Intensive care unit nurses' experiences of moral distress during the COVID-19 pandemic

Moral distress is a response to a moral event in which an individual recognizes or partakes in an action that does not align with their values.

Background Information

- The COVID-19 pandemic has seriously impacted the nursing experience for those working in intensive care units (ICUs), and has contributed to new and exacerbated situations of moral distress
- Intensive care unit (ICU) nurses report high rates of moral distress[1], and reported higher moral distress scores compared to nurses working in other clinical contexts[2,3] and other ICU healthcare professionals[4–6]

Moral Distress Negatively Impacts Multiple Outcomes

NURSE OUTCOMES[2,6]

- ↓ Psychological health
- ↓ Physical health
- ↓ Social health
- ↑ Burnout
- ↑ Attrition

PATIENT OUTCOMES[7]

- ↓ Quality of care
- ↓ Patient safety

ORGANIZATIONAL OUTCOMES[7]

- ↑ Staff turnover
- ↑ Onboarding costs of new staff

- Research has been conducted to develop theoretical models to describe the experience and outcomes associated with moral distress
- Less work has been dedicated to developing interventions to mitigate moral distress.

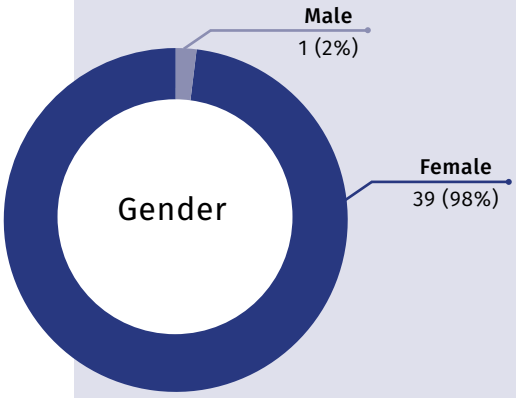
Study Methods

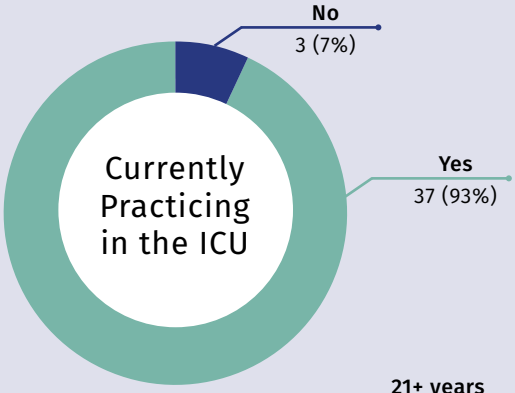
A primary objective of this study was to learn directly from ICU nurses as to what types of supports and strategies they need from their teams, units and organizations to help them understand and respond to experiences of moral distress when it occurs in the ICU environment.

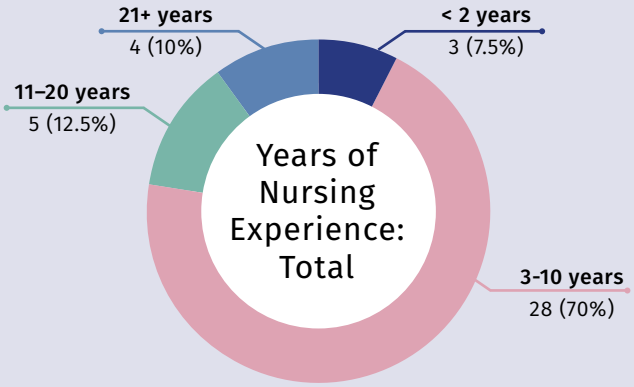
Research Question	How do RNs providing direct patient care in Canadian ICUs during the COVID-19 pandemic, describe their responses to moral distress experienced in their professional practice?
Design	Qualitative Study – Interpretive Description
Sample (Population)	40 adult-patient ICU nurses from across Canada, that reported experiencing at least one episode of moral distress between March 2020-September 2021
Data Collection	Each participant completed a: • Demographic survey • Measure of Moral Distress Healthcare Professional • One-to-one, semi-structured interview (via videoconference platform)
Analysis	Quantitative data analysis: Descriptive statistics Qualitative data analysis: Reflexive thematic analysis 1. Familiarizing with & re-reading data 2. Assigning labels of meaning to text 3. Developing & grouping themes 4. Answering the research question with data 5. Writing report

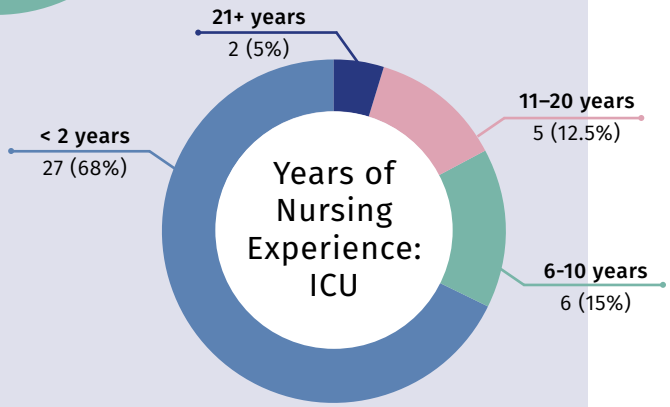
Study findings

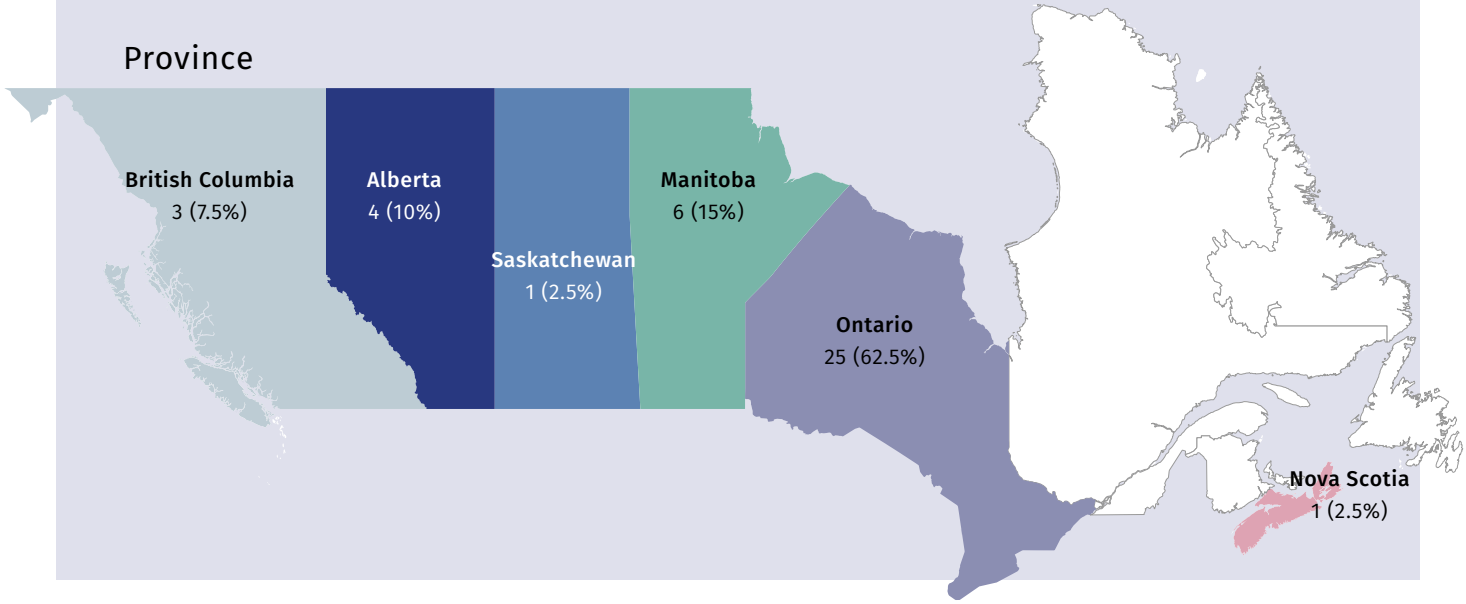
PARTICIPANT DEMOGRAPHICS





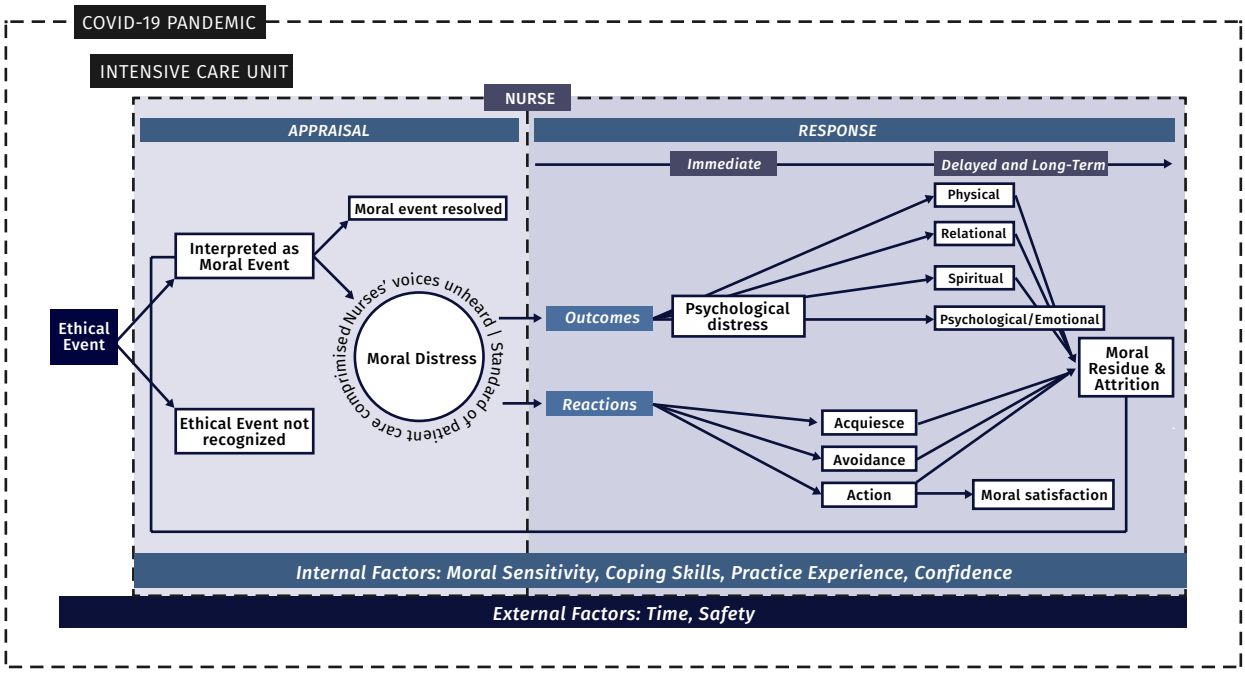






CONDITIONS OF MORAL DISTRESS: BEING HEARD IN THE PURSUIT OF COMPREHENSIVE, PATIENT-CENTERED CARE

Figure 1: Nurses' experience of moral distress in the context of the intensive care unit during COVID-19



Nurses' experiences of moral distress included two phases:

PHASE 1: NURSES' APPRAISAL OF ETHICAL EVENTS

- Nurses appraised an ethical event in practice, and then determined if it was a moral event
- A moral event is a term used to describe an ethical event that leads to or precedes moral distress
- The appraisal of the moral event led to a second pair of responses:
  - The moral event was resolved before moral distress occurred; or
  - Moral distress transpired
- **Nurses experienced moral distress under the complex interplay of two overarching, broad conditions:**
  - When nurses' voices, driven by efforts to optimize patient care at an exceptionally high standard were not heard; and
  - When patients received substandard levels of care, that was not patient-centered, pain free, or that did not align with organizational, professional, or personal standards.
- **Contributing to these broad conditions were the sub-conditions:**
  - Lack of respect for expert nursing knowledge
  - Culture of communication within the healthcare team, and between the healthcare team, patients, and families
  - Organizational approaches to staffing and safety

"And even if you [the nurse] try to speak up and say, "This is unsafe for both the nurse and the patient," we're not being heard"

"…. our workload has doubled and the resources from the hospital have not …. So, we're having a hard time achieving the same standards that we would achieve before…. they're not getting ICU level care anymore. They're getting a big step below that because we just can't keep up. So, I would say the hospital probably deems that we're doing an appropriate job, but any ICU nurse worth her salt is not happy with what the current [situation is like]."

PHASE 2: NURSES' RESPONSES (OUTCOMES AND REACTIONS)

A) Nurses' Perceived Outcomes of Moral Distress:

- Nurses experienced immediate, delayed, and long-term outcomes of moral distress affected multiple health domains: physical, relational, spiritual, psychological, and emotional well-being.
- They also reported feelings of burnout, moral residue, desire to leave practice, and feeling like a "bad nurse" (i.e., self-doubt, guilt).

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B) Nurse Reactions to Moral Distress:

- To address causes of moral distress OR cope with the outcomes of moral distress, nurses' engaged in three patterns of reaction:
  - Acquiesce (i.e., passive acceptance)
  - Avoidance (e.g., ignoring, numbing)
  - Action (e.g., self-care, sought connection, advocated, strive to optimize patient care)
- Some responses led to moral satisfaction, but more often led to moral residue and attrition

"I was just someone who always would go the extra mile and… nothing was too big of a deal …. then all of a sudden like a switch flipped. Then I just was totally done. I started applying to different jobs. I thought about leaving nursing. And I just couldn't…cope at all 'cause for so long I've just been bottling everything inside. And I hadn't been talking to anyone about what we were going through. "

NURSES' DESIRED ORGANIZATIONAL INTERVENTIONS TO MITIGATE MORAL DISTRESS

- Nurses described the types of interventions they desired and that they believed would help to mitigate moral distress[10]
- They also reflected on the interventions offered by their organization, and provided feedback about what interventions they perceived were helpful or not helpful in mitigating or reducing their moral distress

QUALITIES AND COMPONENTS OF INTERVENTION DESIGN	
Perceived as Effective	**Perceived as Ineffective**
• Authentic • Genuine • Engaging • Promoted psychological safety • Designed to change conditions of moral distress	• Implemented poorly or rapidly • Resulted in increased nursing workload • Tokenistic • Difficult to access • Posed risk to confidentiality • Facilitated by unqualified individuals
Example: Quality improvement projects led and evaluated by advanced practice nurse to address patient-centered issues and processes that influenced conditions of moral distress	**Example**: Redeployment of staff with inadequate training, that resulted in increased ICU nurse workload (e.g., teaching new staff) and compromised patient care

Type/Level of Organization	Nurses' Recommendations to Mitigate Moral Distress

Healthcare System: Unit Level	• Infrastructure and skilled staff to facilitate accessible and confidential nursing support groups to specifically address moral distress
	• Education to support clear communication systems, processes, and skills within healthcare team, and between family and healthcare team
	• End-of-life education for all healthcare team members to promote confident, consistent, and quality approaches to end-of-life and prognostic conversations
	• Dedicated human resources (e.g., clinical nurse specialist) and evidenced-based tools to identify, measure, and evaluate practice-based issues that contribute to conditions of moral distress
	• Formal multi-disciplinary debriefing, to address moral distress
	• Inclusion of comprehensive ethics education in ICU nursing orientation, that review concepts of moral distress and teach pragmatic approaches to ethical events
	• 'Good Nurse Manager': An individual who is visible, present, accountable. They authentically seek nursing input and provide feedback, create a safe space to share concerns, advocate for nurses, and engage in clear communication
	• Emergency Preparedness:
	  • Comprehensive nursing education for re-deployed staff and ICU team leaders
	  • Adequate number of electronic communication devices
	  • Adequate number of personal protective equipment
	  • Clear communication between organizational leadership about policy changes and decision-making processes

Healthcare System: Organization Wide	• Clear and accessible processes for nurses to take personal or mental health days • Formalized focus and human resources to engage in nursing retention, recruitment, and safe staffing levels at baseline • Formalized policies that mandate bedside nurses at decision- and policy-making tables • Authentic and transparent communication with all staff
Community	• Resources and tools to support mandated advanced care planning in community settings (e.g., family practitioners' offices) • Public health education focused on advanced care planning
Public Policy	• Mandated attendance of bedside nurses at local, provincial, and federal decision-making tables
Nursing Advocacy Groups & Unions	• Advocate and negotiate for increased number of paid mental health days and increased psychological service coverage (e.g., greater than $800.00/year) • Advocate and negotiate for adequate staffing levels to support safe practice and coverage to support approved time off for nurses
Academic Nursing Institutions	• Inclusion of ethics education in critical care and baccalaureate nursing programs to empower nurses with the knowledge and confidence to respond to ethical clinical practice scenarios

Implications

Nursing Education	• Prioritize curriculum that equips nurses with the tools & skills to address ethical events
Clinical Practice	• Assess & address sub-conditions of moral distress • Create cultures & systems that amplify nurses' voices • Invest in strategies to mitigate ICU nurse moral distress
Policy	• Mandate attendance of bedside nurses at local, provincial, & federal decision-making tables • Prioritize advanced care planning & education in primary care settings
Research	• Use findings from study to inform interventional studies aimed at mitigating moral distress • Ensure inclusion of ICU nurses as partners throughout research study design, implementation, & evaluation

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