deeper embodiment of the experience

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

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Therapeutic Intervention Learnings

Recommendations from Neuroscience Research

Experiential Interventions

- Somatic Experiencing (SE) – using the whole body, psychologically and physiologically, to build capacity to expand and regulate psychological and emotional experiences.
  - Supports individuals in accessing their innate resiliency and their inherent capacity to rebound and recover from overwhelming experiences.
  - Employs awareness of body sensation to help individuals "re-negotiate" and heal rather than re-live or re-enact the trauma.
  - Focuses on and integrates all elements of human experience with added foundational emphasis on shifting the underlying physiology of trauma as an essential ingredient in the healing

(Trauma Literature: www.traumahealing.org)

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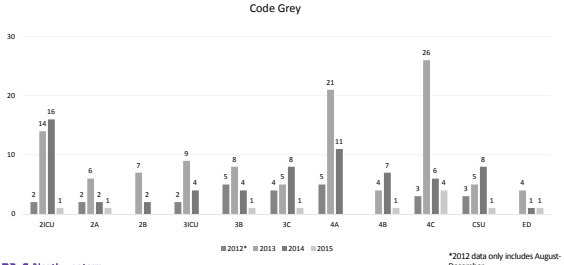
CDH Code Grays 2012-Current

Consistent need for education and training across CDH clinical departments



*2012 data only includes August-December
2015 Jan- Feb only

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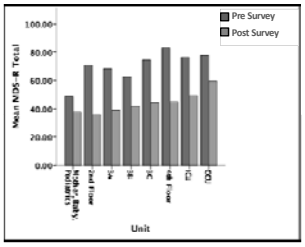
MDS-R Total by Unit Data



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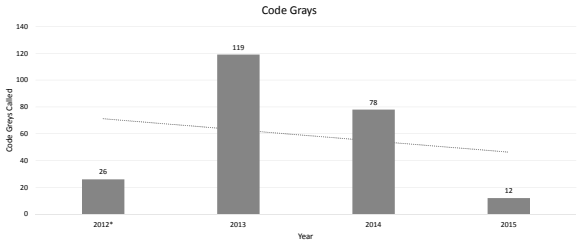
Code Gray Reduction

Through focused BHS initiative, code greys continue to trend downward



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Extending BHS Hospital Initiatives

Supporting other clinical areas that treat patients with behavioral health needs

- Designing dedicated space in the Emergency Department to accommodate behavioral health patients with safety modifications to the rooms
- Establishing a sitter observation area in the ED
- Continuing efforts to help reduce the number of Code Grays
- **Proposing to carve out space on the adult medicine units to treat patients with significant mental health co-morbidities through a partnership of the hospitalists, psychiatrists and nursing**
- **Training inpatient nursing staff on treating detox patients**
- **Developing ongoing education for the inpatient units related to managing difficult med/surg patients with psychiatric needs including medication management and de-escalation techniques**
- **Launched a Consult Liaison Service in July**

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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 debriefs) via a process that respects staff self-determination in self-care
- Provide educational seminars:
  - Emotional Intelligence
  - Resilience Theory
  - Somatic Regulation Interventions

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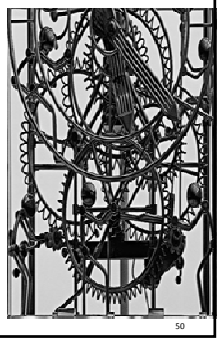
Future Research

- 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 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.



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