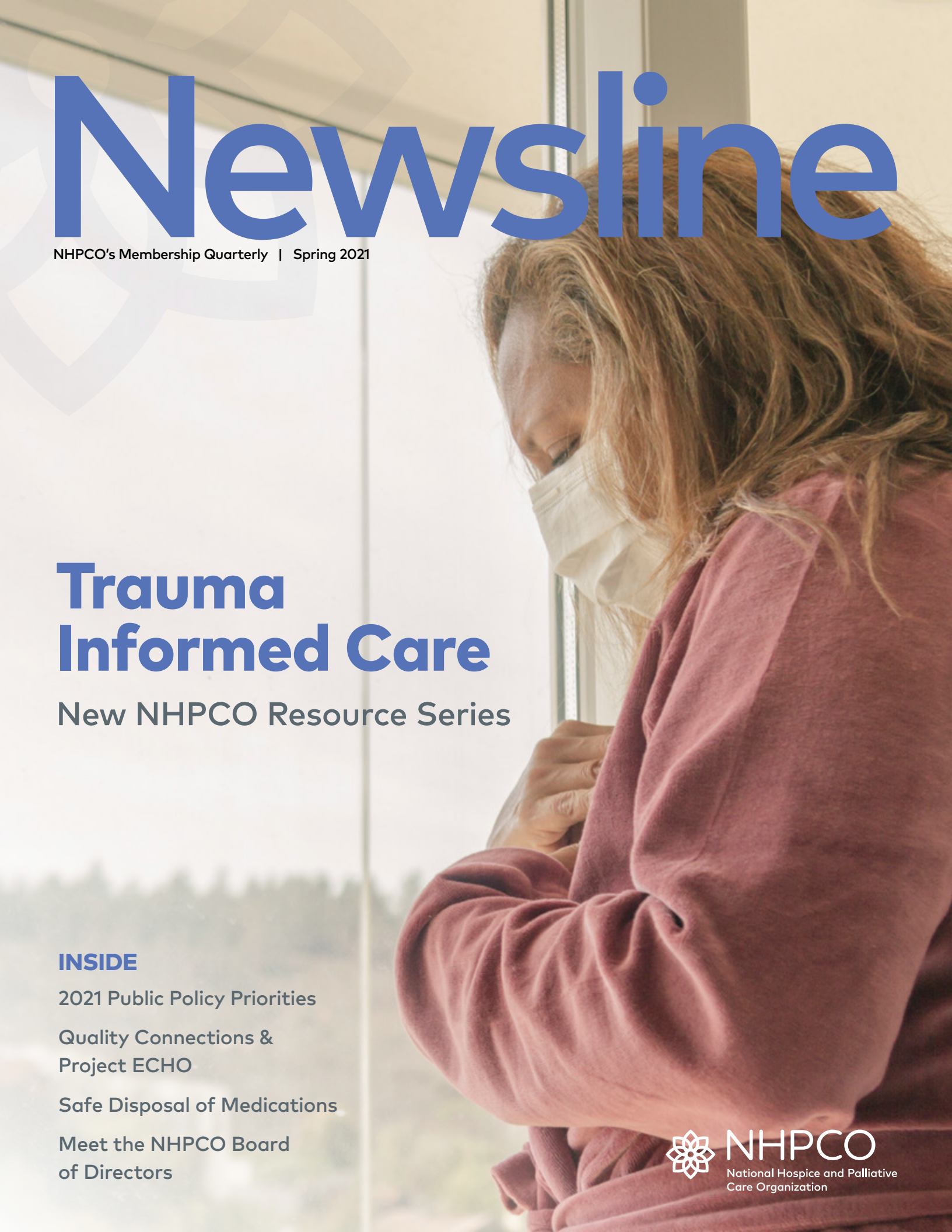
Newsline

NHPCO's Membership Quarterly | Spring 2021



Trauma Informed Care

New NHPCO Resource Series

INSIDE

NHPCO
National Hospice and Palliative Care Organization

Trauma Informed End-of-Life Care

INTRODUCTION TO NHPCO'S RESOURCE SERIES

by NHPCO TIEOLC Work Group

Uncertainty, unpredictability, and a lack of control characterize traumatic events. In the current pandemic, these have become an everyday way of life. These conditions are challenging for us all, especially for the estimated 82 percent* of us who have experienced some form of trauma in our lifetime.

These abnormal situations can make individuals feel as if there is something wrong with them as they struggle. In fact, these reactions are normal in the face of abnormal events such as the ones we are currently experiencing. To respond to this need, the NHPCO Trauma Informed End of Life work group is developing a series of articles that provide information and recommendations to help navigate these unprecedented times.

Understanding the Importance

Pre-pandemic, healthcare professionals were beginning to understand the importance of Trauma Informed Care (TIC) to protect the well-being of both those we serve and our teams and organizations. TIC can contribute to improved well-being for staff and patients, increased satisfaction, decreased complaints, decreased emotional labor, reduced risks of burnout, and save other valuable agency resources. This is especially important while working in pandemic conditions.

The basic TIC principles include:

- safety
- trustworthiness and transparency
- peer support
- collaboration and mutuality
- empowerment, voice, and choice, and
- cultural, historical and gender issues

Re-Envision Support

Learning and implementing TIC principles can feel overwhelming for professionals and agencies. However, the risks are too great and potential benefits too important to delay action. As horrible as this pandemic is, it presents an opportunity to revolutionize our industry as we re-envision how we support each other and those we serve.

One predictor of compassion fatigue is a sense of blurred boundaries, the need to fulfill all of the needs of the patients and families we serve. The enormity of need is now so great that even the healthiest, most seasoned, and boundaried professionals are struggling with the moral distress of not being able to tend to it all.

TIC begins with recognizing and caring for our own needs. As professionals serving others, there is often guilt related to allocating time and resources to our

Psychological Medicine (2016), 46, 327-343. doi: 10.1017/S0033291715001981

own well-being. However, the current crisis has increased threats of moral injury, moral distress, and primary/ secondary and vicarious trauma. This makes self-care critical not optional.

With restrictions and demands increasing, we are asked to evaluate the most important aspects of caregiving and to reconnect with core hospice and palliative care philosophy. It invites inquiry as to why as caregivers we resist self-care and struggle with having too little or too much empathy for ways trauma manifests in others.

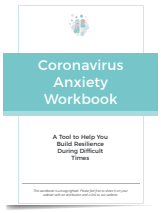
TIC principles endeavor to create an environment that helps staff and leadership adjust expectations, accept our limitations, and find satisfaction in the level of care we are able to provide. Trauma-informed leaders and organizations design policies and procedures that mitigate rather than exacerbate stressors that impact the well-being of our teams, and eventually, the patients and families.

There is an opportunity to create more effective ways for us to heal our past, develop better boundaries and become healthier, more resilient and emotionally intelligent. It will benefit us, those around us, our workplace, and those we serve.

...the current crisis has increased threats of moral injury, moral distress, and primary/ secondary and vicarious trauma. This makes self-care critical not optional.

Helpful resources:

NHPCO's Trauma Informed EOL Care Resources—from the TIEOLC work group



Coronavirus Anxiety Workbook—from the Wellness Society

SAMHSA Concept of Trauma and Guidance—for a trauma-informed approach

Mitigate Our Own Stress

TIC offers frameworks for how to name, process and approach our experiences and reactions to mitigate secondary trauma risks. The use of a trauma-informed lens and implementing debriefing practices can inform and support decision-making. As we grow, we can show up better for patients and their families.

Acknowledging that current challenges impact both our personal and professional lives, it is essential to find ways to mitigate our own stress in order to enhance resiliency and be able to provide care to patients. Below are 5 self-soothing skills that are easy to incorporate even in a busy workflow:

4-7-8 breathing: Research shows that exhaling longer than you inhale calms the nervous system. Try this breath pattern. Breathe in for the count of 4, hold at the top of the inhale to the count of 7, and exhale for 8. If these counts feel too long, adjust as needed. As you practice, your ability to lengthen the hold and exhale will improve. Repeat the cycle at least 3 or 4 times.

Waterfall: As you walk through a doorway, or enter a video conference, imagine a waterfall running down from the doorway washing any negative energy or tension off of you. This will allow you to release stress throughout your day rather than allowing it to build.

H.A.L.T.: When our basic needs are not met, we are less likely to be our best selves and are more susceptible to stress. When you find yourself Hungry, Angry, Lonely, or Tired, then take steps as quickly as possible to tend to those needs. Doing this consistently can help you stay more present for yourself and others.

Shifting our thoughts: Find a phrase that you can use to self-soothe when stress, frustration or despair are emerging. A few examples include: "We are all flawed and limited," "I am doing the best with the resources, skills and knowledge available," or "May I find ease, may I be happy, may I suffer less." Say the phrase on your inhale, and imagine releasing the emotion from your body on the exhale. Repeat this 3-5 times. Pairing your phrase with intentional deep breathing can increase the benefits.

5-S's: Find a space such as a break room, bathroom or hallway where you can take the following 5 actions. Stop what you are doing, Stretch arms toward the ceiling, Shake your entire body, Sigh with a large exhale through the mouth, Smile and notice any shifts in how you feel.

Utilizing these skills, we begin to embody and model the resilience we seek for ourselves and patients we serve. Doing these things will not necessarily change the situations we face or the challenges in front of us. They will not magically fix the source of our stress. These skills will, however, strengthen our resilience and help us more skillfully navigate whatever is in front of us.

For now, keep breathing, focus on what you can change, accept the things you cannot, and remember you are not crazy, you are not weak, and you are not alone.

Topics in this series from the TIEOLC work group will include:

- How Hospice is different now (in the midst of a pandemic)
- Measuring Success in a Pandemic/Redefining Success in a Pandemic –for leaders
- Measuring Success in a Pandemic/Redefining Success in a Pandemic –for frontline staff
- Moral Distress
- Working with and In Nursing Facilities
- Racial Trauma of Staff
- Racial Inequity for patients
- Interpersonal Trauma (Sexual)
- Trauma of marginalization for persons LGBTQ+–and discrimination fears/realities in LTC
- Pediatrics and Young Adolescents
- Brain Failure/Cognitive Impairment
- Health Disparities
- Staff Leadership Skills training

Trauma-Informed End-of-Life Care

Change and Measuring Success – *A Reflection*

NHPCO
Leading Person-Centered Care

It does not matter if you have been doing hospice work for a few months or many years. Changes are always happening around us. These changes affect how we provide care. Change often brings on the "I remember when…" stories. Some may wish for the "Good Ol' Days" while others enjoy the structure we have now. As hospice continues to grow and evolve, we can provide care in a different more efficient way.

How do you measure the success of the care that you and your team is delivering? Prior to the Pandemic? During the pandemic? And how will you measure that success after the pandemic? Caseloads are higher, expectations of numbers of visits are higher. Do more with less. Is this a new theory? No, we have been talking about this for years. Yet, more than ever right now we feel a lack of control. Prior to the pandemic, we placed this lack of control on decreased staff, sicker patients at end of life, and mini-intensive care units in the home setting. During the pandemic, we blame the pandemic. What will we blame after the pandemic?

Perhaps instead of feeling that lack of control we look at how we measure success? During this time, you may be feeling isolated and missing your fellow IDT members (including team leaders). We are, after all, the story tellers, story listeners and only we understand the stories. Hospice stories are not stories that we share with our families at the end of the day, they do not want to hear about that death and dying stuff. If we can't tell our stores and hear our peers tell us what a wonderful job we did in such a difficult situation how are we measuring our success?

When you do hospice work you give all, all of the time. By telling our stories and having those stories validated we get filled again, we share a comradery that others don't understand. We are huggers and touchers. We want to hold the hands of those patients who are dying, we want to sit by the bedside. We want the time to do that and now during the pandemic not only are we not graced with the time, we simply cannot do the things that we have traditionally used to measure our success.

Decreased in-person visits, social distancing, telehealth visits, delivering end of life care behind a mask and a shield these are the tangible changes that present challenges to providing hospice care in our usual fashion.

Measures of success in this sea of change is the ability to adapt- increasing phone contact, optimizing the in-person visits with video buddies from other disciplines, including facilitating communication and contact with the patients' families if they are apart. These adaptations are not a measure of the success of the individual changes. The success is instead the adherence to the true north that is the vision and goal of providing compassionate, palliative end of life care, though it may look different.

If you provide hospice care, you may have experienced a trauma in your hospice journey. Homeless patients, patients dying alone, pediatric patients, veterans with Moral Injuries and re-living their horrors from combat as they take their last breath. The patients and families we are caring for are experiencing their own traumas right now as well. Families separated from their loved ones in facilities that they are unable to enter, saying their goodbyes on the phone or some meeting room on a handheld device. The pandemic is making it extremely clear that we are facing, potentially, more direct and indirect trauma in our jobs.

Did you think you would ever equate hospice care with telehealth visits or window visits? How do we measure the success in that? What refills and refuels you for another day? How do you assure that moral distress, compassion fatigue are minimal as you do your job?

Do you depend on the leadership of your organization to understand the duties you perform every day? Do you look to them for the refuel and refill? Are they trauma informed in how to help you survive your job? How is success measured?

Perhaps, just perhaps, we need to redefine how we personally measure success at the end of our workday. Did you help a family connect by a phone or a handheld device? Did you call a family, unable to see their loved one in a facility after you did that window visit and describe to them what you saw? Did you go the home of a caregiver and sit, socially distanced, from them and hear their distress and did you provide comfort to them? You should measure these things as a huge success. Without you, that family member whose loved one is not accessible to them would not know what is happening to the patient. You have assured them of the comfort they want to hear about.

Did you bathe a patient and call the family to let them know that the patient smiled as you hummed while you worked? HUGE success again.

Did you go home at the end of the day and care for yourself? Now add that you did not feel guilty for this. Did you reach out on the phone to a co-worker to describe your day? Cry and laugh with them. These are our success stories to tell and forever hold on to.

Now is the time to redefine how we measure success going forward. When we get through this pandemic, we can know that even with higher caseloads and more visits in a day we are doing something that no one else can, we are delivering the best end of life care that we can. By not wishing for the "Good Ol' Days" and looking at hospice as it has grown, we set new expectations for measuring the success in the care we provide.

Resources and Tools:

https://www.nhpco.org/education/tools-and-resources/trauma-informed-end-of-life-care/

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This resource was developed by the NHPCO Trauma Informed EOL Care Work Group, April 2021.

Trauma-Informed End-of-Life Care

How Leaders can Measuring Success During a Pandemic

NHPCO
Leading Person-Centered Care

CMS As leaders we have had to guide our staff and organizations through economic crisis, natural disasters, and staffing shortages. For the first time we are leading our staff and organizations through a global pandemic. We have had to prepare for an increase in census, a decrease in census, and a decrease in staffing. Most importantly, we have needed to be acutely aware of how our staff are being affected by the pandemic.

How have you maintained your perspective through this crisis? How have you been present for your staff? How have you changed how you measure success?

The pandemic is traumatic for many individuals and a trigger for others. What tools do you have to assure that you are providing trauma informed care for your staff and community? Being trauma informed will allow you as a leader to care for the staff doing the work. It is difficult amid a crisis to think that you need to be trauma informed. However, a trauma informed organization saves resources; labor, time, unnecessary interventions, improves clinical outcomes, improves employee, patient, and family satisfaction, and decreases staff turnover and burnout.

Did you think you would ever realize a hospice visit was one that is a "window visit" or a telehealth visit? Staff are exhausted and feel traumatized by the COVID-19 pandemic. Along with the pandemic they have had to maneuver through political conversations and racial upheaval. They need their leadership to be there for them now more than ever.

Hospice staff are unique persons of caring. They measure their success as they provide 110% to their families. As leaders we have grown to accept this and set our standards high and expect that 110% will be achieved. During this time, your hospice may have experienced a significant decline or increase in census. Both scenarios demand a change of how care is delivered and how success is measured. As a leader you have had to manage staffing shortages. Staff may have tested positive for COVID-19 or needed to care for a loved one that tested positive or were too afraid of being exposed. Leaders had to assure patient coverage as their staff scheduled time off due to daycare and school closings. Staff were suddenly not only hospice employees but teachers as well.

Hospice teams are fascinating to observe. Dynamics vary widely as teams navigate through interdisciplinary care meetings. Staff are used to being in a room together, offering support and care to one another. Each team has their own level of trust, sharing styles, and issues they are facing. This is not as comfortable on a virtual platform. Some teams may be providing care to all COVID-19 positive patients. Others may be working in areas that are impacted by systemic racism and increased LGBTQ+ prejudice. They miss face to face interactions and need to find ways to adjust.

Staff members who are people of color experience prejudice and micro aggressions from patients and families. This may lead to trauma and feelings of isolation. Staff may be surprised and perhaps disappointed that their organization and leaders are not more vocal in expressing anti-racism values and question why protocols and processes are not in place. They may feel that they cannot report or voice their concerns and experiences.

Hospice staff are missing a valuable component of the care they provide patients and families. They like to hold their patient's hands and hug their patients and families. Now they are masked up, gowned up, and behind a shield of protection. While it is important to regularly thank staff, the words are no longer heard after months and months of what may now sound cliche. Small gestures of appreciation are nice, but months later staff

need to hear from leadership that it is OK and expected that they cannot give 110%. They need to know that a telehealth visit is JUST as important as being at the bedside. They need leadership to reinforce the importance of telehealth to deliver excellent end of life care. They need to be congratulated on helping a family member see their loved one through the lens of the phone or their tablet. Those families have not seen their loved one in months and your staff have made this important connection at end of life happen.

Being trauma informed will help you as a leader reconnect with the true concepts of hospice care and assure your staff are building good boundaries which often leads to resilience for the buildup of day-to-day trauma.

- Leaders should be communicating often with staff by keeping them updated with information from the CDC about potential vaccines and about how their co-workers are doing.
- Give staff words to end all political conversations with patients and their families. Guide them and let them know what to say before they would have to make guesses.
- If you are in an area where extreme racial unrest is occurring, be sure to let staff know what safety measures they should expect from you and how to maneuver through the streets they travel. Assure they understand that you are trying to provide a safe and healthy workplace even if that workplace is their car or virtual.
- Encourage self-care. Add mindfulness moments in your weekly update about the pandemic and express gratitude for all they are doing. This not only builds a foundation of encouragement and strength for your staff; it also forges the positive relationships with patients and caregivers.
- Have team members develop a mindfulness program to help them decrease their stress and anxiety.
- Hospice staff want to feel that they contribute to the success of their hospice program. Measure success by communicating stories from the field to them. The window visits on an anniversary. The face time with loved ones that cannot be together for health reasons. Know that each patient encounter is a success story,
- Measure success in bringing joy to a job that needs joy brought to the forefront.

Now, more than ever before, we need to be trauma informed. We need to assure that we are measuring success not only in numbers but in the resilience we help our staff achieve.

Resources

https://www.nhpco.org/education/tools-and-resources/trauma-informed-end-of-life-care/

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Trauma-Informed End-of-Life Care

Nursing Homes and Trauma-Informed Care

NHPCO
Leading Person-Centered Care

CMS recognized the importance of providing trauma-informed care for nursing homes in their 2016 regulations and that has only grown more important during COVID-19. Trauma-informed care is a whole organization approach to care that makes sure residents and staff operate in an environment that fosters safety; trustworthiness and transparency; peer support; collaboration and mutuality; and provides empowerment, voice, and choice, and takes into consideration cultural, historical, and gender issues (SAMHSA, 2014). These approaches reduce re-traumatization of anyone connected to the organization.

Trauma informed care makes sense for hospice and palliative care because people who are dying often need to come to terms with earlier life events that may have been traumatic (Ricks-Aherne et al., 2020). As hospice and palliative care professionals, we often care for people in nursing homes. COVID 19 arrived just as many nursing homes were implementing trauma informed care (the rule went into effect in November of 2019). COVID 19 rules made trauma informed care more important for all nursing home residents including those at end of life.

Examples of potentially traumatic events for nursing home residents during COVID 19 that raise the need for trauma informed care:

- Restricted visitors, limited contact, and necessity to wear personal protective equipment may make some residents feel isolated or frightened.
- Lack of contact with family members may make residents feel less safe.
- Some nursing homes required residents to stay in their rooms.
- It is more difficult to have goals of care conversations when residents, family members, and providers are unable to be in the same room.
- Dying residents may be unable to fully benefit from hospice services due to visitation restrictions.

Providing trauma-informed care to nursing home residents at the end of life requires the ability to apply the Substance Abuse and Mental Health Services Administration (SAMHSA; 2014)'s four R's to every client interaction.

The 4 R's

	What does it mean?	What can it look like?
Realizes	Hospice and palliative care providers should **realize** the long-term impacts of trauma on people at end of life.	Older adults at end of life may react to earlier traumas previously hidden or experience new trauma as a result of end-of-life experiences. Complicated family dynamics may be a symptom of unrevealed trauma.
Recognizes	Hospice and palliative care providers should be alert for trauma-related symptoms in dying patients, their families, and the staffs that work with them.	Trauma symptoms may not look like we expect them to. They may include irritability, recklessness, hypervigilance, exaggerated startle response, concentration problems, and sleep disturbance
Responds	Hospice organizations should integrate trauma informed care at all levels of practice.	Consider use of language, policies, and practices that are used with staff, clients, and in interactions with nursing home providers. Discuss concerns in a trauma informed way and work collaboratively with non-hospice staff.

Resist re-traumatization	Be alert to the ways agency policies and procedures can be rigid and inadvertently re-create coercive environments	Any organizational change is a journey, not a destination. Policies and procedures should be reviewed on an ongoing basis for slippage, to ensure that they continue to provide a trauma-informed experience.

Nursing Home Residents and Trauma-Informed Care (Kusmaul & Anderson, 2018).

Assessing for trauma in patients at the end of life is complex due to the variability in how it presents and the many layers of trauma an older adult at the end of life may have experienced. In addition, in cases where cognitive impairment is present, a patient may display trauma-related symptoms in response to a past traumatic event about which adult children are unaware. Certain types of trauma, such as child sexual abuse have stigma attached to them and they were often not discussed in families.

Older adults in nursing homes may have experienced more recent traumas, such as trauma related to medical treatments or ICU stays, or trauma related to the losses experienced in the sequelae of events related to nursing home placement. It is not unusual for an older adult to lose a spouse, receive a significant medical diagnosis, lose their home, and lose their independence in rapid succession. Even someone who was coping quite well with an earlier trauma may find themselves in renewed distress when coping strategies are no longer available or working. A trauma survivor who coped in their own home where they could control who entered and exited, what lights to leave on or off, and so on, may now be living in a shared room where staff comes in and out through the night.

There is a growing population of adolescents and young adults in nursing homes; many because they have outlived their prognosis and their families are no longer able to provide all their care. There is the trauma of losing home, usual caregivers, living in a place geared for a completely different population. And trauma for caregivers who have not cared for this younger population and who are not familiar with many of the conditions they have.

These traumas and environmental stimuli can cause increased distress in patients at the end of life. Hospice and palliative care providers should remain alert to trauma related symptoms, and as they have always done, find ways to relieve suffering and distress and whatever level the patient is interested in (Ricks-Aherne et al., 2020).

Final Thoughts

Trauma informed care hospice and palliative care for nursing home residents follows many of the concepts that hospice is known for- collaborating with patients and families, addressing symptoms and suffering, and walking this journey alongside people at end-of-life. COVID has made this more difficult in many ways in the nursing home setting and hospices should be alert to ways they can address/relieve these symptoms and provide additional support.

Resources

Kusmaul, N. & Anderson, K. (2018). Applying a Trauma-Informed Perspective to Loss and Change in the Lives of Older Adults. *Social Work in Health Care, 57*(5), 355-375.
https://doi.org/10.1080/00981389.2018.1447531
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Ricks-Aherne, E., Wallace, C., & Kusmaul, N. (2020). Practice Considerations for Trauma- Informed Care at End of Life. *Journal of Social Work in End-of-Life and Palliative Care,* 6(4), 313-329. **https://doi.org/10.1080/15524256.2020.1819939**
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Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Author. **http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884**

The Institute on Trauma and Trauma Informed Care Organizational Change Manual **http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/Trauma-Informed-Organizational-Change-Manual0.html**

COVID 19 Considerations for a Trauma Informed Workplace **https://traumainformedoregon.org/wp-content/uploads/2020/03/Considerations-for-COVID-19-Trauma-Informed-Response.pdf**

COVID 19 and Stress (for healthcare providers) **https://www.acesaware.org/heal/covid19/**

52 million caregivers (or one out of every five households) are involved in caregiving to persons aged 18 or over.

The young adult population accounts for 37% of the nursing home residents. [Updated February 2015]

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Trauma-Informed End-of-Life Care

Moral Distress

Moral distress is often defined as knowing what you feel must be done, yet not being able to do it. When situational requirements contradict our individual moral compass, the tension between our desires and the actual actions and/or inability to act can create moral distress. For example, restrictions on visitation despite the value of social interaction is an example at the forefront of the current pandemic. Moral distress responses and intensity in a similar situation can vary from person to person.

As hospice and palliative care professionals, we are involved with complex decision-making. When the treatment plan differs from our core values, we may experience moral distress as an uncomfortable feeling such as fear, anger, doubt, anxiety, shame, etc. It can decrease motivation and compassion as well as contribute to lower quality of care and decreased job satisfaction. It manifests differently for each person, based on levels of self-awareness and ability to access internal and external resiliency factors (Jaskela, Guichon, Page, & Mitchell, 2018).

Examples of moral distress in hospice and palliative care:

- Changes in how care is provided as a result of the pandemic such as restricted visitors, limited contact, necessity to wear personal protective equipment.
- Restrictions to protect community health that come into conflict with individual needs.
- Situations that contradict expected natural order such as severe/terminal childhood illnesses.
- Patient continuing to receive aggressive treatment when he or she is unlikely to have a positive outcome.
- Disagreement between patient and family members related to goals of care and preferences.
- Patient or family goals of care contradicting professional opinion of best course of treatment or families not wanting to discuss goals of care/end of life arrangements.
- Interventions such as palliative sedation utilization and voluntarily stopping eating or drinking.

Being able **to address moral** distress requires a willingness to explore difficult issues as well as finding ways to address them on a personal level. In 2004, the American Association of Critical-Care Nurses published *the 4A's to Rise Above Moral Distress* to help clinicians recognize and address moral distress. They are Ask, Affirm, Assess and Act.

The 4 A's

	What does it mean?	What can it look like?
ASK	Moral distress can be physical, emotional, behavioral or spiritual. Recognize your baseline and notice if something has changed.	Determine what suffering looks like and what baseline is; questions to consider: Am I suffering? What does suffering look like? What does wellness look like?
AFFIRM	Recognize, name and accept the moral distress. Determine how to take responsibility for own well-being.	Reaching out to others for validation and support, verbalizing what is upsetting you, connecting to internal and external resources for support.
ASSESS	Identify the source of the distress.	Is the distress connected to an individual event or series of events? policy related? missing support/ resources? Things that our outside of our control? our role?
ACT	Create a plan to process or address the moral distress. If possible, address underlying contributing factors.	Some actions include: discussion and consultation with others, validation with peers, self-care efforts, exploration of your morals and their role on your practice, clarifying your role and what aspects are or are not within your ability to influence.

Moral Residue and the Crescendo Effect (Epstein and Hamric, 2009)

Lingering feelings after the event are referred to as moral residue. It can impact thoughts and actions after the issue or event causing moral distress is over. Moral residue is difficult to characterize because it is not always the same, has varying intensity, and the lasting effects vary from situation to situation**.**

In times of a national health crisis such as a pandemic, there is not one isolated case, but many. The feelings of moral distress left after each case is the residue and can accumulate when they are not addressed and processed.

Both moral distress and moral residue can increase over time, leading to a newly established baseline after each event. This leads to an increasing reaction to moral distress from the previous event and although the event causing the distress has ended, the person does not necessarily return to their original baseline. The clinician continues to experience that distress to a degree which can become cumulative, especially in instances where similar issues prompting moral distress in a clinician are present such as end-of-life care. Instances where the clinician continually cannot provide ideal care due to circumstances and limitations exacerbate moral distress. This scenario is prevalent during the current pandemic.

The residue leaves us physically, emotionally and spiritually worn down. Over time this accumulation can have a cumulative effect on our perspective, our well-being, and our actions. The 4 As, intentional debriefing of challenging situations, and collective acknowledgement and support during instances of moral distress are key to mitigating moral distress impacts. Left unresolved, moral distress and residue can lead to ongoing limitations in ability to solve systemic problems, decreased empathy, compassion fatigue, burnout and vicarious work-related trauma.

Final Thoughts

Moral distress can affect everyone, including our patients, families, caregivers, and coworkers. At the time of this publication, the pandemic has heightened the distress experienced. If left unattended, moral distress (and moral residue) can complicate clinical practice and hasten burnout.

Resources

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Nofziger, D.(2020 June 17). *Staff perspective: Moral distress, residue, and the crescendo effect- understanding the potential impact of the extended Covid 19 crisis.* Uniformed Services University Center for Deployment Psychology. Retrieved from https://deploymentpsych.org/blog/staff-perspective-moral-distress-residue-and-crescendo-effect-understanding-potential-impact

Turning Moral distress into Moral Resilience http://www.ihi.org/communities/blogs/turning-moral-distress-into-moral-resilience-during-the-covid-19-pandemic

Five clinical examples to look at types of moral distress and ways leadership can help address it https://www.ccjm.org/content/early/2020/06/04/ccjm.87a.ccc047

List of suggestions for how to address Moral distress in hospital setting **https://www.aacn.org/blog/facing-moral-distress-during-the-covid-19-crisis**

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