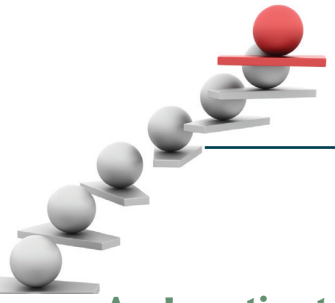

An Inpatient Surgical Oncology Unit's Experience With Moral Distress: Part II

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The purpose of this article is to describe approaches used to alleviate nurse moral distress on a surgical oncology unit and challenges faced when addressing the complex factors that contributed to that moral distress. Moral distress clinical unit survey results identified two themes contributing to nurse staff distress: inadequate staffing (either unsafe staffing ratios or incompetent nursing or physician staff) and physician-ordered patient care that was inappropriate or ineffective for patients (e.g., inadequate pain management). A complete discussion of the problem of nurse moral distress on this surgical oncology unit and the subsequent unit survey can be found in Bohnenkamp, Pelton, Reed, and Rishel (2015).

After assessing the results of the unit survey, a group that included the unit manager, clinical leaders, chief nursing officer, clinical nurse specialist, and an attending physician investigated relevant nursing literature to determine appropriate courses of action. Although ample discussion of moral distress has taken place, relatively few studies have outlined effective interventions (Hamric, 2012). Group members then met to discuss approaches to decrease moral distress. Based on the results of the survey, members of this group planned methods to increase communication between physicians and nursing staff, provide education about the dying process and stress management, and offer therapies and education regarding self-care management.

Communication

Oncology care is complex. Cancer care teams, comprised of members from various healthcare disciplines, may complicate the process of care delivery by not communicating fully with one another. Important care issues may be misinterpreted or misunderstood, resulting in distress for team members. Interprofessional team meetings to discuss the plan of care and concerns (e.g., ethical issues, case scenarios, pain management) may be helpful in achieving transparency and improving patient, professional, and organizational outcomes (Mobley, Rady, Verheijde, Patel, & Larson, 2007; Sirilla, 2014).

To address perceived concerns with interprofessional communication, a retreat was organized that encouraged physicians and nurses to discuss ways to improve team member communication. During the retreat, participants deliberated about key words to communicate a nurse's discomfort with a physician's plan of care. A "time out" would be called when anyone said the key word, and a care conference would be initiated. The physicians also presented information about decision making with various disease processes, which helped unit nurses to more fully appreciate physician knowledge and steps in the process and to discuss how they, as nurses, could contribute their knowledge and experience. In addition, participants worked in interprofessional groups to discuss and develop solutions to common stressors on the unit. The open forum allowed the team to begin establishing interprofessional bonding and to open new channels of communication.

Education

Developing a plan for education regarding ethics, death and dying, and coping strategies can benefit nurses by increasing their self-confidence in their knowledge about the end of life and their awareness of moral distress (Sirilla, 2014). Initiating education during orientation was recommended to ensure that all nurses would be aware of the signs and consequences of moral distress (Sirilla, 2014). In addition, monthly educational sessions were offered on various topics (e.g., ethics, death and dying, pain management, communication, self-care). Staff members who attended the unit retreat were provided with education regarding interprofessionalism, emotional de-escalation, and critical incident management. Another result of the partnering of team members at the retreat was the creation of an interprofessional journal club. Physicians, nurses, and pharmacists now meet bimonthly to discuss evidence-based research about specific topics of interest (e.g., palliative care). This partnering not only provides educational opportunities but also enhances communication among team members.

Self-Care Management

Self-care is a pivotal strategy used by individuals to effectively alleviate moral distress. If oncology nurses are to remain healthy and able to care for patients and families, implementing effective self-care strategies is a must. These strategies include recognizing personal signs of moral distress, searching for appropriate interventions, and maintaining a balance between work and life (Sirilla, 2014). An expert in self-care was recruited to

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demonstrate to the nursing staff stress relief techniques, including breathing exercises, yoga, and meditation. Unit staff members were also provided with information about several other self-care therapies, such as Reiki, pet therapy, music therapy, and massage.

Another key focus was managing stress after critical incidents. A chaplain was assigned to the unit and is available for group or private discussions, counseling, and debriefing following critical incidents associated with high stress.

Addressing Ongoing Challenges of Moral Distress

One challenge that nurses face regarding moral distress is the ability to recognize when it is present (Pavlish, Brown-Saltzman, Jakel, & Fine, 2014). Nurses experiencing moral distress often may feel anxious, frustrated, or guilty but not realize why they have these emotions. In addition, they may not have the tools or ability to adequately express what they are feeling, which can cause further distress (Pavlish et al., 2014). Failure to recognize moral distress can inhibit resolution and contribute to a crescendo effect, which places nurses at risk for burning out or leaving the profession (Hamric, 2012). Education and resources should be made available to nursing staff regarding how to recognize and address personal moral distress.

Once moral distress is recognized, facilitating its resolution to ameliorate additional ill effects is important. Although the situation contributing to moral distress may not be easily or satisfactorily resolved, the feelings that nurses experience must be addressed to prevent escalation. Some morally distressing situations may not be able to be readily fixed (e.g., lack of adequate staffing or resources). In these situations, nursing leaders should work with their staff to find creative approaches to provide quality care within these limitations of the unit. Nursing leaders also can assist staff in resolving moral distress by promoting a culture that encourages open communication surrounding plans of care, promotes relationships among team members that are based on trust and mutual respect, and uses system-wide ethics resources (Pavlish et al., 2014; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015).

Nurses often feel the buildup of moral distress early in a situation; however, they frequently do not speak up, possibly because of a fear of reprisal or an unwillingness to create discord (Pavlish et al., 2014). Consequently, nurses should be encouraged to recognize these feelings as an indication that further conversations are needed with other team members. Nurses report higher job satisfaction and better quality of care for their patients when they are in a truly collaborative relationship with team physicians (Pavlish et al., 2014). This demonstrates the importance of nurses knowing that their expertise and evidence-based concerns are heard and respected. Organizations should invest the time and effort required to create a culture that values all team members' input and discourages hierarchical barriers.

In addition, nurses should be aware of the various resources available to them when they are feeling uncomfortable in a situation. At the unit level, nurses can express concerns to a peer or mentor and involve the charge nurse or manager. Additional resources include social workers, case managers, advanced practice nurses, and hospitalwide nursing supervisors. Nurses also should be encouraged to speak directly with the attending physician and enlist help to form a care-coordination meeting, if necessary. An organizational ethics committee also should be available for questions on a formal or informal basis. These resources, ranging from the interpersonal to the unit to the system level, must be not only widely known by the nurses but also accessible to them.

Next Steps

A continued need exists for comprehensive assessment and planning to recognize and resolve moral distress in a timely manner. The problem is too complex to be addressed by any one assessment tool. Group members tailored an existing survey tool to obtain relevant information to understand the problem. Following the unit retreat, another survey tool was used to obtain feedback on what was helpful. This Likert-type survey asked nurses to rate how helpful certain strategies would be to them (see Table 1). The top three strategies were being able to take time off of the unit when needed, receiving education regarding end-of-life issues and self-care, and having a Zen room on the unit for staff. Based on these results and recommendations, members of the group will work with senior leadership to determine what methods of education and support will be feasible to implement on this unit and on other units in the organization.

Table 1. Nurses' Ratings of Helpfulness of Selected Interventions to Alleviate Moral Distress (N = 34)

Intervention	1	2	3	4	5
Ability to have coverage and take 10 minutes off of the unit to regroup, if needed	–	–	–	11	23
Education about guided imagery or other relaxation techniques (e.g., breathing techniques)	–	4	7	13	10
Educational opportunities about end-of-life care and how to ensure self-care while providing care	–	–	2	14	18
Existence of a Zen room for staff to regroup and refocus off of the unit	–	3	–	11	20
Journal club or other opportunities to converse with physicians off of the unit	–	1	7	18	8
Meeting with chaplain either individually or in small groups	2	3	9	13	7
Staff therapies (e.g., Reiki, pet therapy, music therapy, massage)	–	1	7	14	12

Note. Each intervention was rated from 1 (not helpful at all) to 5 (extremely helpful).

Conclusion

Moral distress is an increasingly prominent issue in oncology nursing. This phenomenon can result in physical, emotional, and psychosocial problems. Nursing management should provide education and tools to assist staff in recognizing moral distress and working toward satisfactory resolution. In this instance, group members identified areas that were causing nurses the most distress and tailored strategies to address those concerns. Three areas of needed improvement were identified as communication, education, and self-care promotion. Positive changes on this surgical oncology unit were observed postintervention, specifically in improved interprofessional communication that helped staff to feel valued as contributing team members.

Additional research is needed to determine what methods are most effective for recognizing and decreasing the effects of moral distress. Nurses should be empowered to promptly verbalize their concerns and address issues that may lead to moral distress. Doing so helps to ensure that individualized quality patient and family care remains the top priority.

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Key words: moral distress; communication; nursing support; self-care; interprofessional collaboration

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Leadership & Professional Development

This feature provides a platform for oncology nurses to illustrate the many ways that leadership may be realized and professional practice may transform cancer care. For more information, contact Associate Editor Cindy J. Rishel, PhD, RN, OCN®, at rishelmom@gmail.com.