Moral Distress

Using mindfulness-based stress reduction interventions to decrease nurse perceptions of distress

Elizabeth A. Vaclavik, DNP, RN, OCN®, NEA-BC, Beth A. Staffileno, PhD, FAHA, and Elizabeth Carlson, PhD, RN

BACKGROUND: Studies have shown that the moral distress experienced by nurses affects patient outcomes and staff engagement.

OBJECTIVES: The purpose of this quality improvement initiative was to implement a process for staff to cope with moral distress.

METHODS: The 21-item Moral Distress Scale–Revised (MDS-R) was administered pre- and postintervention to a sample of 56 oncology nurses to assess moral distress and whether it was alleviated with the use of mindfulness interventions. Chi-square analysis compared the frequency of morally distressing situations.

FINDINGS: Moral distress was identified, with the finding that mindfulness interventions decreased nurse perceptions of distress. Healthcare providers offering a false sense of hope was the most frequently reported situation. Postintervention MDS-R survey results reflected a decrease in frequency of distress.

ONCOLOGY NURSES ARE FACED DAILY WITH A BARRAGE of ethical and moral dilemmas that affect the work environment and can lead to moral distress. According to Jameton (1993), moral distress occurs when a nurse performs duties that are contrary to what he or she believes is appropriate but feels powerless to change those actions. This distress may be caused by internal constraints (e.g., lack of knowledge or support), external constraints (e.g., staffing or supply issues), clinical constraints (e.g., provision of care perceived as futile), or observations of others giving a false sense of hope (Elpern, Covert, & Kleinpell, 2005; Sirilla, 2014). The uncertainty and sometimes futility of treatment, as well as the emotional impact of caring for patients experiencing life-threatening diseases, leads to moral distress, which has a negative impact on nurses’ physiologic and psychological well-being (Elpern et al., 2005; Lawrence, 2011; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015).

Several descriptive studies have shown a correlation between moral distress and patient outcomes, satisfaction, and staff engagement (Elpern et al., 2005; Lawrence, 2011; Whitehead et al., 2015). Nurses experiencing moral distress are at increased risk for burnout, emotional exhaustion, and physical illness (Lawrence, 2011; Rushton, Batchelor, Schroeder, & Donohue, 2015; Whitehead et al., 2015). In addition, this distress often leads nurses to seek out different work environments, such as outpatient clinics, or leave nursing altogether (Giarelli, Denigris, Fisher, Maley, & Nolan, 2016).

The impact of moral distress is multifaceted, and it has become a national workforce priority. The American Association of Critical-Care Nurses (2016) urges hospital administration and individual nurses to work on creating a healthy work environment. Causes and manifestations of moral distress vary by practice setting (Epstein & Hamric, 2009; Lievrouw et al., 2016). A study by Elpern et al. (2005) identified significant moral distress among nurses in critical care units as a result of nurses believing that the treatments they were providing to patients were futile. Sirilla (2014) found that nurses on inpatient medical units experienced less distress than nurses on hematology/oncology or critical care units. A study by Bohnenkamp, Pelton, Reed, and Rishel (2015) that involved administration of a moral distress survey to staff on an inpatient oncology unit determined that a crescendo effect of distress may occur. After the first distressing event dissipates, a residual effect remains with the nurse, creating a lower threshold for future stressful situations. Consequently, the next distressing event will lead to a higher level of moral distress.

A review of the literature provides evidence of the negative consequences that moral distress has on nurses when working with patients every day.

KEYWORDS
moral distress; mindfulness; false hope; mindfulness-based stress reduction

DIGITAL OBJECT IDENTIFIER
10.1188/18.CJON.326-332
MORAL DISTRESS
(e.g., burnout, compassion fatigue, physical effects) (Elpern et al., 2005; Giarelli et al., 2016; Gómez-Urquiza et al., 2016). Sirilla (2014) found that inpatient oncology nurses have lower moral distress than critical care nurses; the events leading to this distress were not noted. Sirilla (2014) also identified that nurses with higher levels of education experienced less moral distress than did nurses with basic or lower levels of education. Elpern et al. (2005) observed higher levels of distress in the critical care setting when nurses feel as though they are providing futile care. A qualitative study by Pavlish, Brown-Saltzman, Jakel, and Fine (2014) explored perceptions of moral distress among nurses working on inpatient and outpatient oncology units in academic medical centers and community hospitals and identified two factors leading to moral distress among oncology nurses: end-of-life situations and provision of futile care. Whitehead et al. (2015) found that poor team communication leads to increased moral distress. In addition, failure to appropriately communicate leads to hopelessness and frustration, and it may affect the nurse’s relationships with other providers and, ultimately, patient care (Blosky & Spegman, 2015). Identifying the factors leading to nurses’ distress is important so that meaningful solutions to minimize or mitigate stressful situations can be implemented.

The American Association of Critical-Care Nurses (2016) recommends that nurses be able to identify their own moral distress and practice self-care. Organizations need to develop a mechanism to identify causes of moral distress in the work environment, as well as create systems and processes to support nurses experiencing moral distress and educate them about ways to minimize this distress.

Mindfulness-Based Stress Reduction
According to Smith (2014), eliminating work-related stress in nursing is impossible; as a result, efforts should focus on helping nurses to cope more effectively. The practice of mindfulness involves being awake in the present moment and accepting it for what it is (Kabat-Zinn, 2005), and mindfulness-based stress reduction (MBSR) has been suggested as one approach to improve empathy and mood (Smith, 2014). Other benefits of MBSR include decreases in stress, anxiety, and burnout, as well as increases in focus and overall health. Cohen-Katz et al. (2005) studied the effects of MBSR and found that the level of psychological distress in healthcare providers decreased significantly following completion of an eight-week MBSR program. Lievrouw et al. (2016) observed that when moral distress is effectively managed, it can lead to introspection and team reflection. Lawrence (2011) identified the use of reflective practices as a method to decrease moral distress and contribute to nurse resilience. This resilience improves spiritual well-being, protecting nurses from emotional exhaustion and moral distress (Rushton et al., 2015).

Mackenzie, Poulin, and Seidman-Carlson (2006) provided an abbreviated mindfulness program to inpatient nurses and noted an increase in positive morale. This four-week program consisted of four 30-minute sessions held weekly and involved the participation of 16 nurses and nurses’ aides. After this intervention, participants reported feeling less exhaustion and a higher level of control and satisfaction, which suggests that mindfulness may be effective when implemented during a shorter period of time (four-week program versus eight-week program).

Coping practices lower levels of moral distress in nurses and can minimize the emotional exhaustion that accompanies distress (Wahlberg, Nirenberg, & Capezuti, 2016). A pilot study to determine the effectiveness of mindfulness to decrease moral distress and burnout showed decreased distress on a medical/surgical inpatient unit (Horner, Piercy, Eure, & Woodard, 2014). Staff have identified organizational support as being important to improving coping practices via employee assistance offerings, mind–body–spirit programs, and support groups (Wahlberg et al., 2016). Consequently, it is critical to have organizational support for inpatient nurses, particularly oncology nurses, to help minimize moral distress.

Objectives
Caring for patients with cancer can, during a period of time, lead to emotional exhaustion when treatments fail and the end of life seems imminent. Observing other healthcare providers giving a false sense of hope to patients and their families was identified as the most distressing situation on an inpatient oncology unit. Therefore, the objective of this quality improvement initiative was to minimize the effects of moral distress among inpatient oncology nurses through a bundle of mindfulness interventions.

Theoretical Framework
This quality improvement initiative was guided by Felgen’s (2007) change model (see Figure 1). Felgen’s change model identifies an ongoing process in which changes to improve continue to evolve and build on previous successes. Staff’s desire to better their outlook and minimize distress motivated them to participate in the interventions. Education on mindfulness and open sessions to practice being mindful, along with the opportunity to reflect on personal feelings of distress, helped to support the change and minimize distress.

Methods
The institutional review board at Rush University Medical Center in Chicago, Illinois, reviewed this quality improvement initiative, which was implemented on an adult inpatient hematology/oncology unit. A convenience sample of 56 nurses was eligible to participate; non-RN staff and per diem nurses were excluded.

Procedures
The 21-item Moral Distress Scale–Revised (MDS-R) assesses perceived moral distress using a four-point Likert-type scale.
MORAL DISTRESS

has been tested for reliability and validity with similar groups of nurses (Hamric, Borchers, & Epstein, 2012). Respondents to the MDS-R are asked to rate the level of disturbance caused by 21 events, as well as how frequently staff experience those events on the unit. In this study, the MDS-R was administered at baseline (preintervention) to all 56 eligible nurses, and the results were used by psychosocial oncology, palliative care, and nursing leadership to create a bundle of interventions addressing moral distress. Three months after implementation of the interventions, the MDS-R was again sent to the sample of 56 nurses to determine if moral distress continued to be identified.

Prior to completing the first MDS-R, all 56 nurses received an introductory email describing the quality improvement initiative, the purpose of the MDS-R, and the estimated time to complete the MDS-R; the email also noted that consent was implied for every survey that was completed and returned. An administrative assistant was responsible for sending, collecting, and tabulating surveys to prevent a sense of coercion. (There was concern that, if the MSD-R surveys were sent by the leadership team, staff may feel obligated or coerced to complete it or fear retribution if they chose not to participate.) The survey included demographic information, such as gender, education, and years of nursing experience. Anonymity was maintained; all records were kept electronically without any individual identifiers. After the MDS-R survey was sent to all 56 nurses, a reminder email was sent. The MDS-R survey was closed two weeks after the initial email was sent.

Components of the Bundle of Mindfulness Interventions

Mindfulness involves being present in the moment and being without judgment. The literature suggests that even abbreviated lessons in being mindful may have a positive impact on stress (Mackenzie et al., 2006). In the current study, the bundle of mindfulness interventions offered was tailored to address the stressor most frequently identified by nurses: others giving a false sense of hope to patients and families. Selected interventions are detailed.

CRITICAL DEBRIEFS: Within 48 hours of a patient experiencing a cardiopulmonary arrest, death, or other significant event, critical debriefs were initiated by staff nurses or unit leadership and facilitated by a licensed grief counselor. Their purpose was to allow nurses to communicate their fears and concerns after these critical events; they were held in a work room or conference room. Three debriefs took place in the first three months of implementation of mindfulness interventions, with two occurring immediately after cardiopulmonary arrest and one occurring 48 hours after a patient’s death. Two debriefs took place in the subsequent six months.

CODE LAVENDER BAGS: Code lavender bags (named to describe a bag for use when a patient crisis is particularly distressing) were created and made available to nurses experiencing a difficult patient care situation and needing a mental or emotional break. Each bag contained a lavender sachet that would help to provide a sense of calm when the bag was opened. Tissues were also included, as was a card with words of encouragement from the unit leadership team, a chocolate bar, and a gift card for the hospital coffee shop. The bags could be obtained at the charge nurse’s desk, and leadership ensured that five bags were available at all times.

TREE OF LIFE: A tree of life was created to celebrate patients’ lives and placed on a wall of the break room. The leaves on the tree held the names of patients who had died that year, and the tree served as a way to honor and remember them. This idea came from Turcotte (2015), who described nurses in an outpatient

“Nurses experiencing moral distress are at increased risk for burnout, emotional exhaustion, and physical illness.”

“Nurses experiencing moral distress are at increased risk for burnout, emotional exhaustion, and physical illness.”

Note. Based on information from Felgen, 2007.
MORAL DISTRESS clinic often not hearing of a patient’s death or having time to grieve the death; in response, a memory tree, with patients’ names on leaves, was created.

WORK–LIFE BALANCE COMMITTEE: Efforts to promote work–life balance and facilitate communication led to the formation of a work–life balance committee consisting of six staff nurses. This committee met monthly; they planned four networking events in the first six months and continue to plan four or more events each year (e.g., recognition events, holiday celebrations). The team also implemented “What the Food” Wednesdays in which staff members brought in various foods to share. Such events helped to foster a strong sense of teamwork in a setting that was less stressful than the work environment. Decorations and music created a relaxing atmosphere, and staff were encouraged to participate in shifts, which allowed those at the event to truly enjoy the environment while those on the floor cared for patients.

YOGA CLASSES: Yoga classes were offered twice weekly on day and night shifts, and yoga mats were available for staff nurses who wanted to stretch on their own. The classes were led by nurses who had previously taught yoga classes and were aimed at stretching and increasing blood flow and movement of air while focusing on oneself. Many nurses reported practicing abbreviated forms of yoga during their shifts by using the empty consultation room for 15 minutes; they simply placed a “do not disturb” sign on the door.

MINDFULNESS SESSIONS: Sessions on mindfulness were offered during a six-week period and led by the psychosocial oncology director, who was trained in MBSR. The sessions were held on the medical center’s campus but away from the inpatient setting. Breakfast was provided, and each session started with deep breathing and relaxation. The room in which the sessions took place was a comfortable lounge area with cushioned armchairs and sofas, carpeting, and ambient lighting. After the initial six-week period had ended, these mindfulness sessions continued every Monday at 6:30 am and involved 10 minutes of mindfulness practice led by unit leadership. These sessions took place in the consultation room on the inpatient unit and were open to all staff.

Data Management and Analyses
Descriptive statistics were used to assess demographic characteristics and the frequency of morally distressing situations. Chi-square analysis was used to compare the change between the pre-/postintervention data, and p of less than 0.05 was considered to be significant. The percent change was calculated to help determine the impact of the bundle of mindfulness interventions.

Results
Of the 56 nurses, 28 completed the initial MDS-R survey and 18 completed the postintervention MDS-R survey. Most respondents were women (see Table 1). Education level ranged from Bachelor of Science in Nursing through Doctor of Nursing Practice. No statistical significance was observed between years of nursing experience and level of moral distress (p = 0.06).

Each of the 21 items on the MDS-R was scored for frequency using a four-point Likert-type scale ranging from 1 (rarely) to 4 (very frequently) (see Table 2). Level of distress was also assessed using a four-point Likert-type scale ranging from 1 (not very distressing) to 4 (very distressing). Of the 21 items listed on the MDS-R, witnessing healthcare providers giving false hope was not only the most distressing situation experienced by nurses, but also the most frequently reported morally distressing situation prior to the intervention. This finding was statistically significant and was consistent with comments made during the support sessions (part of the bundle of mindfulness interventions) when nurses stated that, at times, they were providing treatment to patients who were in the active stages of dying. The frequency with which staff nurses felt distress from observing healthcare providers give a false sense of hope to patients decreased from 81% preintervention to 44% postintervention. This statistically significant finding is noted in Figure 2.

Discussion
A bundle of mindfulness interventions was implemented to address the level of moral distress experienced by nursing staff, and several findings were noted. For instance, a significant

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>PREINTERVENTION (N = 28)</th>
<th>POSTINTERVENTION (N = 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor of Science in Nursing</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Master of Science in Nursing or higher</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>26</td>
<td>17</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Nursing experience (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer than 5</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>6–10</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>11–15</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16 or greater</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
change was detected after implementation in relation to nurses’ observations of other healthcare providers giving false hope to a patient or family. During a clinical debrief, nurses said they felt they should be supporting the patient’s family during the end-of-life process, not administering further treatments or trials, as promised by other healthcare providers. Academic medical centers provide novel treatments and offer hope to patients who have been diagnosed with life-threatening diseases; often, these patients expect providers to try everything. Nurses are challenged to provide care in a nonjudgmental manner, and they must be an expert and a collaborator. The internal struggle faced by nurses who want to provide end-of-life care for a patient, yet know they are expected to offer treatment and hope, is common. Being able to support nurses during this process is essential to decreasing moral distress. Six months after implementation of the mindfulness interventions, 14 of the 18 respondents still felt that this observation of the provision of false hope by other healthcare providers created high or very high moral distress; this did not change from pre- to postintervention. However, what did change was the frequency with which this observation (the offering of false hope) occurred. Nurses reported that they were supported by and gained strength from one another. In addition, they developed resilience from the Monday morning mindfulness sessions, the yoga sessions, and other activities. They also were able to reminisce about patients while looking at the tree of life, and they talked to one another, to other members of the healthcare team, and to their leaders. They were able to verbalize during difficult times, use the code lavender bags, and debrief with one another.

During debriefs, nurses were empowered to request a facilitator at their discretion. This was important because open communication during debriefs and support sessions provided opportunities for nurses to express their feelings, reflect, and develop introspection (Whitehead et al., 2015). Unit leadership initially set up and scheduled debriefs, but staff nurses eventually began coordinating their own debriefs. In addition, these small debriefs exhibited shared governance and allowed nurses to take part in some decision making that affected their environment (Gosselin, Ireland, Newton, & O’Leary, 2015). Nurses also elected to form a work–life balance committee on the unit to help develop a sense of teamwork, community, and outreach and to plan events for staff to relax, eat, listen to music, or talk.

Also interesting was how nurses initially responded to certain aspects of the interventions. For example, the tree of life was originally perceived as morbid and dark because it had a black trunk, as well as black leaves and branches. During a meeting, nurses questioned the value of the black tree, which led some of the nurses to transform the tree into a vibrant tree of life. They painted the tree and added colorful butterflies and flowers. The tree’s transformation provided nurses with a platform to share compassion, accept death, and increase mindfulness. Yoga was also initially met with some skepticism. The nurses work 12-hour shifts, and many said they lacked energy. Yoga mats were purchased and stored in the consultation room, allowing easy access and accessibility. As a result, a few nurses started using the mats for personal yoga practice throughout their shift. By storing the yoga mats in a common area, nurses were able to use them at their discretion to meet their own needs.

Items in the code lavender bags items provided physical and emotional support to staff members who were struggling. The bags were available to all clinical staff and provided a source of comfort for nurses. The mindfulness sessions were intended to help nurses focus on the moment, as well as to let go of past conflicts and distress. Many nurses attended the sessions and admitted that staying focused on the moment and not letting their minds wander was difficult at first. However, by the final session, those attending said they were better able to relax and be in the moment.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>PREINTERVENTION (N = 28)</th>
<th>POSTINTERVENTION (N = 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How frequently does the distressing situation (witnessing healthcare providers giving false hope to a patient or family) occur?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>2. What is the level of distress experienced when the distressing situation (witnessing healthcare providers giving false hope to a patient or family) occurs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>15</td>
</tr>
</tbody>
</table>

Note. For the first question, 1 is rarely, 2 is occasionally, 3 is frequently, and 4 is very frequently. For the second question, 1 is not very distressing, 2 is kind of distressing, 3 is distressing, and 4 is very distressing.
Staff nurses were reminded to use the meditation room on Thursdays at noon to practice mindfulness. Flyers were placed around the unit to alert nurses to MBSR classes; many attended these. The Monday morning mindfulness sessions, which provided 10 minutes of stretching, breathing, and being in the moment, have been well attended, ranging from one to eight nurses. Initially, the sessions were attended solely by nurses who worked on the night shift, but a plan is underway to survey others on their preferences for mindful meditation and yoga, with the hope of offering the sessions to those who work both shifts.

Among the interventions, the work–life balance events and the critical debriefs appear to have had the greatest impact. Communication is open and respectful for most nurses. Staff nurses openly and respectfully discuss patient care and the patient’s care plan with all members of the team. Debriefs are ongoing, and the code lavender bags have been implemented throughout the facility by the professional nursing staff committee at Rush University Medical Center, which represents all nurses. The effectiveness of the interventions can be observed in the postintervention survey results, particularly in the significant decrease in staff perceptions of the frequency with which others provided a false sense of hope. This initiative took place on one inpatient unit using a convenience sample of nurses. Although the survey went out to all 56 nurses on the unit, there is no way to determine the identities of the nurses who participated in all of the interventions. It is also possible that staff who completed the postintervention survey did not complete the preintervention survey. Using this initiative as a template for intervention implementation across units in other institutions may offer additional insight into the impact of mindfulness on moral distress.

**Implications for Nursing**

Having a healthy work environment is essential for patient outcomes, staff satisfaction, and high-quality care. Oncology nurses are often faced with situations in which they are offering care that is contrary to what they believe they should be providing for their patients, their colleagues, and themselves. For instance, many nurses reported believing that they should support a patient’s decision to accept the end of life, provide education on alternatives to care, and simply be present for the patient and his or her family. Oncology nurses benefit by using mindfulness strategies to acknowledge their feelings and beliefs, accept the circumstances, and support efforts to continue providing holistic care without compromising their ethics.

**Conclusion**

This quality improvement initiative identified moral distress in oncology nurses related to the frequency with which they observe other healthcare providers giving false hope to patients and families. Empowering nurses to initiate interventions, like the code lavender bags, debriefs, or individual yoga or mindfulness practice, provides a framework of support in the work environment that fosters resilience and trust. Oncology nurses are motivated by grateful patients, spiritual connections, and their own sense of self (Gosselin et al., 2015). Interventions geared toward having support networks and feeling empowered to speak up and address distress will contribute toward decreasing the impact of the stressful work environment (Epstein & Delgado, 2010). Future research is needed to help determine the effectiveness of strategies to manage moral distress among oncology nurses.

Elizabeth A. Vaclavik, DNP, RN, OCN®, NEA-BC, was, at the time of this writing, the director of the bone marrow transplantation/hematology unit at Rush University Medical Center, and Beth A. Staffileno, PhD, FAHA, is an associate professor and the co-director of the Center for Clinical Research and Scholarship and Elizabeth Carlson, PhD, RN, is the department chair, both in the Department of Adult
MORAL DISTRESS

Health and Gerontological Nursing. College of Nursing, at Rush University, all in Chicago, IL. Vlachokostas can be reached at momofthreern@yahoo.com, with copy to CJONEditor@ons.org. (Submitted June 2017. Accepted October 9, 2017.)

The authors take full responsibility for this content and did not receive honoraria or disclose any relevant financial relationships. The article has been reviewed by independent peer reviewers to ensure that it is objective and free from bias.

REFERENCES


CME ACTIVITY
CNE ACTIVITY
EARN 0.5 CONTACT HOURS

ONS members can earn free CNE for reading this article and completing an evaluation online. To do so, visit cjonoons.org/cne to link to this article and then access its evaluation link after logging in.

Certified nurses can claim no more than 0.5 total ILNA points for this program. Up to 0.5 ILNA points may be applied to Role of the APN OR Professional Practice. See www.oncnn.org for complete details on certification.