USING EVIDENCE-BASED DEBRIEFING TO COMBAT MORALEDISTRESS IN CRITICAL CARE NURSES

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ABSTRACT

Moral distress (MD) is a problem for nurses which may cause helplessness, despair, or disempowerment. MD is an ongoing reality for nurses and is often experienced in critical care when caring for patients at the end-of-life life or when care is futile. MD can have long-term consequences when not acknowledged and resolved. Repeated exposure to MD can result in moral residue which can eventually result in burnout, dissatisfaction, and resignation from the nursing profession. However, some nurses appear more resilient to MD than others. Creating opportunities for critical care nurses to debrief about their MD might equip them with the tools needed to build moral resilience. Measuring MD, using the Moral Distress Thermometer (scored as 0 to 10), could provide insight into how debriefings help nurses manage MD. The purpose of this project was to examine the impact of evidence-based debriefing sessions on critical care nurses’ sense of moral distress. This project used a quasi-experimental, one-group, before-during-after design. Critical care registered nurses (N = 21) were recruited from one critical care unit at a large academic medical center. Four 30-minute debriefing sessions were held every two weeks. Participants completed the Moral Distress Thermometer two weeks before the first debriefing session, at the end of each session they attended, and at one-month after the debriefing sessions ended. Partial participation was allowed. There was no statistically significant change in MDT scores when comparing pre- with post-intervention scores ($t(12) = .78, p = .450$). There
was no correlation between the number of sessions attended and the one-month post-intervention MDT score ($r = .02, p = .937$). Mean MDT scores were 3.12 pre-intervention, rose after each of the first three sessions to 5, and then lowered to 3.31 on the post-intervention survey. In the post-survey, participants felt that debriefing was helpful by increasing their self-awareness, giving them time to commune with colleagues, and encouraging them to improve self-care habits. MD is a reality. The use of evidence-based debriefing may help nurses gain self-awareness of and improve their ability to deal with moral distress. Debriefing may offer nurses strategies to build moral resilience.
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Chapter 1

Introduction

Most bedside nurses as well as healthcare leaders would agree nursing is a stressful career. The complexity of patients in the 21st century often contributes to this (Rushton, Caldwell, & Kurtz, 2016). Moral distress is just one of the stressors nurses face in their day-to-day lives. Moreover, moral distress can be crippling to nurses. When a nurse acts contrary against his or her moral and professional judgment, moral distress can develop (Corley, 2002). The issues associated with moral distress are particularly prevalent and important in the critical care environment.

The purpose of this chapter is to describe the background of moral distress and its impact on nurses. The significance of the problem is introduced, and related concepts are explicited. An organizational assessment, where the project was conducted, is outlined. The clinical question that guided the project is noted and key aspects of that question are defined. Finally, the theoretical framework as well as the evidence-based practice model used to undergird the project are outlined.

Statement of the Problem and Background

Moral distress is a persistent problem for healthcare providers (Lamiani, Borghi, & Agreterno, 2017). First identified by Andrew Jameton (1984), it has been studied in nurses for decades. Considerable work has been done to define and describe moral distress and the resulting helplessness, despair, and disempowerment that results from it (Rushton, 2016, p. 111). However, despite the wealth of information about moral distress and strategies to combat its effects, the incidence of moral distress has remained relatively constant over the past 30 years (Musto,
Rodney, & Vanderheide, 2015; Sauerland, Marotta, Peinemann, & Robichaux, 2014). In addition, the healthcare system is becoming even more complex and patient’s health issues are becoming increasingly challenging to manage. These complexities will only intensify the risk for nurses and other healthcare providers to develop moral distress.

One of the most complex healthcare settings is critical care. Patients in critical care face life-threatening conditions, have the potential to be hemodynamically unstable, and are often unable to communicate with the healthcare team for a variety of reasons. Because of the extreme and volatile nature of critical care, patients and their families are often highly stressed, unprepared, and unequipped for what they will face when they enter a critical care unit (Rah, 2016). Rarely is a visit to critical care planned. During this unexpected stressful time, often situations arise in this setting which require urgent decision making. Often patients or their families are emotionally unprepared to make the life-and-death decisions needed. This creates a high-pressure environment that is rife with morally complex situations for nurses, healthcare providers, patients, and their families.

Nurses who work in the critical care environment are exposed to difficult physical labor, long work hours, demanding interpersonal interactions, and the “suffering and emotional demands of the patients and families” (Raj, 2016, p. 334). This is can be physically, mentally, emotionally, and morally stressful. When morally distressing situations arise, piled atop various other stressors in critical care, nurses can become overwhelmed. Particularly when faced with doing something which they perceive conflicts with their own moral beliefs, the distress could be severe. While many aspects of critical care nursing could contribute to moral distress, often nurses feel morally distressed when providing end-of-life care or when care becomes futile. Moral distress may also develop when there are conflicting opinions among the healthcare team or when
there is a lack of collaboration among the members of the healthcare team (Karanikola et al., 2014). If left unchecked, moral distress can build over time, resulting in disempowerment, burnout, or resignation (Rushton, 2016, p. 111). Effective interventions to reduce moral distress in critical care nurses need to be explored.

**Moral Distress, Residue, Resilience, and Related Concepts**

To provide context and understanding of constructs, key terms are explained below. It is important to differentiate similar constructs. What follows is a discussion of moral distress, its related effect, and a means to compensate for it. Additionally, related concepts are discussed to provide clarity.

**Moral Distress**

Moral distress, defined as “painful feelings and/or the physiological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action because of…obstacles” (AACN, 2008, p.1), is common among nurses. Nurses experience moral distress for many reasons. Most frequently moral distress occurs due to overly aggressive or futile medical treatment plans, inappropriate utilization of resources, lack of respect for the patient’s wishes by the healthcare team, and incomplete or inaccurate information given to patients and families by providers (Gutierrez, 2005). These situations occur frequently in the critical care environment, often at the end-of-life, for patients who cannot speak for themselves, or when less experienced staff completes the provision of care.

Corley (2002) described the impact moral distress has on nurses and patient care (p. 644). First, moral distress impacts nurses individually, leading to personal moral suffering, burnout, resignation from their jobs, and a desire to leave the profession. Second, moral distress can im-
patients and patient care. Nurses with moral distress sometimes avoid patients, do not always provide adequate nursing care, or fail to advocate for the patients’ needs due to moral conflict and perceived stress. It may be too emotionally painful to fully engage with patients and nurses may fear further moral distress if they do engage. Lastly, moral distress impacts healthcare organizations. High nurse turnover, decreased quality of care, and decreased patient satisfaction can impact healthcare organizations (Corley, 2002, p. 644). Critical care nurses, who care for the most ill patients, are at the most risk for developing moral distress (Corley, Minick, Elswick, & Jacobs, 2005, p. 383). Interventions to reduce moral distress in this setting need to be explored.

Moral Residue

Experiencing moral distress continually and/or repeatedly can have long-term consequences. Epstein and Hamric (2009) postulated that repeated exposure to moral distress without appropriate resolution of the distress between episodes results in the formation of moral residue (p. 3). As each new experience of moral distress occurs, the level of moral distress does not return to baseline but in fact leaves behind residue. Subsequently, the next morally distressing situation arises even more moral distress is experienced. Over time this compounding effect crescendos and increases the risk for burnout, resignation, and dissatisfaction with the nursing profession.

Moral Resilience

In recent years, nursing and ethical theorists have identified that some healthcare providers are more adept at dealing with moral distress than others. Rushton (2016) postulated, “Why is it that some people are able to navigate ethical dilemmas and moral distress without the deep
sense of despair and hopelessness that others experience?” (p. 111). It is theorized that this is because some healthcare workers have developed moral resilience. Moral resilience is “the capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion, distress, or setbacks” (Rushton, 2016, p. 112). Moral resilience can develop through self-awareness, fostering connections with peers, discussing morally distressing situations, and developing ethical competency (Lachman, 2016; Rushton, 2016). For critical care nurses, developing moral resilience could be a way to combat the effects of moral distress and the resulting helplessness, burnout, and resignation. Evidence-based interventions may assist nurses improve resilience.

Related Concepts

As healthcare providers who focus their time caring for the needs of others, nurses are at risk for several types of work-related stress. Although moral distress was the focus of this project, it is important to discuss related concepts to illustrate similarities and differences between work-related stressors and moral distress. Examples of work-related stressors include work/life balance stress, interpersonal stress, compassion fatigue, and burnout syndrome. If not mitigated, these stressors can lead to job dissatisfaction, disengagement, a desire to leave a particular job, or even to leave the profession altogether.

Work/life balance stress. As with most jobs, nurses can experience work/life balance stress. Critical care nurses typically work 12-hour shifts, making it difficult to partake in life activities before or after work. If the nurses feel they are missing important life events, they may experience feelings of stress or disenchantment with their job (Happell et al., 2013). The positive tradeoff is that many critical care nurses work only three days a week. Fewer days worked during the week can help nurses gain some form of work/life balance. Nursing in critical care settings
are often asked to work additional hours or complete “on-call” time. Consistently working extra hours increases the potential for work/life imbalances (Griffiths et al., 2014). Work/life balance stress is quite different than moral distress at work.

**Interpersonal stress.** Another type of stress commonly experienced by critical care nurses is interpersonal stress. This form of stress results when negative interactions between nurses, patients, families, or other healthcare providers arise. Nurses, particularly female nurses, experience moderate to high levels of stress when they have negative or argumentative encounters with patients (Al-Otaibi, Makhdom, & Adel, 2012; McGrath & Boore, 2003). This sort of interpersonal stress can lead to job dissatisfaction, burnout syndrome, and psychological distress (Kato, 2014). Interpersonal stress could contribute to moral distress in some situations, particularly when conflict arises among members of the healthcare team about the plan of care for their patient. However, not all interpersonal stress leads to moral distress and as such was not the focus of this project.

**Compassion fatigue.** Another type of stressor experienced by critical care nurses is compassion fatigue. Moral distress and compassion fatigue are similar in some respects but also different. Compassion fatigue is “a state of physical or psychological distress in caregivers, which occurs as a consequence of an ongoing and snowballing process in a demanding relationship with needy individuals” (van Mol, Komparje, Benoit, Bakker, & Nijkamp, 2015). When critical care nurses’ work becomes physically and emotionally exhausting, particularly when caring for needy patients, they can develop compassion fatigue. The major differentiating factor between compassion fatigue and moral distress is the origination of the stressor. Moral distress comes from a conflict between what the nurse knows to be morally correct and not being able to act on their moral belief (Corley, 2002). Compassion fatigue, on the other hand, originates when the
nurse becomes exhausted from caring for their patients—both physically providing nursing care as well as emotionally caring for the patient (van Mol et al., 2015). Sometimes moral distress contributes to compassion fatigue and conversely compassion fatigue could contribute to moral distress. Each of these phenomena are separate stressors, yet are not mutually inclusive or exclusive of each other.

**Burnout syndrome.** Another type of stressor common to nurses is burnout syndrome. Burnout syndrome is a state of “emotional exhaustion, alienation from job-related activities, and reduced job performance as a result of the high stress experienced by those who work in professions that focus on helping others” (U.S. National Library of Medicine, 2013, p. 1). While moral distress and burnout are linked, they are not exclusively proportionately correlated conditions. One can develop moral distress without becoming burnt out, and one can become burnt out without experiencing moral distress. Burnout syndrome can be a consequence of any of the aforementioned stressors, including moral distress.

**Significance of the Problem**

Moral distress has deep implications for healthcare. Nurses who experience moral distress are more likely to neglect patients, leave their job, or even leave the profession. Consequently, quality of patient care can decline (Corley, 2002, p. 641). Loss of nurses puts strain on healthcare organizations, making it difficult to consistently provide safe, high-quality care. Low quality care is even more urgent in the current health care climate of accountable care and reimbursement based on performance. In addition, turnover can financially strain a healthcare organization. Nationally, the critical care nurse turnover rate in 2015 was 17.7% and one third of all nurses left their job after less than a year (Colosi, 2016, p. 10-12). This represents a significant financial burden on healthcare organizations to recruit, hire, and train a constant stream of new
staff. Nationally, it can cost over $40,000 to recruit, hire, and train each newly hired nurse and each one percent increase in turnover rate can cost over $300,000 (Colosi, 2016). This is a costly problem. Lastly, hospital leaders have an ethical obligation to create a healthy and safe work environment for their employees (ACHE, 2014). Healthcare leaders need to create opportunities for equipping their staff with the tools needed to build moral resilience.

**Organizational Needs Assessment**

The hospital where this doctor of nursing practice (DNP) project was implemented is a 1000-bed Magnet® designated, quaternary care facility in the southwest region of the United States (US). It provides advanced medical care to patients throughout the region, the state, and the nation. Furthermore, the hospital provides care to a considerable number of patients from Central and South America and the Middle East. The hospital has affiliations with hospitals in these regions and as such patients who need specialized care travel internationally to this facility. It is a center for organ transplantation, particularly liver, heart and lung, and pancreas transplants. Additionally, many patients come to this region of the US to seek care for cancer at one of the top cancer treatment facilities in the country. When patients do not qualify to receive care at other facilities, they often seek treatment at this institution. Patients treated at this organization have complex and often incurable diseases. The nurses are frequently faced with providing care under extremely difficult circumstances. This creates the potential for moral distress to develop.

In the medical intensive care unit (MICU), a 23-bed unit that provides critical care services to medical, oncology, and pre-and post-transplant patients, the nurses are at risk for moral distress. Daily, nurses advocate for their patients, particularly related to end-of-life issues. They must balance the expectations and demands of patients, families, consulting physicians, and the intensivists, all while dealing with their own values and mores. With such complex patients
needing large interdisciplinary teams for the provision of care, conflicting opinions about treatment plans often occur. This can make it quite difficult for the MICU nurses to do what they believe is the best care for the patient, leaving them open to the development of moral distress. Because ethical and moral circumstances arise frequently, the risk for significant moral residue also exists.

The MICU is one of six units assigned to this author in her role as a clinical nurse specialist (CNS). As the CNS, she oversees staff education, orientation of newly hired nurses, conducts quality improvement projects, implements evidence-based practice projects, and consults with the nursing leadership on staff development, patient safety, and cost reduction. She often coaches nursing staff as they provide direct patient care, provides “just in time” education, and if available, participates in daily care coordination rounds.

To date, moral distress has not been quantitatively measured in the MICU nurses within this organization. Levels of moral distress may be high on this unit, based on the nursing leadership’s direct observations of the nurses and anecdotal information gathered from the nursing staff. In the past, a chaplain was involved in discussing moral distress with the staff, particularly after a difficult death. However, this chaplain left the organization two years ago and her work was not continued.

As such, moral distress is not something often discussed by the nurses although its consequences are felt and seen. For instance, the turnover rate on the unit has risen from 12% in 2015 to 16% in 2016 (L. Caston, July 23, 2016, personal communication). While some nurses left to seek advance practice nurse opportunities after completing graduate school, other staff left the unit for jobs in lower-stress environments. Lower stress jobs sought by nurses who have left the MICU were typically in settings such as physician’s offices, pre-operative screening clinics, and
Two MICU nurses have left nursing altogether (K. Gloria, September 3, 2016, personal communication). It is acknowledged that staff turnover is likely caused by a myriad of stressors, one of which is moral distress. The increase in turnover is not unique to the MICU. The turnover rate throughout the hospital has increased from 10% in 2015 to 18% in 2016 and 2017 (N. Emelogu, May 25, 2017, personal communication). The national benchmark for turnover at Magnet® designated facilities is less than 10% (L. Ortegon, September 27, 2016, personal communication).

Since each increase in percentage of turnover costs the institution approximately $400,000 (E. Emelogu, August 25, 2016, personal communication), this represents a multi-million-dollar issue for the department of nursing. A near crisis state had been reached. Executive nursing leaders, leaders of the department of nursing education, and unit-level leaders were all seeking solutions to this urgent issue. The risk for moral distress in this unit remained high, and there were no mechanisms in place to measure or combat it. There was a need for the implementation of an evidence-based program to assist unit nurses identify their own moral distress, de-brief about it, and find means to mitigate its effects. This doctoral project was a means to this end.

Considering that moral distress contributes to nurse burnout, resignation, and leaving the profession, finding ways to diminish moral distress and improve moral resilience could decrease turnover for the MICU. Since on-boarding a new critical care nurse at this author’s facility is estimated to cost $30,000 (N. Emelogu, April 2, 2016, personal communication), this project could potentially save the hospital money in hiring and training costs. Additionally, decreasing moral distress and building moral resilience might help the nurses provide more compassionate care and improve the patient experience.
Research Question

When conducting clinical inquiry, nurses evaluate their current practices, compare it to the latest evidence in the literature, and utilize well-defined clinical parameters to select the best choice for their practice environment (Melnyk & Fineout-Overhold, 2014, p. 27). The PICOT question format for clinical questions is often used in practice. Letters in the mnemonic stand for population, intervention, comparison, outcome, and time. This format is used to create an answerable question when completing an evidence-based practice project. By utilizing the PICOT format, each essential component is included in a concise manner, ensuring the literature review results are applicable to every element under study.

For this project the PICOT question is: In medical intensive care unit nurses (P), what is the effect of bi-weekly evidence-based debriefing sessions (I), compared to no debriefing sessions (C), on medical critical care unit nurses’ sense of moral distress (O) over a sixteen-week period (T)?

Theoretical Framework

The theoretical framework utilized for the project was the theory of moral residue and the crescendo effect (Epstein & Hamric, 2009). The moral residue and crescendo effect theory hypothesizes that with each incident of moral distress that is not appropriately resolved, the baseline level of moral distress is reset at a higher level than before. Over time, after multiple episodes of “moral distress crescendos” (p. 2), moral residue will form. Essentially, moral distress crescendos over time, resulting in moral residue. This may eventually cause burnout, resignation, and dissatisfaction with the nursing profession (p. 3). Figure 1 depicts this crescendo effect.
Evidence-Based Practice Model

When completing an evidence-based practice project, a model should be used to guide implementation of the project. The Iowa model (Doody & Doody, 2011) was utilized as the evidence-based practice (EBP) model for this project. This EBP model is utilized by the department of nursing at the facility where the DNP project was implemented; therefore, staff are knowledgeable about the model. As such, it was an appropriate fit to utilize for this project. The Iowa model utilizes a series of decisions that guides the user in organizing a team for the EBP project, gathering and critiquing research, and implementing a practice change or research project based on the evaluation of the evidence. The Iowa model contains seven steps, discussed below.

Step One: The Topic

Step one of the Iowa EBP model is the selection of a topic (Doody & Doody, 2011). The topic should reflect issues noted in the practice environment. Moral distress was identified as a topic through conversations with the nursing staff and through discussions with nursing leadership. Rising staff turnover rates, due in part to moral distress and its effects, were also a key driver for change.
**Step Two: The Team**

After identifying the topic, a team needs to be formed (Doody & Doody, 2011). This team is responsible for carrying out the project. The team members for this project included the principal investigator, the nursing leadership on the unit, and the social worker who moderated the debriefing sessions. Key stakeholders included the MICU nurses, the nurse scientist at the institution who served as a content expert, and two faculty members from Georgetown University who served as mentors to this author.

**Step Three: Review the Literature**

For step three, the team conducts a review of the literature (Doody & Doody, 2011). They do this to see what has already been researched about the topic. For this project, two professional data bases were searched for the terms moral distress, moral resilience, debriefing, and critical care. Articles were filtered for English language, publish dates between 2000 and 2016, and adult population. A description of the results of the literature review is discussed in chapter 2. Additionally, the best quality literature was located to support the project methodology, the evidence-based debriefing, and the measurement outcome. This literature is discussed in chapter 3.

**Step Four: Grading the Quality of the Literature**

After gathering relevant literature, step four of the Iowa model involves grading the quality of the evidence (Doody & Doody, 2011). When searching for evidence, one wants to search for the highest quality and most recent literature. As such, each article located during the literature review was graded using Melnyk’s Levels of Evidence (Melnyk & Fineout-Overholt, 2014). Most of the evidence found on moral distress, moral resilience, and debriefing were descriptive studies, qualitative studies, or expert opinion. This was considered adequate for this project because there were no higher levels of evidence available.
**Step Five: Evidence-Based Practice or Research**

Once the evidence has been closely examined, the team can then develop an evidence-based practice standard to address their topic. At this stage, if there is not sufficient evidence upon which to create an evidence-based practice standard, the team would conduct research to create new knowledge and evidence about their topic (Doody & Doody, 2011). For the topic of moral distress, there was sufficient evidence to confirm its existence in the critical care environment. There was also evidence indicating that models such as AACN’s 4A’s of moral distress (AACN, 2008), may help address moral distress. However, these was a gap in the literature about what effect an intervention would have on a measured moral distress score. Thus the decision was made to conduct translational research to fill that gap.

**Step Six: Implementation**

Implementing the project, whether it is an evidence-based project or a research project, is the sixth step of the Iowa Model (Doody & Doody, 2011). This DNP scholarly project was implemented on the MICU during the summer and fall of 2017. An evidence-based debriefing strategy was implemented with unit nurses not only with the hope of fostering quality discussion about moral distress but also as a means to enhance resilience. Debriefing sessions were moderated by the unit social worker who has an expertise in moral distress.

**Step Seven: Evaluating the Results**

Upon evaluating the results, the whole model can begin again. Once project results are obtained, the team can determine if they have solved their original topic or practice issue. If they have, they can determine how to sustain the project. If they have not, they need to review the evidence again and establish new evidence-based practice standards (Doody & Doody, 2011).
Definition of Terms

When performing any clinical inquiry, defining key variables for the project is important (Melnyk & Fineout-Overholt, 2014). What follows are the conceptual and operational definitions for this DNP project.

*Critical Care Nurses* were the population of interest in this inquiry. For the purpose of this project, critical care nurses were defined as full time, part time, per diem, day or night shift nurses, charge nurses, and/or nurse managers who provide care to the patients in the medical intensive care unit. *Critical Care Nurse* did not include non-licensed nursing support staff, such as patient care assistances or unit administrative assistants. Nurses who were pulled from other units to care for patients in MICU were not included.

*Moral distress* was the key outcome variable of interest in the project. Moral distress was conceptually defined as; “when one acts in a manner contrary to your personal and professional values, which undermines your integrity and authenticity” (AACN, 2008, p. 1). The concept of moral distress was operationalized for the project using the Moral Distress Thermometer (Wocial & Weaver, 2013). This scale is an established and validated measure of moral distress.

A different but related term is also important to define. *Moral residue* was conceptually defined as the “long-lasting and powerfully integrated…residue that remains that can be damaging to the self and one’s career, particularly when morally distressing episodes repeat over time” (Epstein & Delgado, 2010, p. 331). No tool exists to measure moral residue. This project was focused on helping nurses develop techniques to reduce their moral distress so that over time moral residue would not develop or was, at least, minimized. The evidence-based debriefing sessions were used as a means to mitigate moral residue.

Another concept related to moral distress is that of *moral resilience. Moral resilience* is
conceptually defined as “The capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion, distress, or setbacks” (Rushton, 2016, p. 112). The operational definition of this concept for this project was inferred from the scores on the Moral Distress Thermometer before and after the intervention. There is currently no quantitative measure that directly assesses levels of moral resilience. The evidence-based debriefing sessions were used to help promote moral resilience.

Evidence-based debriefing was the intervention undertaken in the study. Evidence exists which describes debriefing related to moral distress as a moderated discussion about the nurse’s feelings of moral distress and the events which caused the moral distress (Hanna & Romana, 2007, p. 39). The American Association of Critical Care Nurses (AACN) model for moral distress, the 4A’s of Moral Distress (AACN, 2008), provided the structure to operationalize the evidence-based debriefing sessions.

The debriefing moderator was a vital role in this project. This person is a social worker and a trained group counselor with experience in moral distress. The same moderator led all discussions in the debriefing sessions. The project was intentionally designed so the principal investigator was not the moderator.

Conclusion

This chapter explicated the problem under study and its significance. Moral distress affects many nurses, particularly in the critical care environment. In the MICU where this DNP project was implemented, moral distress had not been measured in the nurses but due to the complex and critically ill patients cared for on the unit, morally distressing situations are common place. Concepts related to moral distress were detailed in this chapter to provide context of similar, yet different concepts related to stressors that nurses experience. The clinical question that
framed the project, the theoretical framework, and EBP model were articulated. Finally, im-
portant terms were both conceptually and operationally defined. The systematic approach used to
search and appraise the literature about moral distress, moral resilience, and evidence-based de-
briefing will be discussed in the following chapter.
Chapter 2
Review of the Literature

With moral distress being such a critical problem in healthcare and nursing, evidence-based interventions need to be explored. This chapter explains the systematic review, appraisal, and critique of the literature for this project. The grading system used to evaluate the literature is introduced. Lastly, the rationale for this project is discussed.

Introduction to Search Criteria

General Database Search

A comprehensive review of the current literature was conducted using two databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Ovid Medical Literature Analysis and Retrieval System Online (MEDLINE). Three searches were conducted; one for moral distress, one for moral resilience, and one for debriefing which resulted in seven articles about moral distress, four articles about moral resilience, and three about debriefing.

The subject heading used in CINAHL database search was “moral distress.” Inclusion criteria were English-language, peer-reviewed publications, adult population, and published between 2000 and 2016. Initially this search returned 633 articles. After adding the subject heading “critical care”, 17 articles were found. Ten articles were excluded as they were related to a neonatal or pediatric patient setting and seven articles were retained.

The second search in CINAHL used the subject heading “moral resilience.” Inclusion criteria were English-language, peer-reviewed publications, adult population, and published between 2013 and 2016. Moral resilience is a relatively new term, first appearing in the literature in
2013. Originally the literature was searched using the years 2000 to 2016 but there were no results before 2013. Three articles were retained that met inclusion criteria. Ovid MEDLINE was also searched, using the subject heading “moral resilience” and 12 articles were found. Eleven articles of the 12 were eliminated as they were duplicates from the CINHAHL search or were non-published literature, such as abstracts from symposiums or posters from conferences, leaving a total of four articles from both databases.

The final search in CINAHL used the subject heading “debriefing.” Inclusion criteria were English-language, peer-reviewed publications, and published between 2000 and 2016. Eight hundred and eighty articles were initially returned. Debriefing is a common term used in simulation education; thus, the search was repeated using the Boolean operator NOT along with the term simulation. The modified search resulted in the location of eight articles. Three articles were eliminated as they discussed debriefing after completing simulation training. Another two articles were eliminated as they were commentary about other articles on debriefing, leaving a total of three articles.

The final sample of literature retained for appraisal consisted of fourteen articles. Of the 14, ten were descriptive studies, two were qualitative studies, and two were retained as supporting theoretical evidence. Upon reflection of the literature searching phase of the project, it may have been useful to search extensively all key terms in both CINAHL and MEDLINE.

**Critique of the Previous Evidence**

Each article retained from the literature search was evaluated for study methods, quality, consistency of results, and outcomes using Melnyk’s Levels of Evidence. According to this leveling model, level 1 is meta-analyses and systematic reviews, level 2 is well-designed randomized control trials, level 3 is non-randomized control trials, level 4 is case-control and cohort
studies, level 5 is systematic reviews of qualitative or descriptive studies, level 6 is single qualitative or descriptive studies, and level 7 is expert opinion (Melnyk et al., 2014, p. 11). All studies included in this literature review were level 6 or 7: single descriptive or qualitative studies and expert opinion. This was not surprising due to the nature of moral distress; descriptive and qualitative type studies are acceptable study types. Randomized or even nonrandomized studies are less feasible to study this phenomenon. Most typically, this concept is examined in its natural setting with no manipulation of variables. As such, this evidence is an acceptable level for the topic area (Melnyk et al., 2014, p. 81). Additionally, much of what is found in the literature about moral distress and moral resilience is expert opinion or theoretical frameworks for understanding these phenomena.

**Synthesis of the Previous Evidence**

This section of the scholarly paper addresses the evidence located about moral distress, moral resilience, and evidence-based debriefing. Each piece of literature was leveled using Melnyk’s Levels of Evidence (Melnyk & Fineout-Overholt, 2014). Each piece of literature was appraised for design, rigor of methodology, and quality of results. Overall, the body of literature was evaluated for quantity and consistency.

**Contributing Factors of Moral Distress**

Since first identified in the 1980’s, much attention has been paid to the effects of moral distress on nurses. Initially, moral distress was identified among critical care nurses; more recently studies have shown that moral distress is present in most nursing specialties as well as in most types of healthcare providers (DeVillers & DeVon, 2012; Houston et al., 2012). While most healthcare providers experience moral distress, research evidence supports that nurses experience
it more frequently and at higher levels than other types of healthcare providers. This may be related to the types of relationships and bonds that nurses form with their patients (Houston et al., 2012). One study found that 2043 nurses were uniquely positioned to screen critical care patients for ethical issues. However, nurses were not always empowered—or they did not perceive themselves as being empowered—to act upon the ethical issues they encountered when providing critical care nursing, causing them to experience feelings of moral distress (Pavlish, Hellver, Brown-Saltzman, Miers, & Squires, 2015).

Four studies examined factors that contribute to moral distress. One study used a qualitative interview design to examine 16 critical nurses’ feelings of disempowerment when facing ethical/moral situations (Bruce, Miller, & Zimmerman, 2015). The most frequent contributors to feelings of disempowerment were: (1) ambiguous institutional policies; (2) lack of personal ethical competency; (3) lack of education about ethical situations; (4) unhealthy work environments; and (5) strained nurse to physician relationships. Poor inter-professional collaboration, discordance among the healthcare team, and maladaptive team dynamics all contributed to moral distress in nurses.

In 2014, Karanikola et al. conducted a cross-sectional correlational study in Italy. The purpose of the study was to assess factors that contributed to moral distress in 566 critical care nurses. Findings from this inquiry were strikingly like those of the Bruce et al. (2015) study. Karanikola et al.’s results revealed factors that contributed to nurses’ sense of moral distress were lack of autonomy, poor nurse-physician collaboration, and unhealthy work environments. However, poor nurse-physician collaboration led the list as causing the highest amounts of moral distress among participants.

One study examined the concept of moral distress not from the perspective of general
contributing factors but instead from the perspective of the influence of team collaboration. Two publications were written to highlight different aspects of this one study. Huynh et al. (2013) described how they conducted a study about perceived futility of critical care while Neville et al. (2016) discussed the outcomes of this same study in terms of its effect on team collaboration. Neville et al. (2016) and Huynh et al. (2013) conducted a descriptive study and found that 23 critical care nurses and 13 critical care physicians perceived futility differently. This difference in the understanding of an ethically complex situation like futile care can lead to moral distress among all members of the healthcare team. Interestingly, Neville et al. (2016) also found that when nurses and physicians collaborated to determine futility, they were much more accurate in predicting futile outcomes than when they worked separately. This may indicate that fostering inter-professional collaboration, particularly nurse/physician collaboration, might be beneficial to reduce levels of moral distress.

The literature appraised in this section overwhelmingly revealed moral distress is experienced by nurses. The articles reviewed were Melnyk Level 6 as they were single descriptive or qualitative studies (Melnyk & Fineout-Overholt, 2014). This is an acceptable level of evidence for this subject matter. It is evident that moral distress is a common experience for nurses and other healthcare providers. Critical care nurses, who may form tight bonds with their patient and families, may not feel empowered to use moral agency. They might also disagree with their physician colleagues about the plan for the patient, which leaves them at particular risk for moral distress. Evidence revealed that ineffective collaboration among the healthcare team and unhealthy work environments contribute to moral distress. Despite a body of literature addressing the prevalence of moral distress, there is a lack of literature about interventions to mitigate its effects.
Building Moral Resilience

Empirical evidence confirms that moral distress does exist and that various factors contribute to it. Equipping nurses with the skills and knowledge to handle morally distressing situations may help nurses build moral resilience. The term moral resilience has existed in the literature only since 2013. No interventional or even descriptive studies were found that specifically examined moral resilience. Thus, the literature that does exist about moral resilience is expert opinion and theoretical frameworks. This literature was examined for common themes about moral resilience. Elemental to building moral resilience is the ability of nurses to become self-aware of their own moral distress, to understand that others likely experience similar feelings, and to develop ethical competence.

Several authors have described theoretically how to foster moral resilience in nurses and other healthcare providers. Several experts on moral distress and moral resilience described strategies for building moral resilience (Lachman, 2016; Rushton, 2016; Rushton et al., 2016). First, nurses must develop self-awareness of their moral distress. Since each individual nurse might develop moral distress differently, being aware of what triggers their moral distress is key to understanding it and building resilience to it. To develop self-awareness, experts recommended engaging in dialogue about moral distress as a means of developing self-awareness (Lachman, 2016)

Another key method for developing moral resilience is to create opportunities for nurses to connect with other nurses who experience similar situations. Lachman (2016) and Rushton et al. (2016) discussed that bringing nurses together and allowing them to see they are not alone in their distress helps to foster a deeper understanding of themselves and the environment in which they work. Furthermore, bringing nurses together to discuss their distress, feelings, and concerns
allows them to learn coping mechanisms from one another.

Lastly, nurses can develop moral resilience through the development of ethical competency (Rushton, 2016; Rushton et al., 2016). One has ethical competency when one consistency lives out their ethical beliefs, is sensitive to the moral and ethical complexities they encounter in their daily lives, can reflect upon the moral and ethical makeup of their environments, and are strong moral agents (Rushton, 2016). Essential to being ethically competent is being able to learn from difficult or distressing experiences and enacting action plans for how to handle similar situations in the future. Ethical competency should be required for all nursing students (Lachman, 2016; Monteverde, 2014; Rushton, 2016).

The articles reviewed about moral resilience were all Melnyk Level 7 as they were theory and expert opinion (Melnyk & Fineout-Overholt, 2014). As this is such a new topic, that is acceptable at this time. One significant gap in the literature was the lack of research studies demonstrating how to build moral resilience. As there is no validated tool to measure moral resilience, one cannot accurately determine what interventions build moral resilience. In light of this, using a tool to measure moral distress and investigating whether the level of moral distress changes with intervention may, at this time, take the place of directly measuring moral resilience.

**Evidence-Based Debriefing**

Debriefing is the practice of reviewing an event or phenomenon and discussing what happened, how it affected those involved, and if lessons were learned (Hanna & Romana, 2007). Debriefing, when done correctly, can be a safe place for participants to discuss their experiences and feelings, similar to counseling. It has been used to review crises, such as after natural disasters or traumatic events (Smith et al., 2014). Debriefing is also used as a learning tool in education, such as after simulation training (Garden et al., 2015). Debriefing can be a useful tool for
many professions in healthcare. It can be done independently, one-on-one, or as a group.

Using debriefing in the critical care environment may be a useful tool to address moral distress. One study used a quantitative pre-test, intervention, post-test design of 82 neonatal intensive care nurses. Results found that education about moral agency and debriefing increased the nurses’ comfort level in caring for dying infants (Rogers, Babgi, & Gomez, 2008). Another study used a qualitative design to examine how 17 nurses responded to utilizing debriefing in the critical care environment. By creating opportunities for the nurses to debrief after morally distressing clinical situations, the nurses verbalized that they felt participating in debriefing improved their ability to handle these situations (Santiago & Abdool, 2011).

One study used a qualitative design to examine how moral distress manifested itself among 29 critical care healthcare providers in two separate critical care units (Bruce et al., 2015). A medical ethicist utilized three recent morally complex patients in their practice setting as case studies. Participants were asked to talk through their experiences with moral distress and team dynamics related to the three cases. They noted the healthcare providers verbalized that they benefited from constructive behaviors, such as debriefing with their peers, building team cohesion, collaborating as a team, and utilizing mentors. These constructive behaviors supported the healthcare providers’ sense of ethical competency (Bruce et al., 2015).

Despite differences in research design and methodology, findings from Bruce et al. (2015), Rogers et al., (2008), and Santiago & Abdool (2011), all revealed debriefing to be a useful tool in the critical care environment. Debriefing allowed the healthcare providers to process their experiences with moral distress. In these studies, debriefing was most typically conducted in a group setting and participants could learn from each other and bond over their shared experiences.
The literature on debriefing showed that it may be a useful tool in the critical care environment for addressing moral distress. Of the three studies found, one was a descriptive study (Melynk level 6) and two were qualitative studies (Melynk level 6). While randomized control trials would be preferred, it might not be possible to study debriefing in this manner. Additionally, it is useful to study debriefing using qualitative methods, so the studies used for this literature review are acceptable for this topic (Melnyk et al., 2014, p. 81).

While these studies did not measure directly how debriefing affects moral distress, it may be reasonable to extrapolate that the principle of debriefing about moral distress might help critical care nurses process their feelings of moral distress. Reduction of moral distress may diminish the long-term effects of moral residue (Epstein & Hamric, 2009). Discussing strategies to overcome moral distress may be useful to build moral resilience (ANA, 2017). Moral resilience is built by: (1) developing self-awareness; (2) fostering connections with peers; (3) becoming ethically competent; and (4) creating action plans for how to handle morally distressing situations in the future (Lachman, 2016; Monteverde, 2014; Rushton, 2016; Rushton et al., 2016). The development of structured evidence-based debriefing sessions, constructed around the principles of building moral resilience could help negate the effects of moral distress and moral residue.

The American Association of Critical Care Nurses’ (AACN) 4A’s of Moral Distress (2008) was developed to address moral distress in critical care nurses. The 4A’s of moral distress is comprised of four distinct components. Ask is the first component of the model in which nurses ask themselves if they are experiencing moral distress. Affirm is the second component of the 4A’s. After determining if one has moral distress, nurses affirm that their feelings of moral distress are legitimate and valid, and they commit to addressing these feelings. Assess is the third component of AACN’s model, during which nurses evaluate the effect moral distress is having.
on their professional and personal lives. Act is the fourth and final component of the 4A’s model. Nurses make a commitment to act in a way that preserves their moral integrity and improves their mental and emotional health. This model, long used by AACN in their work on healthy work environments, could be used to inform the moral distress debriefing process in the critical care environment. Because of the strong relationship of the 4A’s model with the intent of the project, this model was used to develop the evidence-based debriefing sessions.

General Synthesis of the Body of Evidence

Seven studies consistently showed that nurses experience moral distress across different practice settings and levels of experience. Four articles about moral resilience discussed that resilience can be built through self-awareness, conferring with their peers, practicing moral agency, and fostering self-care (Lachman, 2016; Monteverde, 2014; Rushton, 2016; Rushton et al., 2016). Three studies revealed nurses verbalized that debriefing about moral distress helped them process their feelings easier (Bruce et al., 2015; Rogers et al., 2008; Santiago & Abdool, 2011). The studies reviewed consistently had small sample sizes; this was a limitation of all the studies. This could be related to the nature of studying moral distress. Nurses who have more moral distress might be less likely to participate in research about it. In reviewing all of the selected studies, one gap identified was a lack of studies which quantitatively measured moral distress after implementing methods to combat moral distress.

Measuring Moral Distress Concepts

Currently, no tools are available to measure moral resilience or moral residue. However, three tools exist in the literature that measure moral distress. Corley (2002) first developed the Moral Distress Scale (MDS), which measures the “causes and severity of moral distress” (p. 250). The MDS is a 32-item questionnaire, Likert-type scale. The MDS was originally designed
for use with hospital-based nurses. In 2012, the MDS was revised, called the MDS-R, to include 38 items and can be used in multiple healthcare settings and multiple types of healthcare providers (Hamric, Borchers, & Epstein, 2012). Both scales pose various morally distressing scenarios, such as following a physician’s order for unnecessary tests, administering medications against a patient’s wishes, working in unsafe working conditions, withholding information from families about the patient’s condition, and more. All items on the MDS and MDS-R focus on three factors: individual responsibility, providing care which is perceived to be not in the patient’s best interest, and deception (Corley, 2002; Hamric et al., 2012). While both the original and the revised MDS scales are invaluable tools for measuring moral distress, both are long and complex to score. Additionally, both were validated for one-time use; reliability is uncertain when used multiple times on the same nurses.

Because of the long nature of the MDS and MDS-R, Wocial & Weaver (2013) thought there was a need for a new tool. Their desire was to create a tool that would accurately and consistently measure moral distress but would be quicker for healthcare providers to complete and easier to score. Thus, the Moral Distress Thermometer (MDT) was created for just that purpose. The MDT is a single item tool. The tool is depicted as a thermometer on which the subject fills in their current level of moral distress on the scale of 0 to 10. Because of the ease of use, “the MDT may be useful for rapid measurement of [moral distress] and tracking changes to [moral distress] over time” (Wocial & Weaver, 2013, p. 172). For these reasons the MDT was selected over the MDS or MDS-R for use in this study.

**Rationale for the Project**

The reality is that moral distress exists in various settings in healthcare. Critical care
nurses are considerably vulnerable to its effect in light of the difficult and morally complex situations they encounter daily. If left unchecked, moral distress can crescendo into moral residue. Once moral residue develops, nurses become increasingly disengaged and disempowered. However, there is hope for nurses with moral distress. Moral resilience is an emerging concept that describes how nurses can overcome their moral distress by becoming self-aware, communing with their peers, practicing moral agency, and fostering self-care. Considering the extent to which moral distress affects nurses and other healthcare providers, healthcare leaders need to create processes to minimize morally distressing situations and provide opportunities to adequately address moral distress.

Creating opportunities for critical care nurses to debrief about their moral distress could help the nurses feel better about those situations as well as equip them with the tools needed to build moral resilience. Moral distress will be addressed in the MICU using AACN’s 4A’s of moral distress as a framework for evidence-based debriefing. Moral distress will be measured using the moral distress thermometer. Over time, the debriefings might enable them to understand their moral distress and negate moral residue by equipping them to build moral resilience. Quantitatively measuring moral distress, using the MDT (Wocial & Weaver, 2013) before and after evidence-based debriefing sessions could provide a deeper understanding of how debriefings help nurses with their moral distress.

**Conclusion**

This chapter examined the current literature on moral distress, moral resilience, and debriefing. This literature was evaluated utilizing Melnyk’s Levels of Evidence (Melnyk & Fineout-Overholt, 2014) and critically appraised for quality and consistency. The literature reviewed revealed that moral distress is a common issue faced by many healthcare providers, particularly
critical care nurses. The Moral Distress Thermometer (MDT) (Wocial & Weaver, 2013) is a validated tool to measure moral distress. Moral resilience, while a new concept in the literature, can be developed by being self-aware of one’s moral distress, communing with one’s peers, practicing moral agency, and fostering self-care (ANA, 2017). Evidence-based debriefing, during which one discusses their experiences with moral distress, may be one mechanism that can assist nurses to combat their moral distress and build moral resilience. The specific methodology used to implement this project will be discussed in the next chapter.
Chapter 3

Methods

This chapter discusses the design of this DNP project and the implementation framework of Plan-Do-Check-Act. The project primary and secondary aims will be reviewed, as well as the sampling and recruitment, instrumentation, and procedure and timeline. Protection of human subjects is articulated in chapter 3. This chapter concludes with a discuss of outcomes and the data analysis plan.

Primary and Secondary Aims

The primary aim of this project was to examine the effect of four evidence-based debriefing sessions for critical care nurses on their self-reported level of moral distress. There were three secondary aims for this project: (1) Examine if a correlation exists between the number of sessions attended and the amount of change in nurses’ self-reported level of moral distress; (2) Assess if changes in self-reported moral distress are sustainable after a four-week washout period with no debriefing; and (3) Determine if debriefing sessions helped participants create strategies to reduce their moral distress.

Design

The project used a quasi-experimental one group, before-during-after design. Quasi-experimental one-group project design was appropriate for the project since it was not the intent of the study to test one type of an intervention against another (Melnyk & Fineout-Overholt, 2014, p. 459). Instead the intent was to examine the level of moral distress prior to, and during, and af-
ter the evidence-based debriefing sessions. The independent variable in this project was the evidence-based debriefing sessions held on four days over a period of ten weeks. The dependent variable was the self-reported level of moral distress in MICU nurses as measured by the Moral Distress Thermometer (MDT) score. Originally, the project was designed to be implemented over eight weeks, but the fourth debriefing session and post-survey were delayed by two weeks due to a natural disaster in the region where this project was implemented.

A four-week washout period was intentionally included in the design of the study to examine if changes in the MDT scores were sustainable without debriefing. A washout is typically used in research to examine the phenomena being studied during a period of no intervention (Rosner, 2000). This washout period between the last debriefing and the post-survey was intended to examine if changes in the MDT were influenced by not maintaining an every-two-week schedule of debriefings. A four-week period for the washout was selected since this seemed reasonable for the timeframe of the entire project.

**Project Implementation Framework**

To implement this DNP Scholarly Project, the Plan-Do-Check-Act (PDCA) model was utilized. The PDCA model is an implementation framework that guides the user along a defined pathway, which includes planning the project, implementing the project, checking the results, and acting on those results (Tague, 2004, p. 390). With this framework, the project was constantly enhanced through cycles of evaluation and improvement in iterative fashion. PDCA was selected as the implementation framework to enhance step six of the Iowa Model. The Iowa Model was the EBP model used to undergird the project. The use of PDCA was appropriate to guide the implementation phase of the study as the steps for project implementation are not well-defined in the Iowa model.
PDCA uses four distinct steps for project implementation to improve quality of care (Tague, 2004). The planning phase of PDCA involved examining the problem, forming a team of key stakeholders, selecting the intervention, and planning the implementation. For this project, the problem was examined, as explained in chapter 1 and 2. Key stakeholders included the nursing staff of the MICU, the debriefing moderator, and the MICU nursing leadership. The do in the PDCA process was the implementation of the intervention. The intervention was the four debriefing sessions over the course of ten weeks. To check the project’s process, the debriefing moderator and principal investigator met after each session to discuss how group discussion during the debriefing sessions went. While the flow of the sessions was not changed throughout the ten weeks, feedback was used to determine how best to continue the debriefing sessions after data collection ended. For the last step, act, feedback that the principal investigator and the moderator obtained from the nurses was used to determine that debriefings would be continued monthly, even after data collection ended. The decision to continue evidence-based debriefing sessions was not make in isolation but was decided in collaboration with nursing leadership.

Population

Sample

The population studied were registered nurses (RN) who worked in a 23-bed medical intensive care unit (MICU) at a large quaternary care facility in the southwest region of the United States (US). Inclusion criteria were as follows. The nurses must (1) be employed as a nurse on the medical critical care unit at the practice facility; (2) be at least 18 years of age; (3) work full time, part time, or per diem; (4) work any shift; and (5) function as a staff nurse, charge nurse, or nurse manager. All nurses included in the study were required to have direct patient contact.

Exclusion criteria were as follows: nurse residents who have been in nursing practice less
than six months. Since nurse residents participate in debriefing with their resident cohorts as part of their nurse residency program, they were excluded. It would be difficult to discern whether it was the impact of evidence-based debriefings as part of the study or the impact of debriefings as part of the nurse residency which effected their moral distress levels. All nurses, including the nurse residents, were invited to participate in the debriefing sessions. If any nurse residents chose to participate in the sessions, no research data were collected. Nurses who were temporarily pulled to work in the MICU from other units were not included in the study.

Recruitment

To ensure success of the moral distress debriefing project, it needed to be effectively marketed to the MICU nurses. Five strategies were used to recruit the nurses for participation in the study. First, the author introduced the concepts of moral distress and debriefing at the MICU staff meeting in June 2017. This strategy allowed all staff to hear the same message about the project and the intent of the evidence-based debriefing sessions. Second, flyers advertising the sessions were placed on announcement bulletin boards around the unit. Next, information about the project and upcoming debriefing sessions was emailed weekly to the staff. The flyers and email advertisements were completed two weeks prior to the start of the study. This allowed the staff to become aware of the study and add the dates of the debriefings to their calendars. It also helped to create interest among the nursing staff. Fourth, the unit managers reminded staff of the debriefing sessions during daily safety huddles. Reminders provided during safety huddles were scripted; therefore, the same information was given to staff with every reminder. Lastly, on days the debriefing sessions took place, unit managers completed rounds on the unit to remind staff about the session and arranged to cover patient care duties. If patient assignments were covered effectively, it allowed more nurses to participate if they wished to attend.
Evidence-Based Debriefing Intervention

Over the course of ten weeks, four debriefing sessions were held in the MICU. Debriefing session were intentionally designed based on the American Association of Critical Care Nurses’ 4As of Moral Distress (AACN, 2008, p. 1). Table 1 illustrates the lesson plan used for the evidence-based debriefing sessions as it related to each of the four “As” in the model.

**Table 1: Evidence-Based Debriefing Session Lesson Plan**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction:</strong></td>
<td></td>
</tr>
<tr>
<td>• Purpose of the session</td>
<td>2 minutes</td>
</tr>
<tr>
<td>• Discuss ground rules for the session</td>
<td></td>
</tr>
<tr>
<td><strong>Ask:</strong></td>
<td></td>
</tr>
<tr>
<td>• Define Moral Distress</td>
<td>3 minutes</td>
</tr>
<tr>
<td>• Do you feel moral distress?</td>
<td></td>
</tr>
<tr>
<td>Goal: Become aware of your own feelings of moral distress.</td>
<td></td>
</tr>
<tr>
<td><strong>Affirm:</strong></td>
<td></td>
</tr>
<tr>
<td>• Affirm your feelings of distress</td>
<td>3 minutes</td>
</tr>
<tr>
<td>• Commit to taking care of yourself</td>
<td></td>
</tr>
<tr>
<td>• Validate your feelings</td>
<td></td>
</tr>
<tr>
<td>Goal: Make a commitment to address your moral distress</td>
<td></td>
</tr>
<tr>
<td><strong>Assess:</strong></td>
<td></td>
</tr>
<tr>
<td>• What contributes to your feelings of moral distress?</td>
<td>7 minutes</td>
</tr>
<tr>
<td>• What helps you feel better?</td>
<td></td>
</tr>
<tr>
<td>Goal: Understand the impact of moral distress</td>
<td></td>
</tr>
<tr>
<td><strong>Act:</strong></td>
<td></td>
</tr>
<tr>
<td>• Set personal and professional goals for taking action</td>
<td>10 minutes</td>
</tr>
<tr>
<td>• What are strategies you can use to implement your action plan?</td>
<td></td>
</tr>
<tr>
<td>• What can lead to set-backs? How can you avoid these?</td>
<td></td>
</tr>
<tr>
<td>Goal: Have a plan to help you preserve your moral integrity</td>
<td></td>
</tr>
<tr>
<td><strong>Conclusion</strong></td>
<td></td>
</tr>
<tr>
<td>• Conclude what was discussed</td>
<td>5 minutes</td>
</tr>
<tr>
<td>• Affirm the participant’s plans</td>
<td></td>
</tr>
<tr>
<td>• Distribute the survey tool—should take &lt;3 minutes to complete</td>
<td></td>
</tr>
</tbody>
</table>
unit, she felt staff might not be as open or willing to share with her nor did she want to appear to be coercing any study participant if she was both the principal investigator and moderator. Additionally, it was thought that having someone experienced with group therapy might help the sessions go smoothly. As such, a moderator for the sessions was sought. The moderator selected was a social worker with training in group therapy and in moral distress. After agreeing to serve as moderator, she and the principal investigator closely examined the AACN’s 4A’s together and created the lesson plan for the debriefing sessions (Table 1). The lesson plan was used as a guide for the moderator. She had the liberty to spend more or less time on each of the 4A’s based on the discussion of the group, as long as all four of the A’s were discussed by the end of the session. The debriefing sessions lesson plan and schedule for the sessions was reviewed with and approved by the nursing director on the unit.

The debriefing sessions were open to all MICU nurses and were held thirty minutes before change of shift in the evening so that both day and night shift nurses were able to attend. Partial participation was allowed. The nurses were not required to pre-register or commit to attending all sessions; they were able to come to as many or as few as they wished over the ten weeks. It was designed this way to improve the ease for nurses to participate as their schedule and patient load allowed. The intent was to maximize attendance.

**Instrumentation**

The pre- and-during survey (Appendix A) used for this project was the Moral Distress Thermometer (MDT), plus a brief demographic questionnaire. The demographic characteristics collected from participants included: gender, years of experience in nursing, years of experience in critical care, notation of prior education about moral distress, and current healthy coping
mechanisms. For the post-intervention survey (Appendix B), called the Post-Survey, two additional questions were added to the data collection tool which allowed participants to provide feedback about how they believed the evidence-based debriefings impacted them.

**The Moral Distress Thermometer**

The Moral Distress Thermometer (MDT), *Figure 2*, measured moral distress as it was being experienced in real-time. Also, the nature of the tool, being easy to understand and quick to complete, was believed would lead to a higher response rate from the participants. The MDT was designed to measure “acute” moral distress, which the creators defined as being experienced at any point the prior two weeks. They designed the scale to be utilized repeatedly and no

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**Moral Distress Thermometer**

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![Moral Distress Thermometer](image)

*Figure 2: Moral Distress Thermometer. (Wocial & Weaver, 2013). Used with permission.*
more frequently than every two weeks (Wocial & Weaver, 2013). Since the intent of this project was to capture moral distress in real-time, around real-world patient experiences, and to measure changes in moral distress after participating in the debriefing sessions, the MDT tool was selected for this project.

Validity and Reliability

The MDT is a 1-item instrument that produces interval level data. Wocial & Weaver (2013) established convergent validity of the MDT against the existing original Moral Distress Scale (MDS) using a sample of 529 nurses from both acute and critical care areas. The MDT scale developers tested their 1-item scale against the MDS in three groups of nurses: 1. those not considering leaving a position, 2. those considering leaving a position, and 3. those who had left a position. Results from the validation study showed consistent mean moral distress levels among the three groups across both tools. Thus, the instrument developers concluded their brief MDT tool to be a measure of moral distress (p. 171). Reliability was not tested, however, because “the phenomenon of [moral distress] is dynamic and not amenable to a test re-test approach to establishing reliability” (Wocial & Weaver, 2013, p. 170).

Procedures and Timeline

Procedures

This project was implemented in the medical intensive care unit. Participants were recruited through announcements at staff meetings and daily safety huddles, flyers posted around the unit, and email advertisements distributed weekly for two weeks prior to the project start date.

Pre-surveys and consent forms were distributed to eligible nursing staff two weeks prior to the first debriefing session by placing them in their unit mailbox. Each nurse was assigned an
individual identification number (IDN) before the surveys were distributed. The IDNs were written on the surveys which were then placed, along with the consent form, in envelopes. IDNs were necessary to match participants with their other data collection tools. For instance, if a nurse completed the pre-survey and three debriefing sessions, it was necessary to be able to match all the responses to the correct person. A locked box was conveniently placed next to the mailboxes for staff to return the surveys and consent forms. Envelopes were also provided by the locked box. Some nurses placed their completed consents and pre-surveys in envelopes then placed them in the locked box, while others put them in loose. Nurses were asked to complete the pre-survey within one week. At daily safety huddles, nurse managers reminded the nurses of the deadline to complete the pre-survey. They also emailed reminders mid-week.

![Figure 3: Data Collection Process](image)

Debriefing sessions were held four times over the course of ten weeks; one session every two weeks. This timeframe was chosen because the MDT was designed to be used no more frequently than every two weeks (Wocial & Weaver, 2013). There was an unexpected delay of two weeks between the third and fourth debriefing due to a natural disaster in the region. See Figure 3 for an illustration of the flow of data collection. Each debriefing session was held on the unit in
the family consultation room. This space is located on the unit, is private and quiet, which allowed the nurses to speak confidentiality without worrying that others could hear them. The family consultation room was reserved prior to all sessions to ensure a consistent space for each session to be held.

After each of the four evidence-based debriefing sessions, participants completed the MDT. The moderator instructed participants to write their names at the top of the survey. Surveys were then placed in an envelope by the debriefing moderator and immediately after the sessions were taken to the principal investigator’s private office outside the MICU where participants’ IDN was placed on the survey and their names were removed. Data were entered into a password-protected Microsoft Excel™ spreadsheet by the Principal Investigator (PI) of the project. All hard-copy surveys were stored in a locked cabinet and the code key with the names of the subjects and their IDNs was stored in a separate locked cabinet in the locked office off the nursing unit.

After the last of the four debriefing sessions, no debriefing sessions were held for four weeks. At the end of this four-week period, post-surveys were distributed to eligible nursing staff, using the same method of distribution as the pre-survey. Returned surveys were handled in the same manner as described above.

**Timeline**

This project was designed and implemented between September 2016 and October 2017. The key stakeholders and content experts were gathered and consulted with in November and December 2016. They provided insight for the principal investigator into the nature of moral distress and the needs of the nursing unit. Institutional Review Board (IRB) applications were submitted in December 2016 to university where the PI attended the doctoral program and to the
project site facility in April 2017. After IRB approval was received from both institutions, debriefing sessions were scheduled and marketed to the nursing staff. Pre-survey was distributed at the beginning of July 2017. Debriefing sessions were held from July 13 through September 12, 2017. Post-survey data were collected on October 10, 2017. Data analysis took place in October 2017. During fall 2017, results were summarized and disseminated.

**Human Subjects Review**

Protecting human subjects during project implementation is vitally important. To ensure subjects of this study were appropriately protected, this author completed human subjects and biomedical research training through the Collaborative Institutional Training Initiative (CITI) Program (copyright 2016). IRB approval from two organizations were sought before the project was initiated. To avoid any perception of coercion, a decision was intentionally made that the principal investigator would not moderate any debriefing session. Additionally, written consent was obtained from all participants prior to completion of the first MDT.

**Emotionally Charged Sensitivity**

The debriefing sessions had the potential to arouse emotionally difficult topics. Some of these could be addressed during the debriefing session by the debriefing moderator. If, however, something was discussed that caused emotional strife beyond the scope of the debriefing, or if participants found themselves distressed after the session, a plan was in place. Contact information for the employee wellness center at the project site was available to all participants at each session through the form of contact cards placed on the front table in the room the sessions were held. If any participant felt he or she needed additional assistance, appointments with the wellness center could be made. These papers could be taken subtly at the end of any session. In the employee wellness center, counsellors were available who could have addressed the subjects
Data Management Plan

Due to the nature of the study and the pre-, during, and post-design, anonymity was not possible. Protecting the confidentiality of the subjects, however, was important for this project. The pre-and-post-surveys did not need the participants’ name, as they had IDNs placed on them before distribution of the surveys. For the surveys completed after each debriefing session, the subjects’ names were removed immediately after the debriefing session and their IDN was placed on the surveys. All hard-copy surveys and consent forms were kept in a locked cabinet inside a locked office in a different building from the implementation unit. The code key was also kept in a separate locked cabinet. The data were compiled into a password-protected Microsoft Excel™ file on a password-protected laptop housed in a locked office. These measures ensured only the principal investigator has access to who completed the surveys. Data will be retained for a period of three years. After this time, hard-copies of surveys and consents will be shredded. Electronic files will be deleted from the principal investigator’s computer and the ‘trash bin’ on the computer will be purged.

Outcome Measurements and Data Analysis Plan

This study had one primary aim and three secondary aims: measure MDT scores before, during, and after each debriefing session; correlation between the number of sessions attended and the post MDT score; sustainability of the change in MDT after a four-week washout; and how the evidence-based debriefings helped the participants’ moral distress. Measuring the moral distress scores before, during and after the debriefing sessions was important to determine its impact on moral distress and it ability to help build moral resilience. Measuring correlations between the number of sessions attended and the post MDT score determined if any debriefing
helps or if continued participation in debriefing is needed to change the moral distress score.

Statistical analysis was completed by a bio-statistician using International Business Machines Corporation (IBM)’s Statistical Package for the Social Sciences (SPSS), version 24 (2016). The data analysis plan was four-fold. 1) Analyze the demographics with descriptive statistics. 2) Use Repeated-Measures Analysis of Variance (RM-ANOVA) to analyze the change in the MDT scores at each data collection point. This test is used to determine if there is a difference in means for a single outcome measured three or more times (Sylva, 2014). This could also be used to determine if change was sustained after the four-week washout period. 3) Use the Pearson’s product-moment correlation coefficient to analyze if a relationship exists between the number of sessions attended and the post-MDT scores. Pearson’s product-moment correlation is used to determine a relationship between two interval-level variables (Sylva, 2014). 4) Thematic analysis was conducted on the two open-ended questions on the post-survey.

**Conclusion**

This chapter explained the implementation plan for this quasi-experimental one-group, before-during-after project. This chapter outlined the study design, the sample, instrumentation, project procedures and timeline, data collection plan, and data analysis plan. Protection of human subjects and data management was articulated. Chapter 4 will discuss the analysis of the data and the findings of the study.
Chapter 4
Evaluation Results

After completing the design phase of this project, four debriefing sessions were held once every two weeks over the course of ten weeks and the moral distress thermometer was used to collect the medical critical care nurses’ self-reported moral distress scores after each session. The resulting data were analyzed. This chapter presents the findings of the study. Attendance at the debriefing sessions and sample characteristics are discussed. Findings are presented in a logic fashion, as they relate to the aims of the study.

Attendance

This study was conducted on a 23-bed medical intensive care unit at a large, four-time Magnet® designated academic medical center in the Southwest region of the United States. Participation was fully voluntary. There are 87 nurses, including charge nurses and nurse managers, employed on this unit. Of the 87, a total of 21 participated in some aspect of this project, resulting in a 24% participation rate. The project was designed so that any eligible nurse could participate at any point in the study. No nurse had to commit at the beginning to attend every session or complete every survey, nor were any nurses excluded if they had not completed the pre-survey and then subsequently participated in the debriefing sessions. It was designed this way to maximize participation since nurses on this unit have flexible schedules; hence, attendance at all debriefing sessions could not be guaranteed. Additionally, the debriefing sessions were held during work hours and due to the unpredictable nature of the critical care environment, flexibility was required to foster participation.
Because of these factors noted above, the total number of participants (N=21) is higher than the number of participants who completed both pre- and post-surveys (n=13). Figure 4 further explains the attendance rates at each session. The variable nature of the participation led to variations in the data. For example, one participant could have completed the pre-survey and one debriefing session, another participant could have completed the pre-survey and attended all debriefings, and a third participant could have only completed the pre-and-post-surveys. It is important to note that of the 16 nurses who completed the post-survey, 13 attended at least one debriefing session. For clarity and comprehensiveness, each result table discussed hereafter will display the results for all participants (N=21) as well as only those that completed both a pre- and-post-survey (n=13).

Figure 4: Participation at Each Data Collection Point
Sample

Demographics

Twenty-one nurses participated in this project. Table 2 details the demographics of the participants. Seventy-one percent of participants were female and 28.6% were male. Three ethnicities were self-reported by the participants; 66% white, 19% Hispanic, and 14.3% Hispanic. Eighty-five percent of all participants had some prior exposure to the concept of moral distress while 14.3% (3 participants) noted that moral distress was a brand-new concept.

The mean years of experience in nursing was 7.93, with a range of 1 to 27 years, and the mean years in critical care was 6.36, with a range of 1 to 20 years. The years of experience in both nursing and critical care were highly positively skewed. Eighty percent of the nurses had less than 5 years of nursing experience while the remaining 20% of participants had over 20 years of experience as a nurse. The more seasoned nurses on the unit pulled the mean to the right. As anticipated, most participants in the study were nurses with fewer than five years of experience.

Table 2: Characteristics of Sample

<table>
<thead>
<tr>
<th></th>
<th>All Participants</th>
<th>%</th>
<th>Pre and Post only</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>71.4</td>
<td>9</td>
<td>69.2</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>28.6</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>14</td>
<td>66.7</td>
<td>9</td>
<td>69.2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4</td>
<td>19.0</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>14.3</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>Previous Exposure to MD</td>
<td>18</td>
<td>85.7</td>
<td>12</td>
<td>92.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>M (SD)</th>
<th>Median</th>
<th>M (SD)</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years Nursing</td>
<td>7.93 (6.40)</td>
<td>7.00</td>
<td>8.50 (6.45)</td>
<td>8.00</td>
</tr>
<tr>
<td>Years Critical Care</td>
<td>6.36 (5.46)</td>
<td>4.00</td>
<td>6.81 (5.06)</td>
<td>5.00</td>
</tr>
</tbody>
</table>
Healthy Coping

At each point in the data collection process, the participants identified their current healthy coping techniques. Table 3 describes the healthy coping techniques used by the study participants. The most frequent healthy coping techniques were spending time with family and friends, exercise, watching television, and participating in hobbies. Two participants identified “other” techniques, which included being alone and spending time with their pet. No participant indicated he or she had zero healthy coping techniques nor did any participant list any unhealthy techniques.

Table 3: Healthy Coping Techniques used by Participants

<table>
<thead>
<tr>
<th></th>
<th>All Participants, N=21</th>
<th>%</th>
<th>Pre and Post only n = 13</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise</td>
<td>15</td>
<td>71.4</td>
<td>9</td>
<td>69.2</td>
</tr>
<tr>
<td>Hobbies</td>
<td>13</td>
<td>61.9</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Yoga</td>
<td>2</td>
<td>9.5</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Meditation</td>
<td>3</td>
<td>14.3</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Prayer</td>
<td>9</td>
<td>42.9</td>
<td>6</td>
<td>46.2</td>
</tr>
<tr>
<td>Social Media</td>
<td>5</td>
<td>23.8</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Watching TV</td>
<td>15</td>
<td>71.4</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Browsing the Internet</td>
<td>10</td>
<td>47.6</td>
<td>7</td>
<td>53.8</td>
</tr>
<tr>
<td>Listening to Music</td>
<td>12</td>
<td>57.1</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Spending Time with Family or Friends</td>
<td>19</td>
<td>90.5</td>
<td>12</td>
<td>92.3</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>9.5</td>
<td>1</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Primary Aim Findings

The primary aim of this project was to examine the effect of four evidence-based debriefing session for critical care nurses on their self-reported level of moral distress. The data analysis plan was to use Repeated-Measures Analysis of Variance (RM-ANOVA); however, this study was too underpowered to complete the data analysis as planned. Additionally, due to the variable participation rates across all data collection points, there was too many missing data to conduct
the RM-ANOVA. Thus, the primary aim is unable to be answered the way it was originally intended. Instead, the pre-survey moral distress thermometers (MDT) scores and the post-survey MDT for the 13 participants who completed both a pre- and post-survey were analyzed. Using paired sample $t$ test, no significant difference was found between mean MDT pre and post ($t(12) = 0.78, p = .450$).

The mean MDT scores were also examined using descriptive statistics. Table 4 illustrates the descriptive statistics about the MDT scores at each data collection point through the project. As a reminder, MDT scores range from 0 to 10. The baseline “pre” mean MDT score was 3.12. At the first three debriefing sessions, the mean MDT score actually rose each time. Then the fourth debriefing session and the post-survey the mean MDT drifted down towards the baseline pre-survey score. It is important to note there was a four-week gap between the third and fourth debriefing session, instead of the usual two weeks. This unintended gap in time was due to a natural disaster that occurred in the region where the project was implemented. The effect of this disaster will be further explored in Chapter 5.

Table 4: Scores on Moral Distress Thermometer *

<table>
<thead>
<tr>
<th></th>
<th>N=21</th>
<th>M (SD)</th>
<th>Median</th>
<th>n=13</th>
<th>M (SD)</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>17</td>
<td>3.12 (2.62)</td>
<td>2.00</td>
<td>13</td>
<td>3.77 (2.62)</td>
<td>4.00</td>
</tr>
<tr>
<td>Debrief 1</td>
<td>5</td>
<td>3.80 (2.68)</td>
<td>4.00</td>
<td>4</td>
<td>4.50 (2.52)</td>
<td>4.00</td>
</tr>
<tr>
<td>Debrief 2</td>
<td>4</td>
<td>5.00 (2.58)</td>
<td>5.00</td>
<td>1</td>
<td>8.00 (na)</td>
<td>8.00</td>
</tr>
<tr>
<td>Debrief 3</td>
<td>3</td>
<td>5.33 (1.16)</td>
<td>6.00</td>
<td>2</td>
<td>5.00 (1.41)</td>
<td>5.00</td>
</tr>
<tr>
<td>Debrief 4</td>
<td>4</td>
<td>3.25 (0.50)</td>
<td>3.00</td>
<td>4</td>
<td>3.25 (0.50)</td>
<td>3.00</td>
</tr>
<tr>
<td>Post</td>
<td>16</td>
<td>3.31 (2.02)</td>
<td>3.50</td>
<td>13</td>
<td>3.15 (2.08)</td>
<td>3.00</td>
</tr>
</tbody>
</table>

* Each participant may not have completed a survey at each data point

Secondary Aims Findings

This project had three secondary aims. Findings for each are discussed below.
**Correlation Between the Sessions and MDT Scores**

The first secondary aim of this project was to examine if a correlation exists between the number of sessions attended and the nurses’ self-reported level of moral distress at the end of the project. Pearson’s product moment correlation coefficient was used to test this aim. There was no relationship between number of sessions and post MDT scores among all participants ($r = .02, p = .937$).

**Sustainability Over Time**

The second secondary aim was to assess if changes in self-reported moral distress are sustainable. The study used a four-week washout period of no evidence-based debriefing sessions to achieve this aim. Due to the high amount of missing data it was impossible to complete the RM-ANOVA analysis as originally planned. This aim could not be answered.

**Benefits of Debriefing**

The third secondary aim for this project was to determine how debriefing sessions impacted participants’ ability to create strategies to reduce their moral distress. On the post-survey, each participant was asked two additional questions:

- Since participating in the debriefing sessions, what personal action plans have you created to decrease your moral distress?
- If the debriefing sessions helped you with your moral distress, please describe how.

Ninety-three percent of participants who completed the post-survey (15 out of 16 nurses) answered these two questions. The answers to these questions provide insights into how the debriefing sessions helped participants. Table 5 summarizes the responses from participants.
Table 5: Themes from the Participants’ Responses About How Debriefing Helped

<table>
<thead>
<tr>
<th>Theme</th>
<th>Significant Statements</th>
</tr>
</thead>
</table>
| Increase Self-Awareness       | More aware of what causes moral distress  
                               | Understand why I feel sad sometimes                                                    |
| Connect with Colleagues       | Feel less alone  
                               | Helped discussing MD with those who were in the same situation  
                               | Learned what others do to cope helps me cope better                                    |
| Foster Self-care Habits       | Exercise  
                               | Eating healthy foods  
                               | Spending more time with support system  
                               | Spending time in nature  
                               | Take time off work                                                             |

Conclusion

This project’s primary aim was to determine if evidence-based debriefings changed critical care nurses’ self-reported moral distress scores. There was no statistically significant change in the MDT scores when comparing the pre- and post-scores. Participants did, however, comment that debriefing was helpful to them by increasing their self-awareness, giving them time to discuss their distress with their colleagues, and encouraged them to improve their self-care habits.
Chapter 5
Discussion and Conclusions

This final chapter provides a discussion of major findings of the study. Nurses’ exploration of their own moral distress, the impact of debriefings, and strategies to build moral resilience are discussed. Lastly, limitations of the project, implications for clinical and educational practice, and recommendations for future research are also examined.

Discussion of the Findings

This project explored the changes in critical care nurses’ self-reported moral distress level before, during, and after four 30-minute debriefing sessions over a 16-week time period. The scores started low at the beginning of the study and rose as participants engaged in evidence-based debriefing. Participating in the debriefings may have increased their self-awareness, allowed them to spend time with their peers, and to develop ways to foster their own self-care. These actions may help nurses build moral resilience and, subsequently, help combat moral distress.

Discovering Moral Distress

The MDT scores was not significantly changed over the course of this project. This could be due in part to the timeframe for this project. The time between the pre-and post-surveys was sixteen weeks, with each debriefing two to four weeks apart. The project was intentionally designed this way because the MDT was created to be used no more than every two weeks (Wocial & Weaver, 2013). No empirical evidence exists that indicate how long it takes to change one’s
moral distress or how long it takes to build moral resilience. These questions remain to be answered with further research.

The MDT scores reported by the participants on the pre-survey were lower than anticipated. Based on the feedback received from nurse leaders on the unit, during the design phase of this study and while conducting an organizational needs assessment, pre-survey scores were anticipated to have been much higher. Perhaps participants were not aware of their own moral distress at the start of the project. Many of the participants who completed the post-survey commented that they became much more self-aware of their moral distress after participating in the debriefing sessions. This may indicate that before the project they lacked self-awareness and, thus, scored themselves low on the pre-survey.

**Impact of Debriefing**

As previously mentioned, the mean MDT score was lowest at the beginning of the study and rose after debriefing sessions #1-3. One may attribute this finding to the participants increase in their own self-awareness at each debriefing session. Subsequently, becoming more self-aware may actually lead to reported higher MDT scores. Because the first step of AACN’s 4A’s of moral distress is to “Ask” of you have moral distress (AACN, 2008), this was a key component of each debriefing. By giving the participants time to explore their own moral distress, discuss their distress with colleagues, and acknowledging their feelings, the participants likely became more self-aware. This self-awareness might also assist the participants in negating the formation of moral residue and halting the crescendo effect (Epstein & Hamric, 2009). Such improvements in self-awareness and the concomitant rise in MDT scores across the first three debriefing sessions is considered a favorable finding of the study.
The changes in MDT scores during the first three debriefing sessions could also have been influenced by the Hawthorne Effect. The Hawthorne Effect happens when study participants modify their behavior when they know they are being observed (McCarney et al., 2007). The participants might have altered their behavior or their self-reported MDT scores simply because they were being observed as study participants.

The project participants’ self-awareness seemed to spread beyond the debriefing sessions. Anecdotally, the nursing leadership on the unit noted that between sessions, many of the nurses seemed to be discussing moral distress among themselves, sharing their experiences from the debriefings, and talking about their personal action plans for combatting moral distress. This created a positive energy around the unit and other nurses who did not participate at the beginning of the study became interested in the project and joined in. The attention and mental energy being paid to moral distress by the nurses in the MICU may have further contributed to the rise in scores in each of the first three debriefing session.

The region where this project was conducted was struck by a historic natural disaster just prior to when debriefing session four had originally been scheduled. This disaster was not anticipated and was devastating to the region. Many of the participants in the project were mandated to remain at the hospital for four to five consecutive days to provide patient care. During this time, nurses were unaware if their families or friends were safe or if their homes and property had been destroyed. Many others who were not at the hospital during the disaster were evacuated or had to relocate into temporary shelters. More than a week passed until the hospital was able to resume normal operations. The last debriefing session was scheduled a week after normal operations resumed. By this time, the focus on the unit had shifted away from moral distress and any
progress made over the previous weeks of the study. As expected, all of the survivors of the disaster were focusing their mental energy on other stressors, such recovering from the disaster. While they may still have been interested in addressing their own moral distress, this was no longer the focus of many of the participants in the immediate post-disaster time period when the fourth debriefing session and post-survey took place. The mean MDT scores for debriefing session 4 and for the post-survey nearly returned to where they had been at the beginning of the project.

During natural disasters, nurses are at risk for facing morally distressing situations. During Hurricane Katrina in 2005, the situation necessitated that nurses make life-or-death decisions about which patients to evacuate from the hospitals. Furthermore, some reports indicated scenarios where healthcare providers administered medications to hasten death for already dying patients who could not be evacuated (Finks, 2009). Largely this was due to the hospitals flooding, losing water and electricity, and depleting medication supplies. Many facilities had limited capacity to evacuate critically ill patients. Fortunately, the hospital where this project was conducted had spent millions of dollars over the past decade to prepare its infrastructure for such disasters (T. Riley, personal communication, September 8, 2017). While some outpatient offices flooded, electricity was never lost, no inpatient unit required closure during the disaster, and no patients required evacuation. In fact, many surrounding hospitals evacuated their patients to this facility. The hurricane itself likely caused moral distress for the nurses, knowing that there were likely patients who could not reach the hospital and get the treatment they needed during the disaster. Despite this, the MDT scores returning to baseline after the disaster reinforces that the nurses’ attention and mental energy were focused on other stressors instead of their own moral distress.
Moving Towards Resilience

Self-awareness is the first step towards building moral resilience (Rushton, 2016). The debriefing sessions created a forum that allowed participants to explore their feelings of moral distress and created self-awareness. Self-awareness encompasses the first two A’s of AACN’s 4A’s of Moral Distress, Ask and Affirm (AACN, 2008). Many participants articulated this in the comments placed on the post-survey.

One participant wrote: “[The debriefing sessions] helped me vent my feelings. I have more outlets to combat moral distress—to be physically healthy and mentally prepared every time [I] go to work, and to find time to rejuvenate my mind and body when I am experiencing distress.”

Another participant noted: “just talking about things” helped them become more aware. This self-awareness then helps one understand their triggers for moral distress so they can better cope with it.

Another important aspect of building moral resilience is giving nurses time to empathize with their peers (Lachman, 2016; Rushton et al., 2016). By giving them time discuss their feelings with their colleagues and understand that they are not alone, nurses can become more resilient to their moral distress. This opportunity occurred during all parts of the debriefing sessions, but they particularly focused on this when they discussed the “Assess” aspect of the 4A’s (AACN, 2008). During “Assess”, they talked about how their moral distress affected their work and personal lives. During “Assess”, participants were able to discuss with their peers how their shared experiences impacted them individually. Many of the participants in the project expressed that
they benefited from spending time discussing their moral distress with their colleagues during the debriefing sessions.

One participant wrote: “Helped me to realize that we all go through moral distress, that I am not alone. Moreover, there are people with whom I can go to as resources to express when I feel distress.”

Another participant wrote “I’m not alone! My co-workers’ experience is very similar to mine.”

By spending time with their colleagues discussing their moral distress, nurses realize they are not the only ones who experience these feelings. Nursing leaders who create a protected time and space to allow such discussions can help facilitate growth of moral resilience in their staff.

Another technique for building moral resilience is to foster self-care (ANA Professional Issues Panel on Moral Resilience, 2017). The last “A” in the AACN’s 4A’s of moral distress (AACN, 2008) is “Action.” In the last few minutes of each debriefing, the moderator asked the participants to create an action plan for themselves that they would implement after the debriefing. These action plans included many self-care techniques, such as exercise, yoga, healthy eating, spending time in nature, spending time with their social support systems, prayer, or meditation. On the post-survey, 100% of participants noted they were more focused on their self-care since attending the debriefings. Encouraging self-care is crucial for developing moral resilience (ANA, 2017).

**Limitations**

This DNP project had several limitations. First, it was conducted on a single unit at one hospital site. The sample was a convenience sample which was also small. Overall, the study was
underpowered. It is difficult to draw conclusions with such a small $n$. Both of these issues could be addressed by repeating this study on multiple critical care units and at multiple hospitals.

Another limitation of this study was the timeframe. It is currently unclear how long it takes to change moral distress and build moral resilience; this was not discussed in the literature. As such, a timeframe of 14 weeks was selected because it worked well for the needs of the nursing unit and for the time constraints of the DNP program. However, it is likely that this timeframe may have been too short to truly impact the MDT scores as intended. Further research is warranted to examine how long it might take to change one’s moral distress and build moral resilience.

Lastly and perhaps most dramatically, the implementation and data collection for this project was interrupted and delayed by a natural disaster. This natural disaster delayed the project by two weeks. Although the project was able to continue after the hospital resumed normal operations, the mood on the unit following the disaster had changed. While it is unclear how outcomes of the project may have been different had a hurricane not occurred, it is possible the natural disaster influenced the project and its outcomes.

**Implications for Nursing Practice and Education**

This study has several implications for future practice, nursing education, and future research. The primary implication for nursing practice is that the use of debriefing may improve nurses’ self-awareness of their moral distress and may help them build moral resilience. Additionally, when nursing leaders allow their staff time away from bedside practice to engage in an exercise such as debriefing, they are showing their staff that they are valued assets. This may improve the nurses’ satisfaction and desire to stay with their organization.
Another possible implication for practice is a potential for improving patient care. It has been shown that patients have worse outcomes when getting care from nurses with moral distress (Corley, 2002). Patients benefit from receiving nursing care from nurses without moral distress. Healthcare organizations that acknowledge moral distress is a very real issue could support the nursing staff by creating programs to build moral resilience for their staff.

Healthcare organizations may also benefit from routinely using debriefing to combat moral distress. Moral distress is linked to higher turnover rates (Corley, 2002). By investing time and resources in training moderators to effectively debrief and giving staff time away from patient care to participate in debriefing, organizations may be able to retain their nursing staff longer. In fact, turnover is often quite high for recently graduated nurses (Colosi, 2016). By focusing on developing moral resilience in graduate nurses, while they are still in their residency, organizations may be able to retain these nurses longer. Considering that nurse residency programs cost approximately $200,000-$400,000 per year (Hansen et al., 2013), losing these nurse residents after 12 or 18 months is a financial burden. Spending resources to help the nurse develop moral resilience could equate to eventual cost savings.

Lastly, this project has implications for nursing education. Teaching moral agency to nursing students may equip them more effectively as they transition into practice. Nursing faculty and nursing students must become aware of the crescendo effects and moral residue that result from repeated exposures of moral distress (Epstein & Hamric, 2009). Furthermore, teaching future nurses about moral resilience and using debriefing while students are in school may help them build moral resilience before they even start practicing. Preparing them for the moral complexities they will inevitably encounter once they are in practice, teaching them moral agency,
and equipping them with tools to build their own moral resilience may help the future generations of nurses overcome moral distress.

**Recommendations for Further Study**

More research needs to be conducted in the area of moral distress and moral resilience. A longitudinal study, conducted over one year or longer, may shed light on how nurses’ self-reported moral distress scores change over time. Further research could also be conducted to show how using an intervention such as debriefing effects turnover rates and employee satisfaction scores. Studies could also be done in other settings outside of critical care, such as in acute care or the peri-operative environment, as well as at other types of organizations, such as clinics, hospice centers, community hospitals, and public hospitals. Lastly, studying how debriefing affects nurse residents in their first year of practice would also be beneficial.

**Conclusion**

Chapter 5 articulated a discussion of the major findings of the study. A discussion ensued about discovering moral distress, the impact of debriefing, and moving toward moral resilience. Limitations of the study were addresses. The chapter concluded with implications for nursing practice and nursing education as well as recommendations for future research.

Moral distress is a persistent and well-documented problem for nurses. Implementing interventions, such as an evidence-based debriefing, may help nurses become more self-aware, help them foster their self-care, and allow them time to commune with their peers. Creating opportunities for nurses to use debriefing may be an effective way to combat moral distress and build moral resilience.
Appendix A: Pre-and-During Survey

Using Evidence-Based Debriefing to Combat Moral Distress Survey

Gender: ____________________________ Race: ________________________________
How many years have you been a nurse? _____________________________________
How many years have you been working in critical care? _________________________
Have you been exposed to the concept of moral distress before? Yes No
What sorts of health stress reduction techniques do you currently participate in? (Circle all that apply)
   Exercise        Hobbies        Yoga
   Meditation      Prayer         Social Media
   Watching TV     Browsing the internet Listening to music
   Spending time with friends/family
   Other: _________________________________________________________________
   I don’t currently do any healthy stress reduction techniques

Moral Distress is when you must act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity.

Please indicate the level of moral distress you have felt in the past two weeks.

Moral Distress Thermometer

(Source: Wocial, L. D., & Weaver, M. T. (2013). Used with permission from L.D. Wocial)
Appendix B: Post-Survey

Using Evidence-Based Debriefing to Combat Moral Distress Post-Survey

Gender: ____________________________ Race: ____________________________

How many years have you been a nurse? ____________________________

How many years have you been working in critical care? ________________

Have you been exposed to the concept of moral distress before? Yes No

What sorts of health stress reduction techniques do you currently participate in? (Circle all that apply)

- Exercise
- Hobbies
- Yoga
- Meditation
- Prayer
- Social Media
- Watching TV
- Browsing the Internet
- Listening to Music
- Spending time with friends/family
- Other: ____________________________

I do not currently do any healthy stress reduction techniques

Since participating in the debriefing sessions, what personal action plans have you created to decrease your moral distress?

If the debriefing sessions helped you with your moral distress, please describe how.

Please indicate the level of moral distress you have felt in the past two weeks.

Moral Distress Thermometer

Moral Distress is when you must act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity.

Worst Possible
Intense
Distressing
Uncomfortable
Mild
None

References


