

*It's a burden you
carry:* describing
moral distress in
emergency settings

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Emergency Nurses Association
ANA conference
March 11, 2016

What are the goals of nursing?

- Ensure the goals of human good/human flourishing remain the focus of activity
- Provide excellent care to patients
- Ensuring conditions and practices conducive to human beings' humanization, meaning, choice, quality of life, and healing in both living and dying
- Resist subversion to interests that are not conducive to nursing practice

- Willis et al 2008

The social contract

- The philosophical understanding of a social contract between the government and the governed lays the groundwork for advocacy
- Patient advocacy is not merely the defense of infringements of patient rights
 - *It is an ethic of practice*
- We can expand this idea of a social contract to include the nurse-patient relationship. When you enter the profession as a vocation or calling, you accept that the contract between nurse and patient requires “justice.”
- *“Everyone gets treated the same, and has access to the same level of care and resources”*

Definitions and measurements

- Moral distress
 - “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.”
 - Corley, et al 2001
 - Measured (in inpatient settings) using the Corley Moral Distress Scale

Study of moral distress in emergency nurses

Background

- Lot of literature on inpatient nursing. Not a lot on emergency nursing.
- Suspected that moral distress looked different in the ED
- Didn't have a good sense of whether important distinctions might include:
 - Short temporal relationships
 - Chaotic environment
 - Patient volume < resources

Methods

- Qualitative exploratory study using focus groups for data collection
- Sample:
 - N = 17
 - 19 ± 11 years of experience in emergency nursing
 - 89.2% held bachelors or masters degrees
 - 94% female
 - 58.8% were staff nurses working in general emergency departments (94%), in urban areas (47.1%), with fewer than 40,000 annual ED patient visits (52.9%)
- Geographic representation:
 - 5 Western states (47.2%)
 - 3 Midwestern states (17.6%)
 - 2 Eastern states (11.8%)
 - 4 Southern states (23.6%)

Findings

- Challenges of the emergency care environment
- Being overwhelmed
- Adaptive/maladaptive coping

Overall, participants described a profound feeling of not being able to provide the quality of patient care that they believed patients deserved.

Staffing

- *“To me, the whole root of the problem is staffing. They never staff adequately at the hospital where I work.”*

Technology

- *“This is our...choice between good care and good documentation. You [can be] a really good nurse on paper or you can actually be a really good nurse, but you don’t have time to be both.”*
- *“The system is definitely broken when we’re more concerned about putting something in a computer than the [patient care]. And I don’t know how to fix it and it’s very frustrating.”*

Conflicting expectations

- *“I think a good portion of frustration not only for myself but as the staff, is managing what our expectation is of what the ER needs to be versus how HR and administration feels because I don’t think there is that, even though respectfully our CNO is still a nurse. When was the last time she was a bedside nurse?”*

The problem of “frequent users”

- The ED is a unique practice environment related to EMTALA
- Everyone who presents must be medically evaluated
- There are no enforceable nurse/patient ratios
 - You can't close the doors in the ED due to either patient volume or decreased staffing

Frequent Users

- Emergency nurses report frustration in the cases of:
 - Behavioral health
 - Substance abuse
 - End of life care
 - Chronic illness exacerbations

Adaptive/Maladaptive Coping

- Emotional fallout
- Physical symptoms
- Stress management strategies

Etiology

- In inpatient settings, moral discordance stems primarily from:
 - Conflict with physicians or families about the course of patient care
 - Futile treatments
 - Lack of communication which affects patient care

This is generally an interactive process

Etiology

- In the ED, the source of moral discordance was found to be more systemic (Wolf et al 2015)
 - No resources (staff, especially)
 - Overburdensome metrics and technology
 - Frequent users

This is generally an environmental issue

“*This is what nursing is*”

- What our participants reflect, and what places this feeling of discordance squarely in the moral arena, is the emphasis on the *disciplinary obligations of nursing* to care for others.
- They described their experience of moral distress in *direct relation to the inability to meet their perceived moral obligations* to provide safe and effective patient care.

Outcomes of moral distress

- Burnout
- Turnover of staff
- Identity stripping

Implications for patient care are profound

Potential solutions

- The majority of recommendations are centered *around the nurse*
 - Better self care
 - Less overtime
 - Self regulation
 - Communication

Who decides?

- Is it easier to blame the person (nurse or patient) than to take on the whole system?
- Is a system that deems some more “deserving” than others legitimate?
- How does this affect how we perceive the provision of care?

Potential solutions

- What is required is a *change in the environment of care*:
 - Thoughtful technology
 - Appropriate staffing that allows for focused care of patients
 - Administrative support
 - Better community resources for high frequency users

Potential solutions

Allow nurses to do nursing, without barriers

Things to consider

- What is the understanding of the role and purview of nursing in a given practice setting?
 - Specifically, how much authority over practice and advocacy are nurses afforded?
 - How do nurses understand the moral implications of nursing practice?
 - What is the relationship between medicine and nursing?
 - Is “patient satisfaction” the primary driver of care?
 - What are the implications for epistemic nursing authority?

Things to consider

- What are the environmental facilitators and barriers with regard to unimpeded nursing practice? (*ie, How can we provide nurses with the resources they need to make clinical decisions and be present for patients, and not just carry out tasks?*)
 - Staffing?
 - Technology?
 - Time mandates?
 - Unit leadership?
 - Institutional leadership?

The takeaway

- Emergency nurses in this sample described strong feelings about the “lost art” of nursing and the desire to have the time and staffing resources available to recover their practice in a way that is consistent with the core functions and goals of emergency nursing.

The takeaway

- Given the conditions under which moral discordance occurs, possible solutions include:
 - Improvement in
 - Nursing autonomy
 - Staffing
 - Administrative support
 - RN-MD relationships
 - Use of technology