

## Creating Healthy Work Environments 2019

### Development and Pilot Testing of the New Moral Comfort Questionnaire

**Natalie Bermudez, MSN, RN, PCCN-K**

Ruth M. Tappen, EdD, RN, FAAN

*Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, USA*

#### **Moral Comfort, Moral Distress, and the Healthy Work Environment**

Moral comfort (MC) is defined as a nurse's feeling of ease with decisions and actions related to ethical problems (Corley & Minick, 2002). In contrast, moral distress (MD) is defined as a nurse's feelings of frustration, anger, guilt, and powerlessness when ethical decisions cannot be translated into actions due to institutional constraints (Henrich et al., 2017; Jameton, 1984). MC (positive) and MD (negative) are potential outcomes of ethical situations; both influencing and being influenced by the work environment. Supportive characteristics of MC, such as nursing expertise, administrative support that promotes nursing autonomy and moral agency, and ethical work environments, are often lacking in situations leading to MD (Corley & Minick, 2002). MD negatively impacts and disrupts healthy work environments thereby posing a threat to patients, nurses, and healthcare organizations at large (Burston & Tuckett, 2012). Several studies have shown alarmingly high levels of MD in nurses (de Boer et al., 2016; Dumouchel et al. 2015; Lusignani et al., 2017) potentially leading to accumulation of negative moral residue subsequently resulting in nurse burnout and increases in nursing staff turnover (Savel & Munro, 2015, Hamric, Borshers, & Epstein, 2012), further affecting the work environment and patient safety. However, literature on MC is sparse. A better understanding of MC may lead to evidence for developing strategies to prevent MD and its negative outcomes and negative impact on the work environment.

Violation of specific healthy work environment (HWE) standards as outlined by the American Association of Critical-Care Nurses (AACN; AACN, 2016) (Skilled Communication, Effective Decision-Making, Appropriate Staffing, True Collaboration, and Authentic Leadership) also contributes to MD. For example, lack of Authentic Leadership of nurse administrators and managers may propagate unhealthy work environments by implementing policies and practices that are unsupportive of Appropriate Staffing, True Collaboration, and Effective Decision-Making, potentially leading to MD. Disruption of nurse autonomy and opportunities for collaboration in making nursing care decisions leads to nurse demoralization (AACN, 2016). Inappropriate Staffing contributes to job dissatisfaction and burnout, increases in nursing staff turnover, and increases in healthcare costs (AACN, 2016). Combined, violation of these HWE standards leads to MD potentially impacting patient safety and resulting in poor patient outcomes.

MD is a longstanding issue in nursing and has been studied both quantitatively (Hamric, Borshers, & Epstein, 2012; Pauly et al., 2009; Wocial & Weaver, 2012) and qualitatively (Deady & McCarthy, 2010; Heinrich et al., 2017; Varcoe et al., 2012). However, literature is sparse on the concept of MC, an alternative positive outcome of ethical situations. MC was introduced by Corley and Minick (2002), however without further examination or elaboration. While moral resilience, an emerging concept, is currently being explored in response to dealing with the aftermath of MD (Rushton, 2016), literature on preventing and decreasing the incidence of morally distressing situations is sparse. While Rushton (2016) asserts that MD is unavoidable, efforts to *decrease* the incidence of MD must be explored. Investigation of MC may offer insight that will assist with developing interventions to mitigate the incidence of MD and its associated negative consequences. The work environment impacts MC, therefore examining MC and factors that promote it will also highlight the importance of cultivating HWE's thus preventing or diminishing the occurrence of MD, positively impacting patient safety and outcomes.

A literature search for instruments to measure MC yielded no results. However, several instruments for measuring MD were found. While these instruments are useful for measuring MD, this indicates that MD has transpired, thus risking the associated negative repercussions. Therefore, development of an instrument for measuring MC in nurses would be beneficial for use in future research projects designed to

investigate prevention of MD, thereby promoting and sustaining HWE's throughout healthcare organizations and ultimately promoting safe nursing care and positive patient outcomes. The purpose of this pilot study was the development and pilot testing of a new instrument, the Moral Comfort Questionnaire.

### **Development of the Moral Comfort Questionnaire**

The Moral Comfort Questionnaire (MCQ) is a theoretically derived 28-item self-report instrument intended to measure the construct of MC in nurses. The framework used to develop the instrument was Tappen's (2016) concept tree model. Items were developed using a ladder of abstraction to move concepts from abstract to concrete. The overall purpose of the MCQ is to measure nurses' MC and to identify factors impacting MC (both negatively and positively). The item statements are rated using a 4-point Likert-type scale (1 = Strongly Disagree, 4 = Strongly Agree). Higher overall score averages indicate higher levels of MC, and inversely, lower overall score averages indicate lower levels of MC; range is 4 to 112.

### **Pilot Study Methods and Results**

A pilot study for initial psychometric testing of the MCQ is currently in progress. The pilot study was approved by Florida Atlantic University's and the hospital system's institutional review boards. A PhD Student Research Grant from the Versant Center for the Advancement of Nursing funded this pilot study. Prior to recruiting participants, three content experts in the field of MD evaluated the original 29-item MCQ to establish content validity. The experts were asked to rate the relevance of each item (1=Not Relevant, 2=Somewhat Relevant, 3=Quite Relevant, 4=Very Relevant), with a combined content validity index of 84% agreement between the experts (goal was 75%). The content experts were also provided specific comments for each item, as well as general comments. As a result, 12 items were reworded for clarity and one item unanimously rated as irrelevant was removed. The revised 28-item MCQ was sent to the content experts for a second evaluation. No changes were made to the instrument thereafter.

Acute care staff nurses, providing direct patient care at least 50% of the time, employed within a not-for-profit South Florida community hospital and a South Florida hospital system with both Magnet-designated and non-Magnet-designated hospitals were recruited to complete the MCQ and revised Moral Distress Scale - Revised (MDS-R); target sample size is 150 participants (104 nurses have participated in the study with 94 valid completions). Agency nurses, primary charge nurses, and nurses in managerial or administrative roles were excluded from the study. Recruitment methods included using posters, announcing at staff meetings, electronic mail, and personal invitation. Participants' characteristics were as follows: age ranged from 22 to 62 years ( $M = 36.6$ ,  $SD = 12.148$ ); years of experience ranged from less than one year to 41 years ( $M = 8.6$ ,  $SD = 9.431$ ); 89.6% were females and 10.6% were males; highest nursing education, 36% associate degrees, 56% bachelor degrees, and 9% master degrees. Participants were given the option to complete paper surveys ( $n = 10$ ) or an on-line version of the surveys using Survey Monkey ( $n = 94$ ). Upon completion, each participant received a \$15 Amazon gift card as compensation for time spent completing the surveys (approximately 20 minutes); one hospital system did not allow its nurse participants to receive compensation. Nurses from the original sample were recruited to take the MCQ a second time within at least two weeks of the first time (for test-retest reliability testing). Thirty-two nurses responded; each received an additional \$15 Amazon gift card as compensation for their time; nurses from the hospital system where compensation was restricted were not recruited to participate in the secondary survey. Data were collected from August 2017 through June 2018.

Data were analyzed using version 24 of the Statistical Package for Social Sciences (SPSS) program. Results to suggest the MCQ's internal consistency show a Cronbach's alpha value of .825 (target  $\geq .70$ ). Pearson's correlation coefficient showed a strong positive correlation between Time 1 and Time 2 ( $r = .769$ ,  $p < .001$ ). Discriminant validity between the MCQ and MDS-R was evaluated by calculating Pearson's correlation coefficients; results showed a weak negative relationship between the MCQ and MDS-R frequency ( $r = -.193$ ,  $p = .055$ ) and no relationship between the MCQ and MDS-R intensity ( $r = .085$ ,  $p = .402$ ).

## Discussion

These results support further psychometric testing of the MCQ. Future data analyses include exploratory factor analysis (EFA). After EFA has been conducted, future plans for psychometric evaluation includes reliability and validity testing, including confirmatory factor analysis (CFA), in a larger sample of 300. CFA will include development and testing of a theoretical mapping of factors derived from the EFA. Recruitment plan includes collaborating with nursing organizations, such as American Nurses Association, Florida Nurses Association, Sigma Theta Tau International, and American Association of Critical Care Nurses, to send electronic mail recruitment letters to its members and post recruitment information on their website bulletin boards.

## Conclusion

MD is a serious issue that negatively impacts nurses and the work environment, potentially jeopardizing patient safety. Gaining further understanding of MC may provide knowledge for preventing or decreasing MD. At present, there is no measure for MC therefore a new one has been developed. Establishing reliability and validity of the new Moral Comfort Questionnaire will provide a measure for use in future research studies designed to further our understanding of MC in nurses and investigate strategies to prevent MD.

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### Title:

Development and Pilot Testing of the New Moral Comfort Questionnaire

### Keywords:

instrument development/testing, moral distress/moral comfort and patient safety

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### **Abstract Summary:**

The purpose of this presentation is to share the development and pilot psychometric evaluation results of a new instrument that measures moral comfort in nurses. This measure is intended for use in future research studies designed to explore strategies to prevent or diminish the occurrence and/or intensity of moral distress.

### **Content Outline:**

1. Introduction
  1. Moral Comfort, Moral Distress, and the Healthy Work Environment
    1. Definitions of moral comfort and moral distress
    2. Moral distress' impact on AACN's Healthy Work Environment Standards
    3. Moral distress is a longstanding issue in nursing; moral comfort as an alternative outcome of ethical situations
    4. Literature shows several measures of moral distress; none to measure moral comfort
2. Development of the Moral Comfort Questionnaire (MCQ)
  1. Tappen's (2016) Concept Tree Model for instrument development
  2. Brief description of the Moral Comfort Questionnaire
3. Pilot Study Methods and Results
  1. Description of sample, setting, recruitment, and data collection
  2. Reliability testing results:
    1. Test-retest method
    2. Cronbach's alpha level (internal consistency/homogeneity)

3. Validity testing results
  1. Content validity
  2. Divergent validity
4. Discussion
  1. Future analyses:
    1. Exploratory factor analysis
    2. Confirmatory factor analysis (larger sample size)
5. Conclusion
  1. Implications for future research on moral comfort and moral distress

First Primary Presenting Author

**Primary Presenting Author**

Natalie Bermudez, MSN, RN, PCCN-K  
Florida Atlantic University  
Christine E. Lynn College of Nursing  
PhD Candidate  
Boca Raton FL  
USA

**Professional Experience:** I have been a nurse for 18+ years with 12 years of experience as a hospital-based clinical nurse educator. I have also served as a primary presenter for concurrent sessions at AACN's National Teaching Institute annual conference in 2014, 2015, and 2016. I have also been involved with planning conferences, locally and nationally.

**Author Summary:** Natalie Bermudez has been a registered nurse for 18 years and serves as the Lead Clinical Educator in a South Florida community hospital. She currently holds a master's degree in nursing. She is currently a PhD candidate and her research area of interest is transforming the health care environment; her dissertation work is focused on addressing moral distress in nurses and is currently working on validation of an instrument to measure moral comfort in nurses.

Second Author

Ruth M. Tappen, EdD, RN, FAAN  
Florida Atlantic University  
Christine E. Lynn College of Nursing  
Professor/Eminent Scholar  
Boca Raton FL  
USA

**Professional Experience:** Dr. Ruth M. Tappen is the Christine E. Lynn Eminent Scholar at the College of Nursing, Florida Atlantic University in Boca Raton, Florida. She is the author of an award-winning text on nursing research, *Advanced Nursing Research: From Theory to Practice* and co-author of a nursing leadership and management text now in its 6th edition.

**Author Summary:** Dr. Tappen is an active researcher, having received federal and private funding from NINR, PCORI, HRSA, CMS, Robert Wood Johnson Foundation, Retirement Research Foundation, and others. She has published over 80 articles, primarily data-based. Her current research focuses on prevention of unnecessary transfers from nursing home to hospital and patient and family participation in these important decisions. She has been a mentor to many doctoral students and junior faculty at the College of Nursing.