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Dr Pamela Page
Churchill Fellow 2019

Bearing witness and being bounded: The personal and professional challenges experienced by nurses in adult critical care.

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Churchill fellow 2019

Page P, Simpson A, Reynolds L. 2019 Bearing witness and being bounded: The experiences of nurses in adult critical care in relation to the survivorship needs of patients and families. Journal Clinical Nursing 1–12. https://doi.org/10.1111/jocn.14887

University College Hospital
London, England.

Qualifying as a
Registered Nurse
1984

Nurse Academic
2018

Results presented form part of a larger study; "*Critical illness survivorship and implications for care provision; a constructivist grounded theory*".

http://openaccess.city.ac.uk/id/eprint/17242/1/Page,%20Pamela_Redacted.pdf

Aim

- To discern, understand and explain the relationship between patient, Registered Nurse (RN) and family member (FM) in the context of adult Critical Care

Research question

- How do RNs respond to the survivorship needs of patients and family members in adult Critical Care?

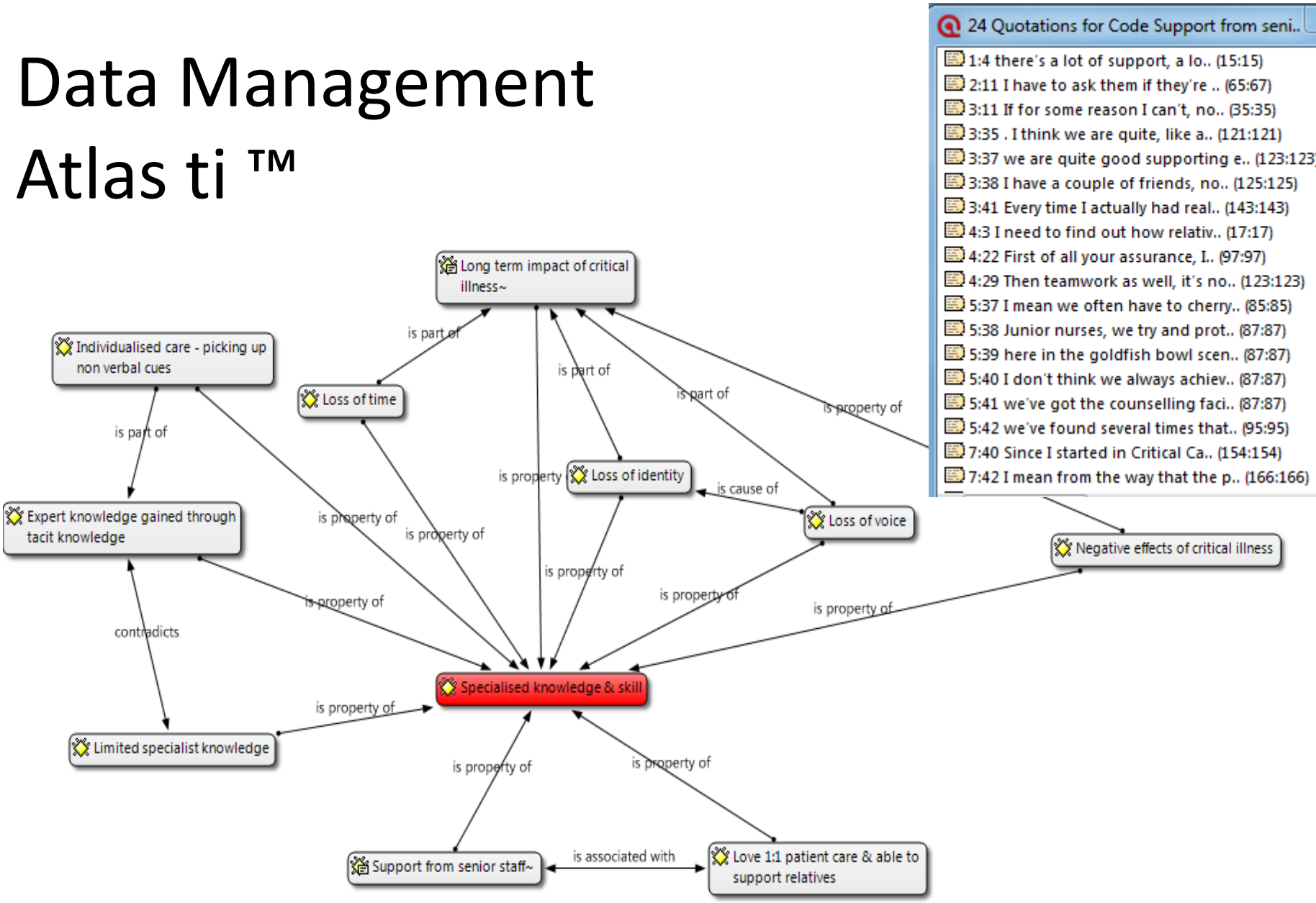
Methodology & ethical approval

- Constructivist Grounded Theory (Symbolic Interactionist perspective)
- A spiral of concurrent data collection, analysis and theory construction
- Coding and memo writing starts with first interview
- Purposive sampling with theoretical sensitivity
- Theoretical sampling - searching for patterns and variations
- Theoretical saturation – no further data required
- Substantive or formal theory that accounts for data and context variations
- IRAS approval gained via proportionate review (13/LO/0798)

Critical Care Registered Nurse demographics

Research code	Gender	Pseudonym	Years of critical care experience	Post registration education in critical care	Salary Band (UK)
S01	F	Gail	11	Yes	6
SO2	F	Amanda	18	Yes	7
SO3	F	Aricha	1.5	No	5
SO4	M	Paco	4	Yes	5
S05	F	Kay	24	Yes	7
S06	F	Karen	27	Yes	6
S07	F	Clarin	3	No	5
S08	F	Mary	25	Yes	5
S09	F	Jane	11	Yes	6
S10	F	Cathy	11	Yes	6
S11	M	Velta	1.5	No	5

Data Management
Atlas ti ™



Focus codes

- *Personal & professional challenges*
- *Delirium assessment & management*
- *Family presence*
- *Crafting specialist knowledge and skill*
- *Challenges in care transition*

Personal and Professional Challenges

Gail: '*what I find difficult is when I've looked after patients with bowel cancer, my dad had bowel cancer, so you can relate to things, and when relatives have got small children, I've got small children, and seeing what they're going through, that's quite challenging and hard emotionally…'.* (S01)

Mary: ' *…we are emotional people and we are professionals ...one relative the other day, when her loved one died, she fell to the ground, and so I sat on the ground with her, …sometimes we cannot want to... it's hard to go to that place, but it's vital for the families that we do'* (S01).

Illustration of the emotional labour of critical care nursing.

Personal & professional challenges

Amanda after working in critical care for 18 years appeared to be struggling with the emotional challenges of working in an environment where proximity to death is ever present:

- **Amanda***: I'm sick of death, I am sick of death, I went through a phase, about six months ago I thought, I am just so sick of death, not necessarily that we had a big patch of people dying, we're either stopping somebody dying, they're dying, ...perpetual death, isn't it? Perpetual death, and I have had enough now, I have had enough. I've got another year and I'll be happy to go. (S02).*

Amanda seriously questioned the appropriate use of technology that may prolong life, which in her view, was of very poor quality:

> *'I think medical science is absolutely fantastic, but it needs to be used properly and I don't think necessarily these days it is, and that's why we've got the problems that we've got.'*(S02)

Potential evidence of moral distress.

Personal and professional challenges

Aricha: *'…it can be stressful because of workload, it can be stressful because of your emotions, you sometimes just have horrible, horrible days that you run all day and you don't get anywhere with a patient, you don't see the patient getting any better, actually sometimes just see the person going backwards and you just feel frustrated.' (S03).*

Aricha went on to explain the personal cost of working in Critical Care in contrast to the ward environment:

'When I used to work on the wards and now, I see the difference, I can't actually go home and switch off.' (S03)

Personal and professional challenges

In contrast Mary who had 25 years of bedside critical care nursing experience spoke of her ability to '*switch off'* having done all that she could to care for both patient and family member in the fullest sense of the word. There was one caveat:

Mary: "*I think I'm able to switch off at the end of the day, I do my best while the patient is here, I do anything, I've taken a patient to a wedding, I've done all sorts, I take them out for walks and really tried to do my best while the patient's here. But once they've gone [died]…. then that's it…I don't go to patient's funerals...*" (SO8)

Delirium assessment & management

- **Karen:** *"I'm mentoring at the moment A and B on the course, and I've learnt a lot [about delirium] because they're doing a different course to the one I did, and I think it is something we need to work on quite a lot. I didn't know all the sorts of delirium there are and I thought I did, but I didn't know anything."* (S06)

Kay described the risk and consequence of caring for patients who are experiencing hypo-alert delirium.

- **Kay**: *"…it's a failing probably from us and nursing, when people are withdrawn they're less demanding of our nursing time in terms of when you've got a very busy unit, and sometimes I think our focus can be shifted."* (S05).

Family presence
Visiting hours –contention!

Paco: "*Right, from my point of view unfortunately it's good as we've got the restriction visiting simply because you won't be able to do all stuff that we have to do, personal care, physiotherapy, ward rounds, medication, investigation, kind of tests, etc, etc, it's impossible*" (S04)

Karen, however, objected quite strongly to the visiting regime in place at the time of interviews:

Karen: "*I don't like it... if this was my family member in here, I would find the hours very restricted...*"

Family presence

Cathy also expressed concern over the restricted visiting hours:

- **Cathy:** "*Currently our visiting hours are limited to two hours in the early afternoon and then four hours later on in the day. I think they should be a bit more flexible to the patients' needs actually… especially if they have delirium, because often it's their loved ones that bring them back to where they need to be*" (S10).

Clarin struggled with working in a "*goldfish bowl*" environment.

- ***Clarin**: "…but the people [family members], they're just constantly like observing you or they're telling you, oh, you haven't done anything, it does intimidate me, or you're just going to do something and they just make a joke like, but it's not a nice joke, I don't like that, and I try to back off a little bit because that will make me fail as a nurse, because it will stress me out." (S07).*

Working Together: Our ICU Partnership

- The ICU doesn't have set visiting hours. You may visit any time.
- Support groups/family gatherings are available.
- Daily ICU rounds are open to you as family members/loved ones.
- Hospitality cart with snacks for visitors.
- ICU Aftercare and Recovery Clinic – please ask for a referral!
- Family involvement in bedside care – please ask how you can be part of the care team!
- Ask for more information about what to expect after you leave the ICU.

Ask for more information about how we are improving care and working to provide the best treatments for you and your loved ones. We have projects in many areas, including:

- The patient and family ICU experience.
- Lung disease and acute respiratory distress syndrome (ARDS).
- Blood and clotting disorders.
- Body's response to infection (often termed SEPSIS).

Learn more at:

- www.myicucare.org/thrive
- www.IntermountainHealthcare.org/HumanizingCriticalCare

Please ask your healthcare team for more information, or email additional questions to ICU_ARC@imail.org.

Intermountain Healthcare

Transitional Care

- **Gail:** *"…it's a big jump when you've had that one to one and then going to the wards where you might not see anyone for ages, or you see a lot of agency staff, you don't get that continuity".* (S01)

She went on to refer to the pressure on critical care beds that could lead to a "*busy discharge*" but how she would endeavour to prepare patients for the transfer to a different level of care:

- **Gail:** "…*sometimes it is quite a busy discharge I must admit, if we've got pressure on us to get patients out, but if I know I've got a patient going [to the ward], I talk to the patient about how things are on the ward and obviously you're not going to have this one to one care*,…(S01)

Limited preparation for transition

- **Kay:** *"…do we prepare patients for discharge? We talk to them just generally…."*

Cathy described, in technical detail, how a discharge can be enacted.

- **Cathy**: *"suddenly they've been half asleep using their PCA, pain control's better, inotropes are off, they've still got a chest drain in, they're coming round, they're waking up, we've said everything's alright, we're going to try and get you a bed, they don't really know what that means, and then a bed comes up, this is in an ideal situation obviously, quick as a flash, arterial line out, off we go. You know, we're sending more patients out with central lines now*," (S10).

Challenges to person centred care

- Emotional work or labour (Stayt 2008, Siffleet et al 2015, Kelly and Smith 2016) clearly forms a central role for critical care nurses; the daily confrontation with death is abundantly evident in this study.
- Emotional toll is exacerbated further by the increased bed pressures aggravated by current austerity measures.
- Nurses appear to be bounded by the walls of the critical care unit, and experience personal and professional conflicts in their role.
- Experienced critical care nurses can transcend the obtrusive nature of technology.
- Journey to such proficiency is demanding and the data presented reveals the challenges that nurses experience along the way.

Implications for practice

- Nurses thrive in a practice environment and culture that allows them to be seen, heard and understood.

- Transformational leaders who demonstrate empathy and engage with staff evoke the human emotion of feeling cared for in the workplace (Baggett et al 2016).

- Help build critical resilience* against compassion fatigue (van Mol 2015) and ultimately prevent the development of PTSD in staff (Mealer 2012). (*see Traynor M. Critical resilience for nurses)

Strategies for all of us

- Strive to understand the values of others
- Provide fora for discussion/debriefing
- **Collaboratively** establish goals of care
- Use, as appropriate, decision making frameworks
- Being alert to the development of compassion fatigue and act pre-emptively to diminish its development

What organisational changes are needed to preserve **moral integrity**?

Moral Distress

is the psychological distress that occurs because of a moral event or ethical issue.

4 Types of Moral Distress[1]

1. **Moral-uncertainty distress:** you feel distressed because you are uncertain about whether you are doing the right thing.
2. **Moral-dilemma distress:** you feel distressed because you are unable to choose between two or more ethically supportable options (you feel stuck between a rock and a hard place).
3. **Moral-conflict distress:** you feel distressed because you are conflicted about the most appropriate ethical action.
4. **Moral-constraint distress:** you feel distressed because you are constrained from doing what you think is the ethically appropriate action.

If the moral event or distress is not addressed then you may experience...

Moral Residue: the lingering negative emotions experienced when you feel you have compromised your core values[2]

The Crescendo Effect: when unresolved residual feelings accumulate into a crescendo, causing you to have stronger reactions to similar future situations[2]

Turnover: leaving your position or healthcare entirely despite your passion for patient care; interferes with organizational efficiency and continuity of care

[1]Morley, 2018: https://research-information.bristol.ac.uk/en/theses/what-is-moral-distress-in-nursing-and-how-should-we-respond-to-it(08e7e5ca-14f6-443d-91a2-b50d4cd00cbc).html

[2]Epstein, 2009 *Moral Distress, Moral Residue, and the Crescendo Effect.* J Clin Ethics. 2009 Winter; 20(4): 330–342.

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Signs of Moral Distress

Depersonalization: Detaching oneself from patients as human beings and focusing on task based care. This may be adopted as a coping mechanism.

Distancing: Detaching oneself from patients, families or other caregivers in an attempt to reduce ones psychological response to troubling situations.

Horizontal Violence: Coping with moral distress by gossiping, lashing out, or other harmful behaviors that result in teams losing trust in each other.

Resources for Moral Distress*

**These resources are available within the Cleveland Clinic system. On-site availability at specific locations varies.*

The Ethics Consultation Service (ECS) provides support to patients, loves ones and healthcare professionals grappling with ethical issues in the provision of patient care. *To contact the ECS, refer to the On-Call Directory via the Intranet.*

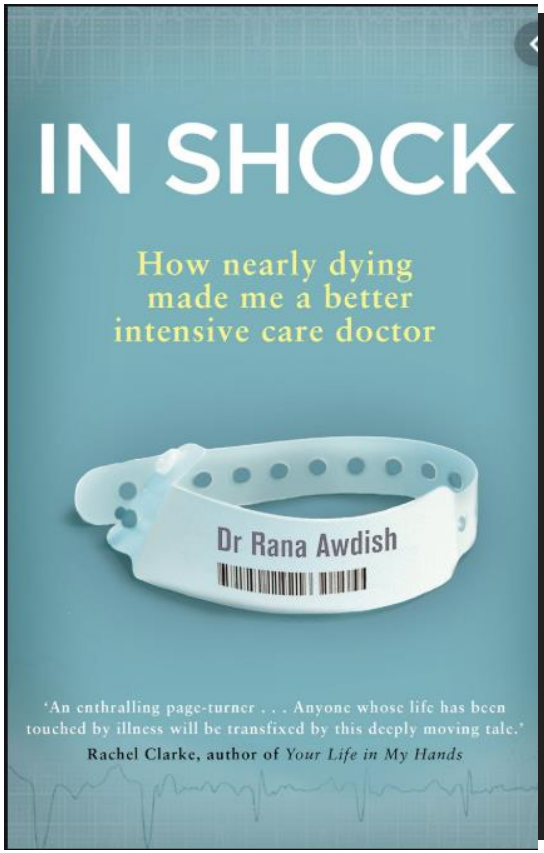
Code *Lavender** supports caregivers in times of high emotional stress through holistic care. Services may include touch therapies, energy-based methods, expressive arts and mind/body tools.

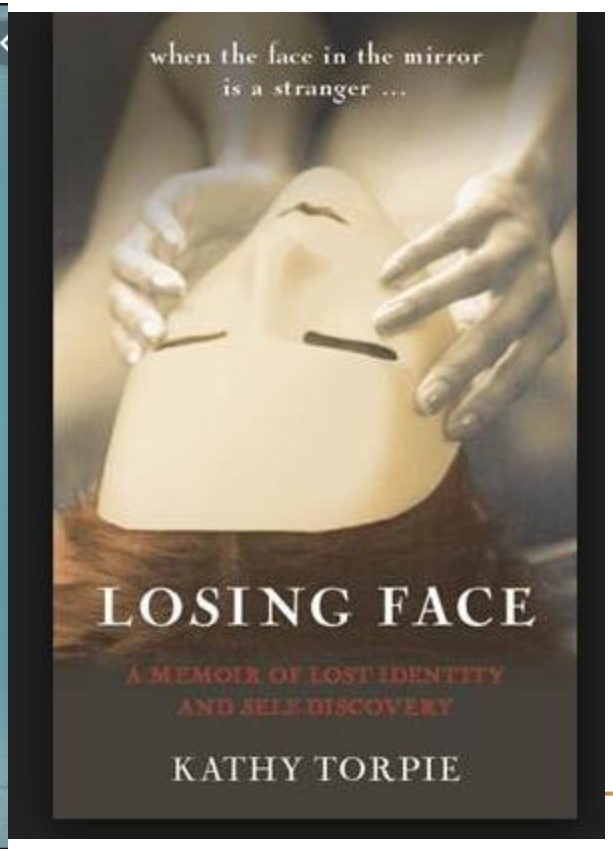
Spiritual Care/Healing Services*. *Spiritual Care* is available for coping with loss, stress, suffering and more as well as for faith-based concerns. *Healing Services** provides holistic care, integrating a myriad of modalities and other relaxation techniques to encourage healing with attention to mind/body/spirit and emotional issues.

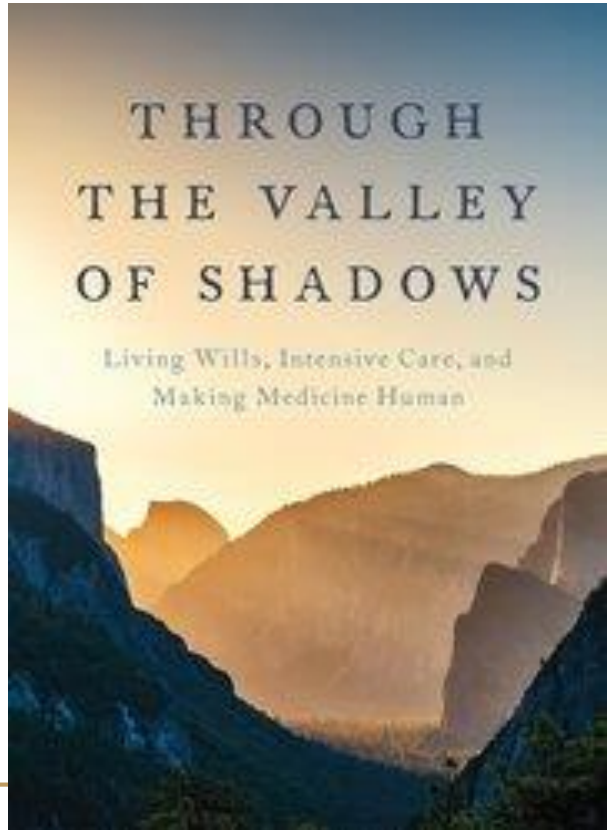
Caring for Caregivers is available to support caregivers through life's challenges, providing counseling and Critical Incident Response services. *You can contact*

Critical Care nurses in this study experienced and demonstrated:

Reading material….







References

Baggett, M., Giambattista, L., Lobbestael, L., Pfeiffer, J., Madani, C., Modir, R., Zamora-Flyr, M. and Davidson, J.E., 2016. Exploring the human emotion of feeling cared for in the workplace. *Journal of nursing management*. DOI: 1111/jonm.12388

Carmel, S., 2013. The craft of intensive care medicine. *Sociology of Health and Illness,* 35 (5), pp.731-745.

Gonzalez, J., 2016. Exploring the Presence of Moral Distress in Critical Care Nurses. *Master's Theses, Dissertations, Graduate Research and Major Papers Overview*. 184

Morley, G. (2018), What is "moral distress" in nursing? How, can and should we respond to it?. J Clin Nurs, 27: 3443-3445. doi:10.1111/jocn.14332

Morley, G, Ives, J & Bradbury-Jones, C 2019, 'Moral Distress and Austerity: An Avoidable Ethical Challenge in Healthcare', Health Care Analysis, vol. 27, no. 3, pp. 185-201. https://doi.org/10.1007/s10728-019-00376-8

Siffleet, J., Williams, A.M., Rapley, P. and Slatyer, S., 2015. Delivering best care and maintaining emotional wellbeing in the intensive care unit: the perspective of experienced nurses. *Applied Nursing Research*, 28 (4), pp.305-310.

Stayt, L.C., 2009. Death, empathy and self-preservation: the emotional labour of caring for families of the critically ill in adult intensive care. *Journal of Clinical Nursing,* 18 (9), pp.1267-1275.

van Mol, M.,M.C., Kompanje, E.J.O., Benoit, D.D., Bakker, J. and Nijkamp, M.D., 2015. The Prevalence of Compassion Fatigue and Burnout among Healthcare Professionals in Intensive Care Units: A Systematic Review. *PloS one,* [e-journal] 10 (8), pp.e0136955. Available through: < http://journals.plos.org/plosone/ .