

Understanding Moral Distress: How to Decrease Turnover Rates of New Graduate Pediatric Nurses

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In today's healthcare market, about 30% of all nurses leave the profession with less than one year of experience (Nursing Solutions, Inc., 2016). This article postulates that a major cause of high turnover is due to the detrimental effects of moral distress. Between sweeping legislative changes, including the implementation of electronic medical records, and a push toward tracking and improving patient satisfaction markers, the nursing profession struggles with a critical nursing shortage that is predicted to continue through 2025 (U.S. Department of Health and Human Services, 2014). The shortage is so severe that the American Nurses Association (ANA) (2018) considers nurse staffing a health crisis in the United States. The combination of these stresses from healthcare delivery along with the nursing shortage has led to an increase in nurse dissatisfaction, burnout, turnover, and moral distress in the new graduate nurse population (Krautscheid et al., 2017). Moral distress is defined as a "psychological disequilibrium associated with knowing the morally right course of action to take in a given situation but failing to follow through with that action because of institutionalized constraints" (Bell & Breslin, 2008, p. 94). This means that nurses feel the work environment prevents them from delivering optimal care (Bell & Breslin, 2008).

Currently, there are not enough nurses graduating to compensate for

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For the past 10 years, the United States has been experiencing a critical shortage of registered nurses (RNs), and data suggest this trend will continue through 2025. Compensation for RN burnout cannot be achieved by simply hiring new nurses because the rate of graduation is less than the rate of need. During this period of critical shortage, federal healthcare reforms, most notably the Patient Protection and Affordable Care Act (PPACA) of 2010, have placed additional demands on physicians and nurses. These trends have led to increased RN dissatisfaction, moral distress, and subsequent turnover. Literature reviews, case studies, and methodological pieces regarding moral distress in new graduate pediatric nurses were studied, and 34 articles were analyzed; articles before 2010 were excluded unless considered a sentinel piece. Results show new graduate pediatric RNs experience moral distress as they transition from academia to the professional setting, which leads to rates of new graduate RN turnover that outpace nurses of all other tenure. With the goal of decreasing RN turnover, this article briefly examines factors that contribute to moral distress in new graduate pediatric nurses and explores unit-based interventions to reduce levels of moral distress. Interventions found to decrease moral distress include early detection of moral distress, fostering feelings of nurse engagement, participation in ethics education, promotion of mindfulness, and the creation of pediatric palliative care teams within hospital units.

Key Words: Moral distress, ethics, new graduate nurse, empowerment.

the current nursing shortage (Snavely, 2016). As such, hospitals must focus on retaining existing employees instead of simply hiring new nursing staff. When examining the nursing workforce, new graduate nurses with less than one year of nursing experience have the highest rates of turnover (Nursing Solutions, Inc., 2016). These new graduate nurses are a vulnerable subset of the nursing workforce and are thus particularly susceptible to moral distress (Krautscheid et al., 2017). The internal struggle created by moral distress is compelling enough to cause turnover (Duchscher, 2009). Pediatric nurses are especially vulnerable to moral distress due to the unique relationship and ethical conflicts that arise between patients, families, and care teams

(Ghasemi, Negarandeh, & Janani, 2017). Additionally, advances in healthcare technology expose pediatric nurses to conflicts involving aggressive life-prolonging treatments that may not necessarily be in the best interest of the child (Trotochaud, Coleman, Krawiecki, & McCracken, 2015).

This article first examines the various factors that contribute to moral distress, and then discusses how moral distress can be decreased in new graduate pediatric nurses through the implementation of unit-based, micro-level changes. Next, information is provided on understanding the new graduate nurse experience and the impact of moral distress on this experience, strategies to reduce moral distress, as well as key clinical implica-

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tions of moral distress on the nursing workforce and healthcare market. Finally, the article reviews known strategies found to minimize moral distress in the new graduate RN, including early detection of moral distress via scaled surveys, new graduate nurse engagement, unit-based education sessions on ethics, the promotion of mindfulness, and unit-based palliative care programs.

Moral Distress in the New Graduate Nurse

Understanding the New Graduate Nurse Experience

As early as the 1970s, the new graduate nurse experience has been recognized by nurse researchers as traumatic and shocking (Casey, Fink, Krugman, & Propst, 2004). Duchscher (2009) describes this transition, summarizing that “the new nurse is immersed in a firmly entrenched, distinctively symbolic and hierarchical culture that exposes them to dominant normative behaviors that have been described as prescriptive, intellectually oppressive, and cognitively restrictive” (p. 104). The author goes on to explain that new graduate nurses are shocked by the realization that the idealized nursing profession they learned in school is not the reality in a hospital setting, and instead, nurses are part of a productive, achievement-oriented system (Duchscher, 2009). The career transition forces graduate nurses to leave a familiar learning environment, quickly become competent caregivers, and adjust to institutional norms – all at the same time. The resulting role of ambiguity is a driver of new graduate internal conflict, causing disillusionment and career dissatisfaction (Duchscher, 2009).

The Role of Moral Distress

New graduate disillusionment and dissatisfaction can quickly escalate within the first few months of a nursing career, leading to feelings of moral distress (Duchscher, 2009). Sasso, Bagnasco, Bianchi, Bressan, and Carnevale (2015) found that feelings of moral distress often develop while still a nursing student, thus amplifying stress and internal conflict within the new graduate nurse.

As is true for most professions, the first months following graduation are crucial for developing a professional

identity, and within this identity is a sense of moral integrity (Kelly, 1998). At first, new graduate RNs feel vulnerable as the most inexperienced members of the healthcare team. The focus is initially on “getting through the day” and performing safe care; however, as the months progress, this sense of moral integrity grows stronger as ethical components of care become more evident to nurses (Kelly, 1998). Kelly (1998) demonstrates the transition from competence to independence, showing that new graduate levels of moral distress increase when the time pressure of completing tasks left “no time to be caring” (p. 1139). New graduates compensate for moral distress by working fewer hours, quickly leaving their unit for a different position, or leaving the profession completely (Kelly, 1998).

Healthcare Reform and New Graduate Nurses

As previously mentioned, healthcare workers are impacted by multiple federal reform acts passed within the last decade. In 2010, President Obama made history by passing the Patient Protection and Affordable Care Act (PPACA). The PPACA aims to increase access to care and improve the quality of health care while decreasing costs (Keller & Chamberlain, 2014). Although improved quality and patient satisfaction are not new goals for healthcare providers, the PPACA outlines novel reimbursement criteria tied to satisfaction scores (Fontenot, 2014). Nurses and physicians must adapt to the new reimbursement systems and increased focus on patient quality and safety scores (Clipper, 2014). Further, the increases in insurance eligibility mean more people have access to care than ever before, which can potentially inundate an already-strained healthcare system (Snavey, 2016). Although pediatric nurses have a unique opportunity to improve the health of vulnerable patients with the support of the PPACA, new graduates are surely challenged to understand this complex and ever-changing healthcare environment (Keller & Chamberlain, 2014).

Moral Distress and Pediatrics

All new graduate nurses are susceptible to moral distress; however, as mentioned earlier, pediatric nurses are especially vulnerable. Although in

adult nursing, most communication occurs between only the patient and care team, nurses in pediatrics must communicate with and consider the wishes of the family, as well as the patient and care team (Ghasemi et al., 2017). Conflicts often arise between these three groups, and pediatric nurses suffer from unique ethical dilemmas surrounding whose wishes to follow (Ghasemi et al., 2017). For example, pediatric nurses feel distress when parents insist on treatments that may not be in the best interest of the child, and nurses feel torn between respecting the parents' wishes and doing what they feel is in the best interest of the patient (Carnevale, 2013).

Technological advances also complicate the ability for pediatric nurses to be caring because they allow for increased life-prolonging interventions that may not be in the best interest of the patient. Research conducted by Borhani, Abbaszadeh, Nakhaee, and Roshanzadeh (2014) showed that this role conflict is felt more strongly in PICUs and NICUs, where nurses care for the most fragile children and neonates. Specifically, PICU nurses experience moral distress surrounding end-of-life care, while NICU nurses identify moral distress related to resuscitation efforts and potential negative outcomes of premature infants (Trotochaud et al., 2015). Premature infants born at 22 to 24 weeks' gestation may face many long-term and devastating complications, such as moderate-to-severe cerebral palsy, profound hearing and/or vision loss, and significant cognitive impairments (Gunasekera & Isaacs, 2017). PICU nurses especially experience distress when they feel that other care providers offer parents false hope about the condition of their critically ill child or do not obtain fully informed consent (Trotochaud et al., 2015). Understandably, levels of moral distress tend to be higher among ICU nurses than other pediatric nursing colleagues.

Although certain unit-based differences exist, Trotochaud and colleagues (2015) found in a survey sent to pediatric physicians and nurses that two over-arching variables led to pediatric RN moral distress: poor team communication and lack of provider continuity. Levels of moral distress increase for nurses when inconsistent care plans are created and there is poor communication between

healthcare providers. By constantly switching care plans and teams, nurses feel their level of autonomy and ability to provide competent care decreases, resulting in disillusionment, conflict, and moral distress (Henrich et al., 2016). Finally, poor communication causes feelings of hopelessness and frustration for nurses, which can negatively impact patient care (Vaclavik, Staffileno, & Carlson, 2018).

Strategies to Reduce Levels Of New Graduate Moral Distress

Balancing Micro and Macro Level Changes

Interventions to combat moral distress can be easily implemented into an existing nursing routine. However, some caution is required. As noted in the sentinel piece by Bell and Breslin (2008), the best intervention may depend on the ethical dilemma faced by nursing staff and institutional constraints. System-wide initiatives must be considered to create lasting change, through both micro and macro level interventions. According to Musto, Rodney, and Vanderhide (2015), "If we focus only on agents as individuals or only on larger-scale system problems, we will miss the reciprocity between the two" (p. 99) Two examples of system-wide issues are staffing ratios and institution-based ethical policies and procedures (Bell & Breslin, 2008). Unit-based initiatives include early detection of moral distress, new graduate engagement, ethical education sessions, promoting mindfulness, and unit-based palliative care programs.

Detecting New Graduate Moral Distress

Formal assessment of moral distress started in 2001, when Corley, Elswick, Gorman, and Clor (2001) created a moral distress scale (MDS). The original survey listed 32 statements with a 5-response format to assess levels of moral distress, ranging from never to great. The MDS was a sentinel tool that was both valid and reliable in detecting levels of moral distress in nurses (Corley et al., 2001). More recently, the original MDS was updated to include additional possible root causes of moral distress, including clinical situations and internal and external constraints (Af

Sandeberg, Wenemark, Bartholdson, Lützén, & Pergert, 2017). This revised moral distress scale (MDS-R) is now able to assess both acute and long-term levels of moral distress, and has been further customized for physicians, nurses, and other care providers in both pediatric and adult settings (Af Sandeberg et al., 2017; Wocial & Weaver, 2012).

For example, the pediatric MDS-R includes questions about discussing death with pediatric patients, performing patient care when the nurse feels the treatment plan is not in the best interest of the patient, and including both patients and families in treatment plan decisions (Brandon, Ryan, Sloane, & Docherty, 2014). A simple intervention to detect moral distress in new graduate nurses is to perform routine surveys using the pediatric revised moral distress scale. Implementation of the MDS-R tool allows the unit to track feelings of moral distress, enabling nursing leadership within each unit to appropriately intervene before negative sentiments escalate in new graduate nurses.

New Graduate Engagement

Along with monitoring levels of moral distress in new graduate nurses, at-risk nurses will also greatly benefit from promoting feelings of engagement and empowerment. Feelings of engagement at work lead to higher job satisfaction, lower turnover rates, and improved quality of work life (Kim & Yoo, 2018). To promote unit-based engagement, new graduate nurses in orientation must be exposed to their resources, policies and procedures, and unit culture (Robitaille, 2013). Specifically, the unit culture should foster feelings of motivation, competency, and autonomy for its new graduates (Kim & Yoo, 2018).

Nurse residency programs promote feelings of empowerment in new graduate nurses and can be tailored to fit the specific needs of the unit (Church, He, & Yarbrough, 2018). Nurse residency programs pair a new graduate nurse with a senior nursing mentor who works to increase confidence and competence in new graduates while also improving the quality of care provided to patients (Church et al., 2018). Nurse residency programs provide the platform for nurses to learn the policies, procedures, and culture of the unit in a safe, supervised manner. In addition to engaging new graduate nurses, nurse residency

programs reduce turnover rates and increase job satisfaction and organizational commitment (Church et al., 2018).

Another intervention to promote engagement and minimize moral distress is participation in unit-based committees. Bell and Breslin (2008) found ethics committees particularly helpful in minimizing levels of moral distress. Although specific ethics committees may not currently exist on all nursing units, they are a strong intervention and can be easily implemented. To foster a sense of engagement for nurses of all tenure, new graduate and senior nurses can collaborate to run the unit-based ethics committee. New graduate nurses benefit from ethics committees because they offer protected time to discuss moral integrity, moral distress, and ethics in pediatric health care (Bell & Breslin, 2008). Committee engagement facilitates communication and relationship-building for new nurses to form strong mentor bonds within the unit (Race & Skees, 2010).

Ethics in Education

In addition to engaging new graduate nurses, data show that multiple unit-based educational opportunities exist for ethical inclusion in daily nursing practice. First, ethical talking points should be included in every unit-based education session. Education sessions occur during pre-established meeting times, such as shift huddles or during unit "lunch and learns." A "lunch and learn" is an education session held on the unit during the lunch period, which maximizes efficiency for nursing staff while still allowing them to participate in education. Ethical education sessions allow for informal discussion surrounding moral distress where nurses can learn from, with, and about each other (Musto et al., 2014).

Second, ethical components surrounding moral distress should be incorporated in patient debriefing sessions. The incorporation of ethics into debriefing scenarios is crucial for unit morale, as well as unit-based systems thinking. This incorporation emphasizes that feelings of moral distress are as much of a patient safety concern as communication breakdowns and errors in care (Musto et al., 2014). Finally, ethical dilemmas should be included in unit-based simulations. Research from Krautscheid and colleagues (2017) found that inte-

gration of ethics within simulation “provides explicit, low-risk opportunities to experience and debrief ethical practice, conflict communication strategies, and advocacy” (p. 318). Simulation offers new graduate nurses a safe environment to address concerns surrounding moral distress in their professional practice.

Promoting Mindfulness

Smith (2014) claims eliminating work-related stress in nursing is impossible, and the focus must instead be on promoting effective coping skills (Vaclavik et al., 2018). A study conducted by Vaclavik and colleagues (2018) with oncology nurses revealed the most distressing factor was observing other healthcare providers offer patients and families false hope. The study piloted a “Mindfulness Bundle” that included Code Lavender bags, a Tree of Life, a work-life balance committee, yoga classes, and mindfulness sessions to facilitate coping mechanisms for the nursing staff (Vaclavik et al., 2018).

The Code Lavender bags contained a lavender sachet that would, upon opening, provide a sense of calm, words of encouragement, tissues, and gift card. Nurses were given the bags during particularly distressing patient-care scenarios; the unit leadership ensured the bags were always available at the nursing station. A Tree of Life was created in the nursing break room to celebrate patients who had passed away in the unit and provided a therapeutic way to discuss these patients. The work-life balance monthly committee meeting was a group of six nurses on the unit that planned networking events and themed lunches. The nurses taught bi-weekly yoga classes on the unit on both day and night shifts. Finally, the psychosocial oncology director, who was trained in mindfulness-based stress reduction practices, initiated off-the-inpatient-unit mindfulness sessions. The sessions were well-received, and nursing staff continued “mini” 10-minute sessions on their unit throughout the workday (Vaclavik et al., 2018).

The “Mindfulness Bundle” allowed nurses to acknowledge their feelings and beliefs, experience both physical and emotional comfort objects available on the unit, and support one another in providing holistic care to their patients without violating personal ethics (Vaclavik et al., 2018). Further, the bundle provided a plat-

form for nurse engagement and empowerment because each component of the bundle is monitored and led by nurses on the unit. As previously mentioned, for new graduate nurses, a sense of empowerment is protective against feelings of moral distress. Although this study was not performed with pediatric nurses, the concepts are easily translatable to the pediatric nurse profession and can benefit both new graduate and tenured nurses. Pediatric nursing units can customize their own “Mindfulness Bundle,” incorporating any or all of the original bundle components.

A Place for Palliative Care

An explanation for pediatric RN moral distress is the concept of futile patient care; therefore, recent research focuses on assessing nurses’ levels of moral distress before and after the implementation of pediatric palliative care programs. Brandon and colleagues (2014) postulated implementing a pediatric palliative care program would positively impact levels of moral distress within their institution. The researchers created a multi-professional team of nurses, physicians, social workers, pharmacists, chaplains, child-life specialists, dietitians, administrators, and occupational, physical, and respiratory therapists. This team fostered multiprofessional collaboration and consensus building, interprofessional conferences with patients and families, and an increase in support for families. Additionally, the creation of a palliative care program reduced not only nursing levels of moral distress, but also levels of moral distress of other healthcare providers, including physicians and therapists (Brandon et al., 2014).

Most recently, Wocial and colleagues (2017) implemented Pediatric Ethics and Communication Excellence (PEACE) rounds on a PICU floor. The PEACE rounds are formal, facilitated, weekly discussions to address realistic care goals and ethical dilemmas that arise when caring for pediatric patients with life-threatening illness. Although intensivists provide the clinical synopsis and focus patient care goals, an ethicist proctors the discussion and ensures all team members participate, including nurses and social workers (Wocial et al., 2017). This unit-based intervention dramatically improved team commu-

nication and successfully decreased levels of moral distress for pediatric nurses (Wocial et al., 2017).

These palliative care teams and rounding tools address the complex communication, decision-making, and care coordination needs of critically ill pediatric patients (Brandon et al., 2014). Understandably, these issues are often cited as the factors that contribute to pediatric nurse moral distress. Though these interventions can become hospital-wide, Wocial and colleagues (2017) indicated that unit-based rounding teams were sufficient to decrease levels of moral distress. When thinking specifically of new graduates, unit culture should reflect that all nurses engage in these palliative care discussions regardless of experience level.

Clinical Implications

The Effects of Moral Distress On a Healthcare System

There are not enough new graduate nurses available to compensate for the current United States nursing shortage (Snively, 2016). Pediatric acute care units must focus not simply on hiring new graduate nurses but also retaining their existing employees. As discussed earlier in this article, data published in the 2016 report from Nursing Solutions, Inc. show over a quarter of all new graduate RNs will leave their position in one year, with over one half of all RNs leaving their positions with less than two years of experience. This most recent report is consistent with other years, acknowledging that first-year turnover continues to outpace all other tenure categories (Nursing Solutions, Inc., 2016). New graduate nurses are not retaining hospital positions, and turnover is widely caused by moral distress (Krautscheid et al., 2017).

Nurses who are exposed to even a medium level of moral distress are more likely to leave their profession (Borhani et al., 2014). Not only are turnover and moral distress harmful to patients, but they are also harmful to hospitals and the healthcare system at large; nurse turnover costs can range from \$90,000 to \$145,000 per nurse depending on the localized salaries and particular specialty (Jones et al., 2017). Additionally, graduate nurse turnover also greatly impacts replacement costs, forcing hospital systems to spend premium labor dol-

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Learning Outcome

After completing this learning activity, the learner will be able to articulate the definition of moral distress and explain how pediatric new graduate nurses are uniquely impacted by moral distress.

Learning Engagement Activity

Identify two unit-based tools that could be implemented to minimize moral distress in the new graduate nurse.

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lars on overtime costs and hiring temporary nurses to compensate for the shortage (Ackerson & Stiles, 2018). Although more difficult to quantify than economic costs, nurse turnover also impacts patient satisfaction, quality of care, and patient outcomes (Choe, Kang, & Park, 2015). In fact, nursing shortages due to turnover significantly increase the event of adverse patient outcomes (Dwyer & Hunter Revell, 2016). Finally, high rates of turnover and nursing shortage run counterproductive to the ideals of the PPACA, putting its goals at risk and jeopardizing the success of long-term health reform (Snavelly, 2016).

Recommendations

The current nursing shortage coupled with major healthcare reform has created a tumultuous time for not only new graduate pediatric nurses, but also nurses of all tenure. The pressure to complete care tasks in a timely manner for critically ill children leads to increased RN dissatisfaction, moral distress, and increased rates of turnover. New graduate pediatric nurses are especially vulnerable to moral distress and subsequent

turnover, considering their disillusionment with the harsh realities of a career as an inpatient RN (Kelly, 1998).

Although systems initiatives must be considered for lasting change, the focus should remain mostly on micro-level, unit-based changes. Hospitals should consider implementing tools to support new graduate nurse engagement, such as nurse residency programs and unit-based ethics committees. Further, nursing units should encourage participation in ethical education initiatives and multiprofessional palliative care programs. Finally, nursing units should perform routine screens with tools like the MDS-R and offer mindfulness sessions to promote the well-being of new graduate nurses. Without such interventions, moral distress and subsequent nurse turnover may occur and cause poor patient outcomes (Snavelly, 2016). Nurses are vital members of a healthcare team, and moral distress puts RN mental health, patient safety, and hospital fiscal saliency at risk. Proper unit-based interventions to minimize moral distress will empower new graduate nurses, minimize turnover rates, and improve patient outcomes. ■

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