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Identifying Moral Distress in Emergency Nurses

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DOCTOR OF NURSING PRACTICE (DNP)

IDENTIFYING MORAL DISTRESS IN EMERGENCY NURSES

by

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Abstract

Moral Distress (MD) is an ongoing reality for emergency department (ED) nurses and often emerges when caring for patients at the end of life. Repeated exposure to MD can result in resignation from the nursing profession. This study measured moral distress using the Measure of Moral Distress for Healthcare Professionals (MMD-HP) survey tool. The goal was to identify stressors known to cause moral distress, measure the frequency of their occurrence during the COVID-19 pandemic, and analyze the correlation to influence ED nurses to leave the position. The MMD-HP ranks the frequency of occurrence of stressful situations leading to moral distress with a 5-point Likert scale (0-Never to 5-Very Frequently) and intent to leave their clinical position in the emergency department (ED) with a "Yes" or "No" response.

This study used a Pearson correlation analysis to measure the relationship between the frequency of stressful situations and intent to leave the position. Participants included 17 ED nurses (94% females) aged 22-63 years (mean age = 43) who were actively working or worked in an ED during the COVID-19 pandemic. Strong correlations exist between leaving a clinical position and "Following a family's insistence to continue care perceived to be futile" and "Being required to work with abusive patients and family members who compromised care." Future interventions focused on self-care may help emergency nurses improve their ability to recognize and address moral distress.

Problem Statement and Significance

Moral distress is a pre-pandemic problem for nurses that will endure as long as healthcare providers experience stress related to caring for patients. Despite much information about moral distress and strategies to alleviate it, moral distress remains a healthcare persistence (Musto, Rodney, & Vanderheide, 2015; Sauerland, Marotta, Peinemann, & Robichaux, 2014). First identified by Andrew Jameton (1984), moral distress has been studied for decades. Corley et al. (2001) expanded this definition, describing moral distress as "the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institution policy, or legal considerations." (Wolf et al., 2016). Numerous research studies also define and describe moral distress and the resulting helplessness, despair, and disempowerment that results from it (Rushton, 2016). However, the problem persists, and current interventions lack to identify or sufficiently address it. As healthcare systems become more complex, patient health issues are becoming increasingly challenging to manage. These complexities will only intensify nurses' and other healthcare providers' risk of developing moral distress.

Emergency departments are the most complex environments to practice nursing. Patients presenting to an ED with life-threatening conditions have the potential to be hemodynamically unstable and may not communicate with the healthcare team for various reasons. Because of the fast-paced and chaotic nature of the ED, patients and their families are often highly stressed and unequipped for what they will face while they are cared for in an ED (Rah, 2016). During this unexpected stressful time, situations arise that require urgent and timely decision-making. Patients or their families are often emotionally unprepared to make the life-and-death decisions needed. These decisions create a high-pressure environment rife with morally complex situations

for nurses, healthcare providers, patients, and families. Nurses in the ED are exposed to physical labor, long work hours, demanding interpersonal interactions, and "suffering and emotional demands" (Raj, 2016). When morally distressing situations arise, nurses can become overwhelmed by the piling of stressors. When they perceive care that conflicts with their own moral beliefs, the distress could be severe. While many aspects of emergency nursing could contribute to moral distress, providing end-of-life care or futile care intensifies the moral dilemma. Moral distress may also develop when there are conflicting opinions among the healthcare team or a lack of collaboration among the healthcare team members (Karanikola et al., 2014). Rushton (2016) warns that moral distress can build over time, resulting in disempowerment, burnout, or resignation if left unaddressed. Effective interventions to reduce moral distress in emergency nurses need to be realized. The study recommends interventions leaders can employ to encourage self-care and improve coping mechanisms.

Purpose and Aims addressed by the Project

There are known emotional impacts on nurses witnessing patients' suffering in environments such as emergency departments. Studies show that emergency department nurses experience high-stress levels (Nassehi et al., 2020). This research aimed to examine how working in an emergency department during the COVID-19 pandemic contributes to increased moral distress. Regrettably, the added stress from the COVID-19 pandemic on emergency department nurses is inevitable. This project analyzed data to determine a correlation between frequency rankings of known stressors and nurses' intent to leave the nursing profession.

Methods used to Implement and Evaluate the Project

Design

This researcher chose a correlational design to measure the relationship between high and low frequency of stressful situations and nurses' intention to leave the profession. The intent to

leave the profession is hypothesized as correlated to the increased frequency of stressors. This design measured the dependent variable (stressors) and the independent variable (intent to leave the nursing profession). Quantitative data points from the Likert scale were embedded in the survey.

Population Sample

The population sample surveyed were registered nurses (RN) who worked in an emergency department during the COVID-19 pandemic. *Inclusion criteria* consisted of the nurses (1) be actively employed as a nurse in an emergency department, (2) being at least 18 years of age, and (3) functioning as a staff nurse, nurse manager, nurse leader, or APRN. *Exclusion* criteria consisted of nurses working in similar frontline critical care positions such as intensive care units and urgent care clinics that care for patients with a similar acuity but are not emergency departments.

Recruitment

The moral distress capstone project was posted to the Emergency Nurses Association (ENA) website research page to capture as many actively working ED nurses as possible. A G-power analysis predicted that 154 replies would signal statistical significance. The ENA organization is specific to ED nurses and serves a population of approximately 50,000 nurses (ENA, 2022). Participation in the survey implied consent. Additionally, no personal identifiers were collected. An introduction to the problem of moral distress was provided at the beginning of the survey when respondents participated. Partial completion of the survey was allowed. This freedom allowed nurses to answer essential questions and leave difficult or painful reminders of their COVID-19 experiences questions unanswered.

Instrumentation

The survey tool used for this project was the Measure of Moral Distress – Healthcare Professionals (MMD-HP) (Appendix A). The author, Dr. P. Whitehead, granted permission to use the MMD-HP survey tool for this project. This instrument contained twenty-seven questions related to moral distress according to the results of an extensive literature review. Seven questions collected demographic information, while the last two questions of the survey asked for a "Yes" or "No" answer to two specific self-reporting questions:

28. Have you ever left or considered leaving a clinical position due to moral distress?

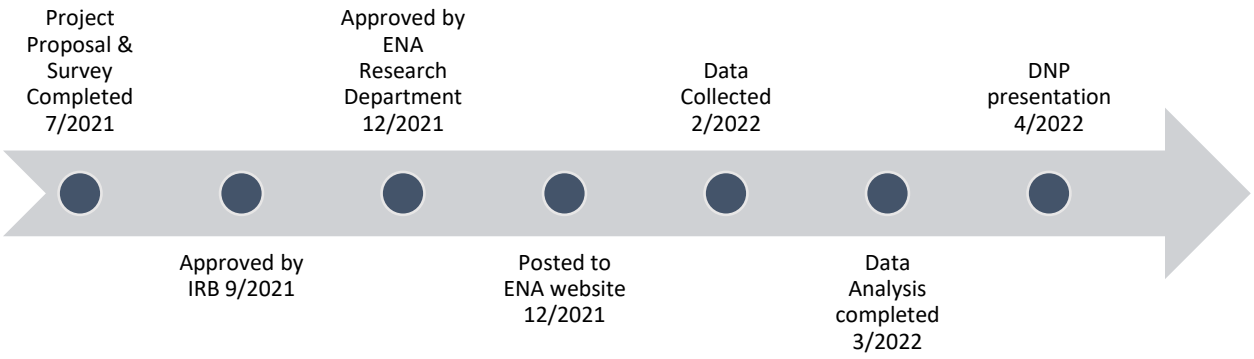
- *No, I have never considered leaving or left a position.*
- *Yes, I considered leaving but did not leave.*
- *Yes, I left a position.*

29. Are you considering leaving your position now due to moral distress?

- *Yes*
- *No*

The demographic characteristics included: age, gender, years of experience in nursing, years of experience in the ED, role, exposure, and setting for the survey collection timeframe during the COVID-19 pandemic. Survey participants rated twenty-seven items on a Likert scale, recording how often it occurs in their practice (frequency: 0 =Never, 1=Seldom, 2=Sometimes, 3=Frequently, 4 = Very Frequently). Epstein et al. (2019) validated the survey tool chosen for this study.

Timeline



This project design was completed and approved by the University of Nebraska Medical Center, Omaha (UNMC) Professional Graduate Nursing Affairs Committee (PGNA) in July 2021 and executed for data collection in December 2021. The Emergency Nursing Research department's research director was consulted in October to ascertain the study's submission criteria to the ENA website. They also provided insight for the principal investigator related to the nature of moral distress experienced by emergency nurses. An Institutional Review Board (IRB) application was submitted in September of 2021 to UNMC IRB, where this researcher attended the doctoral program. After approval by the UNMC IRB, the proposal was sent to the ENA research department for review in Nov.2021. The ENA required no additional IRB, but approval by their research department was needed before posting to the ENA research webpage. This review and approval were completed in December 2021. The survey was scheduled to run for thirty days to collect the most available respondents. By January 26, 2022, only 17 responses were collected. Consultation with capstone project advisors resulted in an agreement with this researcher to extend the survey collection timeframe for one additional week. Two additional responses were collected at the end of the extension, February 2, 2022. During the Spring of 2022, the project results were summarized and will be disseminated at the Virginia Association of Clinical Nurse Specialists spring conference (May 2022) as a podium and poster presentation.

Data Collection

The MMD-HP survey tool was posted on the ENA external research webpage for 35 days. Participants were recruited via their membership in the ENA organization, in that the survey was open to members who visited the research webpage. No other forums on the ENA webpage were approved to disseminate the survey. In the mid-month of January, the few responses gathered threatened the statistical significance needed to be met. Therefore an additional five days were added to the study. Overall, the response rate (N=19) was far below the needed rate (154) to gain statistical significance. Although the predicted response rate did not garner statistical significance, it gained practical significance. This gain is explained in the findings section.

Data Management Plan

Confidentiality was made available in the design of the study. No personally identifiable information from the participants was collected. Research Electronic Data Capture (REDCap), the data collection tool, assures confidentiality with data collection options, meeting Health Insurance Portability and Accountability Act (HIPAA) requirements. While this study offered no free text or "write-in" options, protecting the subjects' confidentiality was essential for this project. Data will be retained in UNMC's McGoogle Library in DigitalCommons@UNMC, an institutional repository, for perpetuity unless withdrawn. Electronic files captured in REDCap will be deleted after the project is completed.

Data Analysis

Study data were collected and managed using the REDCap tools hosted at the University of Nebraska Medical Center. REDCap is a secure, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export

procedures for seamless data downloads to standard statistical packages; 4) procedures for data integration and interoperability with external sources. Service and support are provided by the Research Information Technology Office (RITO), to which the Vice Chancellor for Research funds (REDCap 2022). Data was downloaded from REDCap into a Microsoft Excel spreadsheet by the project's Principal Investigator (PI). Pearson's Correlational coefficient value for nineteen responses was analyzed using the Microsoft Excel Data Analysis Toolkit.

Regression analysis examined the changes in the independent variables (measures of frequency of stressors) with shifts in the dependent variable (intent to leave position). P-values and coefficients in regression analysis revealed relationships in the responses, indicating statistically significant. Use of the Pearson's correlation coefficient analyzed if a relationship existed between the stressor frequency and the number of nurses intent to leave their positions. Pearson's product-moment correlation determines a relationship between two interval-level variables (Polite & Beck, 2016). Results were hypothesized to reveal three moral dilemmas correlated with high levels of self-reported moral distress and the intent to leave a nursing position. Previous studies revealed that health professionals experience various psychological and moral dilemmas when working in high-risk areas during disasters and pandemics (Whitehead et al., 2014). These dilemmas included 1) compromised individual responsibility, 2) delivering care not perceived to be in the patient's best interest, and 3) deception (Corley, 1995; Hamric et al., 2012). Three questions in this author's survey also capture these dilemmas. The figures below demonstrate the survey question and the ED nurse's percentage of frequency responses.

Figure 1

Witness healthcare providers giving "false hope" to a patient or family.

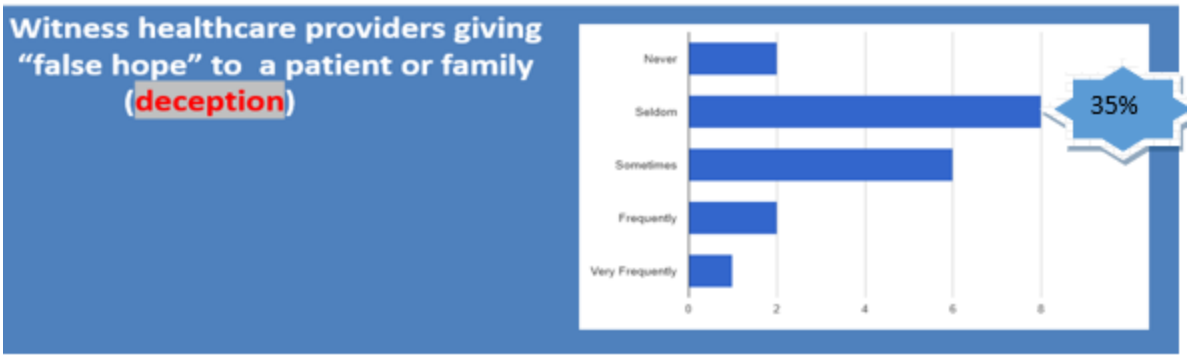
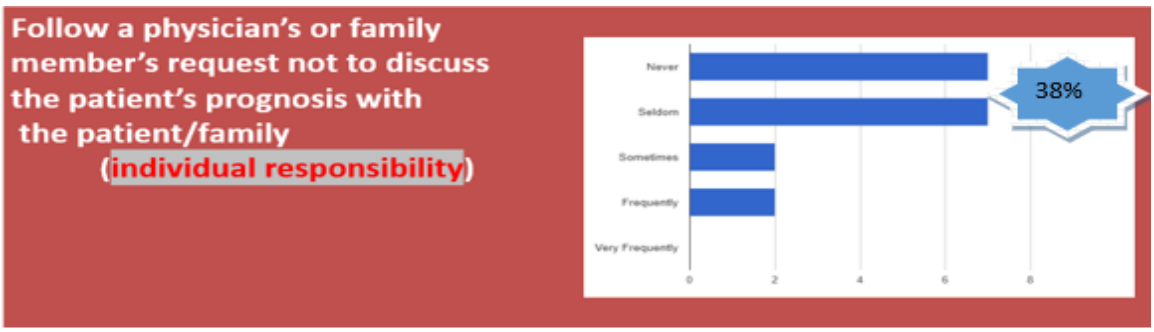


Figure 2

Participate in care that causes unnecessary suffering or does not adequately relieve pain.

Figure 3

Follow a physician's or family member's request not to discuss the patient's prognosis with the patient/family.



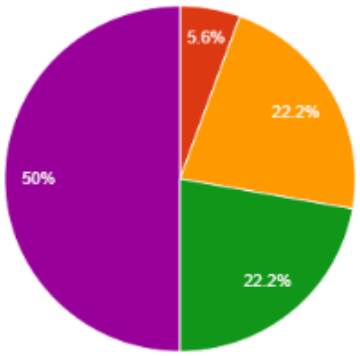
Findings

The MMD-HP scores were not statistically significant for frequency and influence of stressful situations on intent to leave. With a correlation coefficient of +1 indicating a perfect positive correlation, the two most frequent stressful situations were not correlated to the intent to leave the ED position. The Pearson's correlation scores measuring the two most frequent stressful experiences and the intent to leave were less than 1. This loss of significance could be due to the few responses received. Practical significance is gained related to the stressors that did show a strong correlation to the intent to leave. Two stressors, futile care and abusive patients, resulted in *r* coefficients of 0.53 and 0.52, respectively. The real-world significance of these pandemic stressors can be generalized to multiple nursing units as a patient's admission or length of stay will intersect with other units in a facility. Care and concern for nursing safety are highlighted in the stressor of "Be required to work with abusive patients/family members who compromise quality of care."

Approximately 50% of ED nurses reported compromised care related to resources as the most stressful situation occurring "Very Frequently." The Likert rating scale measured the frequency of lack of resources as **Never** (0.0%), **Seldom** (5.6%), **Sometimes** (22.2%), **Frequently** (22.2%), and **Very Frequently** (50.0%). The 5-point Likert rating scale matches the sections of the pie chart below. Figures 4 and 5 outline the percentages of the two most occurring stressors.

Figure 4

Percentage of nurses reporting "Experience compromised patient care due to lack of resources/equipment/bed capacity" occurring "Very Frequently."



A regression analysis of this question related to intent to leave an ED position resulted in a correlation coefficient of $r(35)$, $p=0.19$. The significance value of 0.19 is larger than the "P" value of 0.05, frequently used to measure the statistical significance (0.05 or 5%) and indicates that the study results are likely due to chance rather than intent to leave. The Pearson's Correlation Coefficient of 0.35 is much lower than 1, signaling the likelihood of chance versus a positive relationship between the two variables. The below table outlines the regression and Pearson's analyses results.

Table 1

Regression, ANOVA, Pearson Correlation Coefficients statistics for" Experience compromised patient care due to lack of resources/equipment/bed capacity and intent to leave an ED position related to moral distress."

SUMMARY OUTPUT

Regression Statistics	
Multiple R	0.35
R Square	0.12
Adjusted R Square	0.06
Standard Error	0.97
Observations	16.00

ANOVA

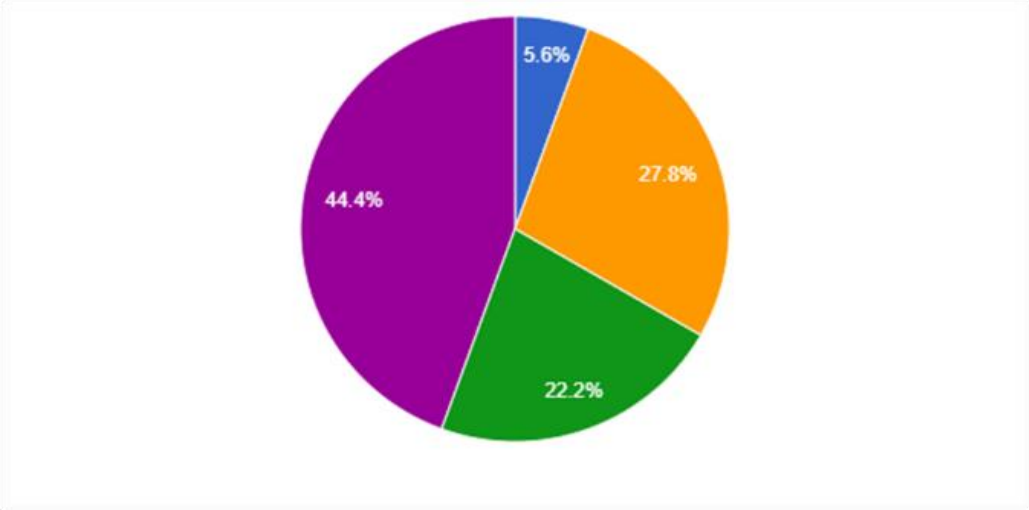
	df	*SS*	*MS*	*F*	*Significance F*
Regression	1	1.8	1.80	1.91	0.19
Residual	14	13.2	0.94		
Total	15	15			

	***Coefficient**s*	*Standard Error*	*t Stat*	*P-value*	*Lower 95%*	*Upper 95%*	*Lower 95.0%*	*Upper 95.0%*
(Lack of Resources)	2.9	1.01	2.88	0.01	0.74	5.06	0.74	5.06
Intercept Have you ever left or considered leaving a clinical position due to moral distress?	0.6	0.43	1.38	0.19	-0.33	1.53	-0.33	1.53

The second most frequent stressful situation reported by 44% of ED nurses was related to "being required to care for more patients than I can safely care for. " Below is a pie chart showing the percentages of frequency results of this question in the survey. The sections of the pie chart below are divided as Never (5.6%), Seldom (0%), Sometimes (27.8%), Frequently (22.6%), and Very Frequently (50%).

Figure 5

Percentage of nurses reporting "Be required to care for more patients than I can safely care for" occurring "Very Frequently."



A regression analysis of this question related to intent to leave an ED position resulted in a correlation coefficient and significance value of $r(27)$, $p = 0.31$. This result also indicates that the study results are likely due to chance rather than intent to leave. The table below shows the values from the regression analysis.

Table 2

Be required to care for more patients than I can safely care for, and intent to leave an ED position due to moral distress.

SUMMARY OUTPUT

Regression Statistics	
Multiple R	0.27
R Square	0.07
Adjusted R Square	0.01
Standard Error	1.18
Observations	16

ANOVA

	df	*SS*	*MS*	*F*	*Significance F*
Regression	1	1.51	1.51	1.09	0.31
Residual	14	19.43	1.39		
Total	15	20.94			

	Coefficients	*Standard Error*	*t Stat*	*P-value*	*Lower 95%*	*Upper 95%*	*Lower 95.0%*	*Upper 95.0%*
(Safely care for patients)	2.83	1.22	2.31	0.04	0.21	5.44	0.21	5.44
Intercept								
Have you ever left or considered leaving a clinical position due to moral distress?	0.55	0.53	1.04	0.31	-0.58	1.68	-0.58	1.68

The responses were not the same results found in the literature review, as hypothesized, for this capstone project. The ED nurses working at the front lines during the COVID-19 pandemic did not rank deception or compromised individual responsibility as the most frequent moral dilemmas. Two of the three themes, deception, and compromised individual responsibility, were ***seldomly*** experienced by 54% of this survey's responders. This response variability is likely related to timeframe differences in this survey and previous surveys measuring moral distress. Factors affecting this variability could be related to a) the absence of an enduring pandemic, b) the specificity of the survey population, and c) advances in technology in healthcare.

The enduring pandemic did not initially offer stress relief through social connectedness, facility or organizational support, or a focus on self-care interventions. The focus of many organizations and healthcare systems was on supplies and bed capacity. Therefore ED nurses relied on experience and self-resolve to cope with moral dilemmas. Henshaw 2020, writes, "The stresses and strains associated with encountering challenging and difficult situations can be tempered by the satisfaction engendered through the intimacy of the nurse/patient relationship." This intimacy was virtually removed through the isolation of COVID-positive patients and the nurses' personal protective equipment (PPE). Throughout the pandemic, emergency department nurses selflessly served the frontlines, while the longevity of the COVID-19 pandemic worsened the moral distress level.

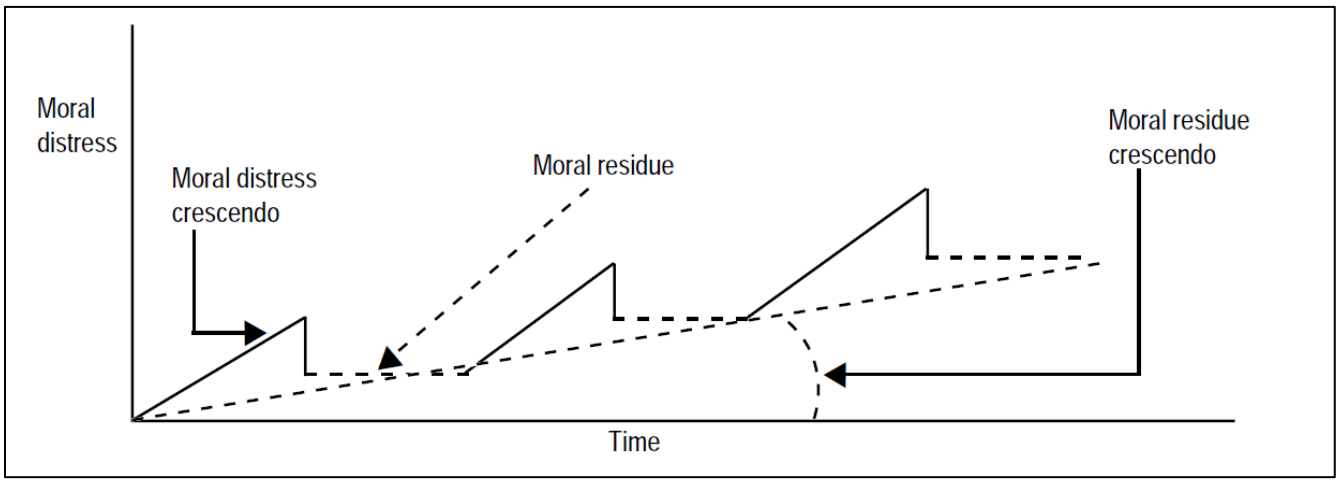
The specificity of the ED nursing population may lend to an ineffective description of moral distress among emergency nurses because of the unique features of the emergency department (Zavotsky & Chan, 2016). During the pandemic, specific challenges in the emergency department created stressors in which nurses' core values and perceived responsibilities were mismatched with the primary views of the work environment. This

mismatch likely happened with greater frequency and intensity and with less opportunity for recovery because of the fast-paced environment of an ED. These unique features are a limitation of this study in that a specific nursing specialty was queried for responses.

The unique nature of emergency nursing and an ongoing inner conflict results in a crescendo effect. Epstein and Hamric (2009) outlined the crescendo effect as a contributory factor and outcome of moral distress. The crescendo effect postulates the relationship between moral distress and moral residue. The term moral residue refers to the enduring feelings of reactive distress identified earlier by Jameton (1993). Over time, after each experience of moral distress, the intensity of the feeling dissipates. However, a level of moral residue remains, creating a new baseline. It is suggested that increasing incidents of moral distress result in cumulatively increasing levels of moral residue creating increasingly intense crescendos. New incidents of moral distress incite more intense emotional reactions as the person is reminded of earlier experiences. Figure 6 shows the crescendo effect over time.

Figure 6

Model of Crescendo Effect



Note: Solid lines indicate moral distress, dotted lines indicate moral residue

Technology during the pandemic was also a factor affecting care related to a lack of sufficient time, resources, and reliance on technological resources that were not dependable. This is evidenced by 44% of survey nurses ranking "*Experience compromised patient care due to lack of resources/equipment/bed capacity*" as occurring "Very Frequently."

This capstone survey revealed two questions that produced high-frequency experiences with stressful situations. One situation was related to working with a lack of resources, bed capacity, and equipment. Another was related to being required to care for more patients than the nurse felt safe to care for (nurse-patient ratio). Additionally, a moderate correlation was found between two other stressors listed in the MMD-HP survey: 1) Being required to work with abusive patients/family members who are compromising quality of care, $r(0.52)$, and 2) Following the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient, $r(0.53)$. Emergency department nurses are at the frontlines of healthcare and are often the first to encounter patients with the highly contagious COVID- 19. This exposure rate makes them more susceptible to infection (Huang et al., 2020). This level of exposure also contributed to high-stress levels during this pandemic. These stressors are specific to emergency nurses and more severe than their peers in other nursing units (Adriaenssens et al., 2013).

No empirical evidence indicates the length of time needed to change moral distress into moral resilience. Further research could answer these questions. A study was performed in Seoul, South Korea, to examine stress coping styles related to work stress and the psychological well-being of clinical nurses. The nurses were divided into two groups based on having three years or less experience or having over three years of experience. Their work stress was measured using The Work Stress Scale. The Work Stress Scale is a Likert scale that consists of which consists of

overload of work, role conflict as a professional nurse, lack of professional knowledge and technical skills, relational problems, personal conflict with doctors, work conflict with doctors, the psychological burden of clinical limitations, improper treatment, dissatisfaction with supervisor, inadequate salaries, dissatisfaction with subordinates, inappropriate physical environments, nonoccupational responsibilities, unfamiliar situations, and night shift work. Levels of work stress were significantly related to the psychological well-being of the nurses with three years or less experience. However, work stress was not significantly related to the psychological well-being of the nurses with greater than three years of experience. Stress coping techniques had different mediating effects on work stress and psychological well-being, depending on nurses' career experience (Dodek et al., 2016). Differing needs of nurses at different levels of nursing experience necessitates sculpting stress and coping intervention plans according to nurses' career experience (Jang et al., 2019). These findings suggest that addressing moral distress in emergency department nurses during the COVID-19 pandemic may necessitate implementing different approaches and coping mechanisms based on years of nursing experience. Twenty-nine percent of the nurses in this study had < 5 years' emergency nursing experience, leaving 71% with 10+ years of ED nursing experience.

Discussion

This project explored the frequency of stressors in the self-reported MMD-HP survey of emergency nurses over 35 days. The rankings of specific stressors occurring most frequently differed from hypothesized, and the strongest correlation to intent to leave a position was also revealed. Fernandez-Parson et al. (2013) also conducted a similar study in which frequency, intensity, and type of moral distress were measured. Their findings were similar to Corley's in that situations with the highest levels of moral distress were related to following the family's wishes to continue life support, also known as futile care. The Fernandez-Pearson study showed

that 6.6% of registered nurses left a position because of moral distress, and 20% said they did not leave. However, they considered it, and 13.3% stated they were currently considering leaving.

The study aimed to determine if COVID-19 exacerbated stressors known to cause moral distress and increase the intent to leave a nursing position and to measure the impact. A validated measurement tool, the MMD-HP, was selected purposefully to see if the same correlations existed pre-pandemic. One stressor did (futile care), and one did not (abusive patients). The stressors related to abusive patients and families did not strongly correlate with intent to leave in Whitehead et al.'s 2015 study. . Two of the three identified themes by Corley et al. 1995, related to moral distress in nurses were not evident in this study's findings. Providing care that was perceived as futile had the strongest correlation $r(0.53)$ with intent to leave. The second stressor that also correlated r(0.52) strongly with impacting the intent to leave was being required to work with abusive patients and family members who compromised care. This correlation was a new finding and is not evident in previous studies of moral distress in emergency nurses. The strain of caring for abusive patients and families ranked second in importance to delivering care that promotes quality of life for the patient. This ranking depicts the essence of emergency nurses' caring and sacrificial character.

Participating in the MMD-HP survey may have increased nurses' self-awareness of moral distress. Hopefully, they will acknowledge this and seek self-care for themselves and their peers. Likewise, leaders are pivotal in developing ways to foster self-care. Multiple nursing professional organizations offer supportive programs for nurses.

Strengths

Self-awareness is the first step toward building moral resilience (Rushton, 2017). The

survey created a forum that allowed participants to explore their feelings of moral distress and potentially create self-awareness. This study's data and results can be used to adjust or develop interventions or policy changes to address moral distress. Additionally, increased awareness of sources of moral distress will be revealed and lend to the understanding of emotions and struggles ED nurses may not be willing to share with their peers or superiors. An anonymous web-based survey allows for disclosing emotions and coping mechanisms that remain hidden in the nurses' work environment. These hidden coping mechanisms may be unconventional, illegal, or damaging to the nurses' well-being. Lastly, sources or reasons for nurses' intent to leave the profession of nursing will be quantified.

Limitations

The small response size is a limitation and adds bias variability to the results. Additionally, the population is specific to emergency nurses, which includes a characteristic of "bearing the burden" of care and the patient responsibility. Additionally, fatigue from the enduring pandemic likely produced "survey" fatigue that many healthcare professionals experience.

The sample was a convenience sample and underpowered. These barriers to statistical significance could be modified by repeating this study in EDs at multiple hospitals. Furthermore, the timeframe proved to be a limitation. The length of time to detect moral distress changes to build moral resilience is not supported in the literature. The 35-day timeframe of data collection was scheduled because it fit the time constraints of the DNP program. However, this timeframe may have been too short to collect MMD-HP rankings as needed.

Conclusions

By spending time in self-care, nurses realize they are experiencing moral distress. Emergency nurses are known to "carry the burden," as described by Wolf et al. Patient care outcomes worsen when receiving care from nurses with moral distress (Corley, 2002).

Healthcare organizations recognizing moral distress as a debilitating workforce issue can support nurses by creating programs to build moral resilience. Moral distress is also correlated with high turnover rates (Corley, 2002). By investing time and resources in providing staff time away from patient care to participate in self-care interventions, organizations may be able to retain their nursing staff longer. Finally, this project has implications for nursing education. Preparing nursing students and faculty for the moral complexities they will inevitably encounter once they are in practice and equipping them with tools to build their moral resilience may help future nurses overcome moral distress.

Recommendations

Implications for nursing practice and future research are found in this study. These findings may improve nurses' self-awareness of their moral distress and may help them build moral resilience. Likewise, when nursing leaders allow their staff time away from bedside practice to engage in self-care exercises such as the 4-A's of the AACN and ENA's Mental Resilience and Well-Being for Nurses, they show their staff is valued. Self-awareness incorporates the first two A's of AACN's 4A's of Moral Distress, Ask, and Affirm (McQue, 2010). This will improve nurses' satisfaction and desire to stay in their organization and position. Moral resilience has been proposed as one strategy to mitigate moral distress in nurses (Rushton et al., 2017). Recent conceptualizations of nurses' resilience by Reyes et al. (2015) showed nurses understood resilience as a "dynamic, action-oriented process of "pushing through." Wolf et al. (2016) lists cause of moral distress in emergency nurses as "environment driven, as is described in other settings, and include a high-acuity, high-demand, technical environment with insufficient resources." Interventions directed toward a safe environment decrease causes of moral distress of emergency nurses. Moral distress is not a problem of individual nurses or

nursing. The problem is that nurses have been so busy taking care of others that no one has cared for them.

Interventions to address moral distress could include safe working environments, safe nurse-to-patient ratios, mental health resources, adequate supply of resources, and specific support programs for new and newer nurses. Pizza parties and snacks do not address moral distress adequately (author's emphases). Additionally, recognition of appreciation is equal to their value. Increased workforce flexibility is beneficial as COVID-19 quicken the implementation of novel staffing approaches to create additional flexibility in workforce deployment. For example, some employers may continue using telemedicine and telehealth, allowing nurses to work remotely more often. Epstein et al. (2020) posit "that health care organizations have a fundamental obligation to mitigate and prevent the costs of caring (e.g., moral distress, secondary traumatic stress) and to foster a sense of mattering.

More research needs to be conducted on moral distress and resilience to show how self-care and safe environment interventions affect turnover rates and employee satisfaction scores. Studies could be conducted in other settings outside of emergency care facilities, such as acute care, urgent care, and other organizations, such as clinics, hospice centers, and community hospitals. A study of moral distress and its effects on new nurses in their first years of practice would also be beneficial. Nursing leaders can create individual time and space to allow interventions to facilitate the growth of moral resilience in their staff. Encouraging personal self-care is crucial for developing moral resilience (Musto et al., 2015).

Disclosure: This author is an emergency nurse with 22-years of experience.

References

Adriaenssens, J., Gucht, V. D., & Maes, S. (2013). Causes and consequences of occupational stress in emergency nurses: A longitudinal study. *Journal of Nursing Management*, *23* (3), 346–358. https://doi.org/10.1111/jonm.12138

American Association of Critical Care Nurses (2021). Moral Distress Tool. https://www.aacn.org/~/media/aacn-website/clincial-resources/moral-distress/recognizing-addressing-moral-distress-quick-reference-guide.pdf.

Arnold, T. C. (2020). Moral distress in emergency and critical care nurses: A metaethnography. *Nursing Ethics*, *27*(8), 1681–1693. https://doi.org/10.1177/0969733020935952

Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics, 9*(6), 636-650. DOI: 10.1191/096973002ne557oa.

Corley, M. (1995). Moral distress of critical care nurses. *American Journal of Critical Care, 4*(4), 280–285. https://doi.org/10.4037/ajcc1995.4.4.280

Dodek, P., Wong, H., Norena, M., Ayas, N., Reynolds, S., Keenan, S., Hamric, A., Rodney, P., Stewart, M., & Alden, L. (2016). Moral distress in intensive care unit professionals is associated with profession, age, and years of experience. *Journal of critical care, 31* (1), 178–182. https://doi.org/10.1016/j.jcrc.2015.10.011

Emergency Nurses Association (2022, March 22). Membership. https://www.ena.org/community

Epstein, E. G., Haizlip, J., Liaschenko, J., Zhao, D., Bennett, R., & Marshall, M. F. (2020). Moral distress, mattering, and secondary traumatic stress in provider burnout: A call for moral community. *Advanced Critical Care, 31*(2), 146-157.

Epstein, E.G., Whitehead, P.B., Prompahakul, C., Thacker, L.R., Hamric, A.B., (2019). Enhancing understanding of moral distress: the measure of moral distress for health care professionals. *American Journal of Bioethics Empirical Research 10*(2), 113–124. doi: 10.1080/ 23294515.2019. 1586008.

Fernandez-Parsons, R., Rodriguez, L., & Goyal, D. (2013). Moral distress in emergency nurses. *Journal of Emergency Nursing*, *39*(6), 547–552. https://doi.org/10.1016/j.jen.2012.12.009

Hamric, A., Borchers, C., & Epstein, E. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *American Journal of Bioethics Primary Research*, *3*(2), 1–9. https://doi.org/10.1080/21507716.2011.652337

Henshall, C., Davey, Z., & Jackson, D. (2020). Nursing resilience interventions-A way forward in challenging healthcare territories. *Journal of Clinical Nursing, 29* (19-20), 3597–3599. https://doi.org/10.1111/jocn.15276

Huang, L., Lin, G., Tang, L., & Zhou, Z. (2020). Special attention to nurses' protection during the COVID-19 epidemic. https://ccforum.biomedcentral.com/articles/10.1186/s13054-020-2841-7

Hunsaker, S., Chen, H.-C., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship, 47*(2), 186–194. https://doi.org/10.1111/jnu.12122

Jameton, A. (1993). Dilemmas of moral distress: Moral responsibility and nursing practice. *AWHONN's Clinical Issues in Perinatal and Women's Health Nursing, 4*(4), 542–551.

Jang, M. H., Gu, S. Y., & Jeong, Y. M. (2019). Role of coping styles in the relationship between nurses' work stress and well-being across careers. *Journal of Nursing Scholarship, 51*(6), 699–707. https://doi.org/10.1111/jnu.12523

McCue, C. (November 9, 2010) "Using the AACN Framework to Alleviate Moral Distress" OJIN: *The Online Journal of Issues in Nursing 16*(1) DOI: 10.3912/OJIN.Vol16 No01PPT02

Musto, L.C., Rodney, P.A., & Vanderheide, R. (2015). Toward interventions to address moral distress: Navigating structure and agency. *Nursing Ethics, 22* (1), 91-102. doi: 10.1177/0969733014534879.

Nassehi, A., Cheraghi, M., Hosseini, A., Pashaeypoor, S., & Mahmoudi, N. (2019). Moral distress in nursing: A concept analysis. *Drug Intervention Today, 11*(5), 1047–1054.

Polit, D. F., & Beck, C. T. (2016). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Lippincott Williams & Wilkins.

Research Electronic Data Capture (2022, February 5). https://unmcredcap.unmc.edu/redcap/redcapv11.4.4/DataExport/index.php?pid=5451&report_id=ALL&stats_charts=1

Reyes, A., Andrusyszyn, M., Iwasiw, C., Forchuk, C., Babenko-Mould, Y. (2015). Resilience in nursing education: An integrative review. *Journal of Nursing Education, 54* (8), 438–444. https://doi.org/10.3928/01484834-20150717-03

Rushton, C., Schoonover-Shoffner, K., Kennedy, M. (2017). Executive summary: Transforming moral distress into moral resilience in nursing. *The American Journal of Nursing, 117* (2), 52–56. https://doi.org/10.1097/01.NAJ.0000512298.18641.31

Sauerland, J., Marotta, K., Peinemann, M.A., Berndt, A., & Robichaux, C. (2014). Assessing and addressing moral distress and ethical climate, part 1. *Dimensions of Critical Care Nursing, 33* (4), 234-245). doi: 10.1097/DCC.0000000000000050.

Whitehead, P. B., Herbertson, R. K., Hamric, A. B., Epstein, E. G., & Fisher, J. M. (2014). Moral distress among healthcare professionals: Report of an institution-wide survey. *Journal of Nursing Scholarship, 47*(2), 117–125. https://doi.org/10.1111/jnu.12115

Wolf, L., Perhats, C., Delao, A., Moon, M., Clark, P., & Zavotsky, K. (2016). "It's a Burden You Carry": Describing Moral Distress in Emergency Nursing. *Journal of Emergency Nursing, 42*(1), 37–46. https://doi.org/10.1016/j.jen.2015.08.008

Zavotsky, K., & Chan, G. (2016). Exploring the relationship among moral distress, coping, and the practice environment in emergency department nurses. *Advanced Emergency Nursing Journal, 38*(2), 133–146. https://doi.org/10.1097/TME. 0000000000 000100

Appendix A

Measure of Moral Distress – Healthcare Professionals (MMD-HP)

Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of constraints or barriers. This survey lists situations that occur in clinical practice. If you have experienced these situations, they may or may not have been morally distressing to you. Please indicate how frequently you have experienced each item. If you have never experienced a particular situation, select "0" (never) for frequency. Note that you will respond to each item by checking the appropriate column for *Frequency*

1. What is your age in whole numbers? (*please provide whole numbers*)

2. What is your gender?

a. Male
b. Female
c. Non-binary
d. Prefer not to answer

3. How many years of experience do you have working in an Emergency Department? (*please provide whole numbers*)

4. What best describes your primary role during the COVID-19 pandemic?
   a. ED Staff Nurse
   b. ED Nurse Manager/Leader
   c. ED APRN

5. What best describes your practice setting during the COVID-19 pandemic?
   a. Hospital- Teaching facility
   b. Hospital- Non-teaching facility
   c. Freestanding Emergency Department

6. What best describes your exposure to the COVID-19 pandemic?
   a. Direct exposure (patient care delivery)
   b. Contracted COVID-19 (personal health)
   c. Witnessing COVID-19 (indirect patient care)
   d. None

7. Do you belong to a professional nursing organization?

   a. Yes

   b. No

	Frequency				
	Never				Very frequently
	0	1	2	3	4
1. Witness healthcare providers giving "false hope" to a patient or family.					
2. Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient.					
3. Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments.					
4. Be unable to provide optimal care due to pressures from administrators or insurers to reduce costs.					

5. Continue to provide aggressive treatment for a person who is most likely to die regardless of this treatment when no one will make a decision to withdraw it.					
6. Be pressured to avoid taking action when I learn that a physician, nurse, or other team colleague has made a medical error and does not report it.					
7. Be required to care for patients whom I do not feel qualified to care for.					
8. Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.					
9. Watch patient care suffer because of a lack of provider continuity.					
10. Follow a physician's or family member's request not to discuss the patient's prognosis with the patient/family.					
11. Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.					
12. Participate in care that I do not agree with but do so because of fears of litigation.					
13. Be required to work with other healthcare team members who are not as competent as patient care requires.					
14. Witness low quality of patient care due to poor team communication.					
15. Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.					
	Frequency				
	Never				Very frequently
	0	1	2	3	4
16. Be required to care for more patients than I can safely care for.					
17. Experience compromised patient care due to lack of resources/equipment/bed capacity.					
18. Experience lack of administrative action or support for a problem that is compromising patient care.					
19. Have excessive documentation requirements that compromise patient care.					
20. Fear retribution if I speak up.					
21. Feel unsafe/bullied amongst my own colleagues.					

22. Be required to work with abusive patients/family members who are compromising quality of care.					
23. Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.					
24. Be required to care for patients who have unclear or inconsistent treatment plans or who lack goals of care.					
25. Work within power hierarchies in teams, units, and my institution that compromise patient care.					
26. Participate on a team that gives inconsistent messages to a patient/family.					
27. Work with team members who do not treat vulnerable or stigmatized patients with dignity and respect.					
If there are other situations in which you have felt moral distress, please write and score them here:					

28. Have you ever left or considered leaving a clinical position due to moral distress?

- No, I have never considered leaving or left a position.
- Yes, I considered leaving but did not leave.
- Yes, I left a position.

29. Are you considering leaving your position now due to moral distress?

- Yes
- No