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Research Article

Causes of Moral Distress Among Nurses in Intensive Care Unit

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Abstract

Introduction: Moral Distress is a Growing phenomenon among nurses in Intensive care unit. The moral distress is a common Problem among Health Care practioners now a day. The word moral distress shows the changes in behavior among the ICU staff Nurses. There are so many reasons of moral distress among ICU Staff the main problems that affect the moral is moral distress, Powerlessness and frustration. ***Aim***: Study objective is to access the effect of powerlessness and frustration among Nurses in intensive care unit. ***Methodology***: Data for the study were obtained from the target Hospitals through Questionnaire. This contains demographic variable and 20 item Likert scale. ***Results***: According to output from 158 staff nurses of ICU the most commonly reported emotion associated with moral distress was frustration. We have find the reliability and validity which shows the alpha value of moral distress among nurses is above .846. Majority 92.4% were female and in this study7.6% were male. ***Conclusion***: This study identified several comprehensive surveys aimed at measuring the experience of causes of moral distress covering a variety of content areas and particle issues that causes moral distress. Future strategies should be focus on the problems of ICU nurses to reduce moral distress.

Keywords: Moral distress**;** Staff nurse; frustration

Introduction

The term "moral distress" was begat in 1984 and characterized as a negative ordeal, in which a medical attendant discovers he/she knows the correct move to make, however can't do that correct activity because of institutional obstructions (Jameton, 1984) Failure to alleviate moral distress can impact patient care, lead to job stress and staff turnover, and cause some nurses to leave the profession (Corley, 2002).

There are numerous open doors for basic care clinicians to experience the ill effects of losing patients; however, they can likewise encounter moral misery from the mind boggling choices and differences related with tolerant care. Albeit moral distress isn't restricted to medical caretakers, it is believed to be particularly common in attendants on account of the training progressive system that positions nurture in the center, between medicinal services establishments, patients and families, and doctors, making the open door for moral pressure (Engelhardt, 1985) Others have offered that because of the close proximity of nurses to patients, nurses are more likely to develop moral distress than are members of other health professions (Peter & Liaschenko, 2004). Another elucidation of moral distress moved it past an affair to "… a negative condition of mental disequilibrium" Two forms of moral distress have been distinguished: initial and reactive

Equally present in the literature, were citations of Corley's work that identified situations that can lead to moral distress, potential consequences for the individual nurse, and the negative impact on the profession as a whole (Corley, 2002) the only published literature that did not cite Corley was the six articles that preceded her work. One situation found throughout the literature and described as causing moral distress, involved nurses delivering care that the nurse identified as not in the patient's best interest. This was one possible avenue for the nurse to conclude that he or she knew "the right action to take," however how the nurse reached this conclusion has not been systemically examined. Since "knowing the right action to take" can be a precursor to the experience of moral distress, a better understanding of its construction is needed.

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Powerlessness and Frustration

Nurses should be extra meaningfully worried inside the walking of hospitals. That is the belief of several recent research performed independently, for instance, the record at the have a look at performed by way of the institute of medication of the national academy of sciences notes the need for employers to encourage "more involvement of nurses in selections about affected person care, management, and the governance of the group. Now not brazenly stated inside the suggestions, yet unmistakably implied by means of their tenor, is the stance that nurses for my part and the nursing department together have to be accorded the authority and organizational involvement essential to carry out their expert duties for patient care. as plans are designed for imposing these pointers, it would be useful to recognize nurses' contemporary level of involvement in making choices and formulating coverage on affected person care, body of workers control, and governance of hospitals. In the direction of this popular quit, the motive of this paper is to explain nurses' perceptions of how guidelines and procedures are formulated as well as their perspectives at the involvement of staff nurses personally and the nursing branch together inside the process. The function of nurses and nursing in policy formation has implications for the power or powerlessness of nurses employed in hospitals.

The idea of powerlessness alludes to a lacking quality or power rendering one vulnerable and absolutely incapable (The American Heritage Dictionary of the English Language, 2009). Sentiments of frailty have been accounted for to influence attendants' apparent capacity to give quality care that guarantees persistent security and has added to moral situations and burnout among medical caretaker's report that medical caretakers lacking fearlessness get self-uncertainty and sentiments of shortcoming and feebleness. The topics introduced inside express characteristics of the debilitation of members prompting sentiments of deficiency, anxiety, defencelessness and disappointment. It must be noticed that the outflow of positive feelings isn't to be required because of the horrendous idea of consumes nursing both physically and psychosocially. Be that as it may, devotion to consumes nursing and its prizes were investigated as with building versatility to adapt to the horrendous encounters of consume patients (Anne Kornhaber and Wilson , 2011).

Nurses regularly felt defenceless to assuage sufferers battling following in medical caretakers feeling discouraged, disappointed and irate. States that gathering of specialists frequently feel remorseful for causing hurt at some phase in debridement and dressing changes (Goodstein, 1985). Nurses in our look at habitually ended up apologizing persistently to the influenced individual for perpetrating throb amid dressing changes which left them feeling deficient and disappointed (David *et al*., 1981). This is consistent discoveries who additionally established that ICU attendants' response to hurt punishment swung into to expressions of remorse bountifully to the sufferers, which added to sentiments of weakness (Dahlqvist *et al.*, 2009). Observe discovered that social insurance specialists shared feelings of blame and weakness by persevering through one's insufficiency while not having the capacity to encourage patients.

Members of watch expected to persevere through patient's sentiments of despairing and futility (Dahlqvist *et al.*, 2009). In addition, that the over the top mortality charges of ICU sufferers is identified with sentiments of vulnerability and disappointment (Tringali, 1982). The ICU nurses displayed a heightened experience of personal vulnerability associated with non-stop publicity to severe ICU (Nagy, 1998). As in our investigation, patients' reaction to ICU injury extended medical attendants' apprehensions bringing about inclination helpless themselves. It is Stated that the results of an ICU calamity on an ICU secured vulnerability, seethe, this is consistent with our investigation's members' response to a consume catastrophe wherein benefactors felt sorrow for the sufferers and transformed into connected to an absence of process fulfilment (Powers *et al.*, 1986). Be that as it may, surveys a particular point, dissecting crisis nurses who have been included with the fear assaults on eleventh of September in ny. Nurses' meeting passed on an inspiring record of their reports settled in with zest, duty and inspiration.

This features how ICU Nurses and Nurses in across the board are steadily revealed to the helplessness of life (Frank, 2001). Nurses always revealed to injury are likely to appreciate dread of biting the dust, behind calendar set up-unpleasant strain reaction, burnout and maladaptive methods for dealing with stress (Davidson and Jackson, 1985). Truly, advised that it's miles the vulnerable people that will probably be pulled in into nursing as an endeavor to overcome their feelings of trepidation. In any case, those feelings of dread are exacerbated and achieve a progression of maladaptive adapting reactions to customary injury (Davidson and Jackson, 1985).

Cases that nurse need to simply acknowledge that weakness and reliance as a, urgent, human quality and in doing as such nurses are then fit for wind up mindful of with patients' necessities and feelings (Hem and Heggen, 2003). People often felt terrified about patients being released from the care of the outrageous ICU harm unit. Concerns have been raised by the people around how the patient, for the most part the ones fundamentally distorted, could adapt without the help of the ICU group. Be that as it may, there is little writing to be needed to help this claim. Indeed, even it demonstrates that a possible wellspring of strain for ICU nurses is the release of distorted sufferer's lower once again into the network.

Members in our investigation did now not give off an impression of being disappeared with distortion or disfigurements since it has turned into a suitable standard on the ward (Tringali, 1982). Another cases that ICU nurses for the most part have a tendency to respond to distortion and deformations as despite the fact that there is nothing amiss with the influenced individual (Hinsch, 1982). Notwithstanding, that is complicated in itself for it doesn't assemble the influenced individual for a large portion of the general population's reaction after release. Exhorted that nurse who work with sufferers, who are deformed, do never again sense enabled to manage the psychosocial issues of restoration (Clarke & Cooper, 2001) .

Found that disturbing weight turn into a detail of common work life. Nurses who have consider experienced absence of time for individual reflection, announcing this routinely felt like a weight and that they talented troubles disengaging from artworks over the span of times of happiness. People in our view have been found to delight in a high phase of disappointment regarding the matter of sufferers' advancement (Olofsson *et al*., 2003). The strengthening of Nurses to the every now and again requesting nature of consume damage is basic to the scholarly wellbeing and prosperity of such nurses. Feelings of frailty inside the situation as a nurses have wind up commonplace as a word related standard along these lines attendants can support engaging connections by means of communitarian session a couple of the ICU gather tending to issues alluding to throb and consume mind (Kilcoyne, M., & Dowling, M, 2008)

Emotional intelligence gives an educational way of pondering, upgrading individual and master change through protracted presence becoming acquainted with stories (Akerjordet & Severinsson, 2008). In truth, Humpel & Caputip (2001) revealed a major seeking between passionate competency and long stretches of nursing background in which it winds up found that nurses with appreciate of 6 years and more prominent, were seen to have a more elevated amount of enthusiastic competency contrasted with attendants with under 2 long periods of nursing tutoring who talented fundamentally better phases of self-question. Enthusiastic knowledge may give nurture the ability to enable themselves in the event that you need to decorate their master change and administration aptitudes. Joining of passionate insight into nursing educational program for every undergrad and postgraduate may help with the development of a collection of specialists that is very much adjusted (Por *et al*., 2011)

Literature Review

Moral distress is caused by circumstances in which the morally proper game-plan is known yet can't be taken. Moral misery is believed to be a major issue among medical caretakers, especially the individuals who hone in basic care. Over the span of the most recent decade, there has been expanded enthusiasm for getting a handle on social insurance experts' encounters of pressure related with moral issues (Austin *et al*., 2005). Nursing staff have been the most prominent focal point of this examination. Good and great issues are a characteristic piece of nursing practice (Austin *et al*., 2005). Answering patients' call for mind, while endeavoring to lighten enduring and upgrading prosperity mirrors the center of medical attendants' expert duty, characterized as expert profound quality. Moral issues rise in hazy areas and are regularly obscured, and henceforth are not given adequate consideration (Davis *et al.*, 2006).

Past research in the human administrations setting has provoked a couple of conceptualizations of stress reactions related to moral issues in nursing practice. The term 'moral wretchedness' to outline such outcomes and describes it as takes after: 'Moral inconvenience rises when one knows the best possible action, however institutional goals make it relatively hard to look for after the right technique. This term has been used and furthermore refined in a couple of examinations. Contended that care providers experience strain when they are in human administrations conditions with contradicting moral solicitations and when they trust that they grasp what should be done, however are kept from acting as per this comprehension (Corley, 2002).

As necessities be, moral torment is portrayed as a negative state of mental disequilibrium, experienced on settling on a moral decision, however fail to execute it in view of honest to goodness or saw institutional prerequisites. In a near vein, suggested that experiences of good wretchedness rise when therapeutic administrations work constrain encounter conditions posing conflicting solicitations, their undertakings at acting are hampered or they see their exercises as wrong or lacking Construed 'moral stress' as: (1) moral affectability to patients' weakness; (2) experience of outside balancing activity of performing moral exercises; and (3) having no impact over a situation (Lützén *et al.*, 2003). Proposed a more extensive meaning of good distress, incorporating negative pressure indications developing in circumstances including moral situations, when the human services supplier feels unequipped for securing all needs and qualities in question. (Sporrong *et al.*, 2006). instituted the term 'worry of still, small voice', characterized as 'a result of the recurrence of the distressing circumstance and of the apparent level of beset still, small voice' with an end goal to disclose responses to morally troublesome circumstances faced by attendants. (Glasberg *et al*., 2006).

Problem Statement

Moral distress is a moral problem for clinical staff, especially among medical attendants and has prompt burnout, turnover, and surrender of the nursing calling. No less than one out of 10 have left a situation because of good trouble. Moral distress impacts maintenance of medical

caretakers and in this manner adds to the nursing deficiency. Various investigations have archived the recurrence and force of good trouble and attendants of patients also annoyed and often complaint.

In any case, the majority of these have been directed inside one social insurance association. This is dangerous in relating these investigation discoveries to all restorative surgical attendants.

Significance of the Study

This study of Moral distress in restorative surgical nurses is vital in light of the fact that verifiably, claims to fame serious care units (ICUs) have been the zone of core interest. Another critical explanation behind this examination is that few randomized investigations of good misery have been led. Studies have demonstrated that the moral atmosphere of an association impacts the levels of good trouble.

Study discoveries of moral distress give pioneers and heads data about how to create projects to help their staff in circumstances of good trouble and moral situations. Other expert associations may take action accordingly relying upon the discoveries of this investigation. "Nurses have numerous moral commitments, some of the time contending, an essential commitment

Research Methodology

Research Design

A descriptive cross sectional research design will be utilized for this examination to survey the Problems, Powerlessness and Frustration of Nurses who are working in ICU.

Study Area

Setting of the study will be the Hospitals of Lahore.

Target Population

We selected the area of Lahore for the study because shortage of time. The target population of our study is Nurses of ICU, the participants will be belonging to different Hospitals and different demographical background, and the participants will be male and female.

Sample Size and Sampling Techniques

Convenient sampling will be chosen as sampling method. The total estimated Nurse in Lahore of Public and Private Hospitals are 400. The questionnaire will be use for the research to collect the data. The questionnaire will be distributed among reasonable Nurses. To collect the most appropriate data and the participants will be selected through simple random sampling method; the sample size for this study will be 158 which is calculated from the **Slovins formula of sampling** which is mentioned here.

If Total number of nurses 260

If N = Population, n=Sample size, E= Margin of error

$n=N/\{1+ (N) (E)^2\}$

$n=260/1+ (260) (0.05)^2$

$n=260/1+ (260) (0.0025)$

$n=260/1.65=157.57$

Round answer = ***158***

Research Tool / Instruments

A self-administered and modified version questionnaire was adopted from the article "MORAL DISTRESS IN EMERGENCY NURSES by Fernandez-Parsons *et al*. (2013) will be used to collect data from the participants. Questionnaire is consist of two Parts, 1st part composed of demographic data which include Institute name Age, Gender, department, Qualifications and Experiences information about the participant. 2nd part composed of the questions regarding the assessment of the following circumstances occurs in clinical practice. If you have experienced these circumstances they could conceivably have been morally distressing to you. How frequently the experience of each item described and how disturbing the experience is for you. If you have never experienced a particular situation, select "0" (never) for frequency. Even if you have not experienced a situation, please indicate how disturbed you would be if it occurred in your practic. Note that you will react to everything by checking the suitable section for two dimensions: Frequency and Level of Disturbance (Fernandez-Parsons *et al*., 2013). A pilot study of the questionnaire will be done before floating the questionnaire in the participants.

Data Collection Plan

Data collection plan is one of the fundamental sources to gather information. A self-regulated questionnaire will be utilized to gather information from the study participants. There will be given a free hand to finish it and return it.

Data Analysis

Data analysis will be done by SPSS form 20. Statistical computer program used for data analysis. This is a spellbinding report and all the clear measurements will be acquired through the SPSS programming.

Including Criteria

- Nurses of the ICU of Services Hospital Lahore, Nurses of the ICU of Punjab institute of Cardiology Lahore, Nurses of the ICU of Mid-City Hospital Lahore and Nurses of the ICU of Omer Hospital Lahore including male and females
- Willing to participate
- Those who understands the Questioner

Excluding Criteria

- Nurses who have past experience of ICU
- Nurses who are the outside from my Target Hospitals of Lahore

Time Framework

This study will approximately take 2 months. Distribution of time period is given below.

- 2 weeks- selection of topic and literature review.
- 2 week- Designing the research, Proposal and questionnaire writing
- 3 weeks- Data collection and analysis
- 1 week- Report Writing

Informed Consent

Assents will be taken from every one of the participants and free hand will be given to the participants to partake in the study or declined to take an interest, participants will have additionally be the privilege to specified name or not.

Ethical Consideration

Enough information of research will be furnished to participant with help of full assent and this will be accomplished by means of an agree frame join to the survey. Classification will be considered by educating participants. The privilege of participants will be secured by Nuremberg Code of Ethics

Results

This study is conducted at Services Hospital Lahore, Fatima Memorial hospital Lahore, Punjab Institute of Cardiology Lahore, Mid-city Hospital Lahore, to access the moral distress among Nurses in ICU. The results of this study is distributed into three sections first section is statistics of demographic factors, and second is powerlessness and third is Frustration, Questionnaire contained 20 items.

Data Analysis

Analysis of Demographic Variable

The Table 1 gives explanation of frequency gender distribution. Out of 100 participants 92.4 were female and 7.6 were male participants.

Table 1: Gender

		Frequency	Percent	Valid present	Cumulative Percent
Valid	Male	12	7.6	7.6	7.6
	Female	146	92.4	92.4	100.0
	Total	158	100.0	100.0	

Table 2: Age group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-25	15	9.5	9.5	9.5
	25-25	97	61.4	61.4	70.9
	35-50	40	25.3	25.3	96.2
	4	6	3.8	3.8	100.0
	Total	158	100.0	100.0	

Table 2 tells about the age group frequency of the participants. The result showed 9.5% were in age between18-25 of age group, 61.4 were belongs to 25-35 year and 25.3% were in between 35-50 year of age group and above are 3.8%.

Table3: **Marital status**

		Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Valid	Married	99	62.7	62.7	62.7
	Single	59	37.3	37.3	100.0
	Total	158	100.0	100.0	

The Table 3 gives information regarding marital status of the respondents, out of which 62.7 were unmarried and 37.3 were unmarried.

Table 4: Qualification

		Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Valid	nursing diploma	81	51.3	51.3	51.3
	BSN post RN	76	48.1	48.1	99.4
	Other	1	.6	.6	100.0
	Total	158	100.0	100.0	

Table 4 explains frequency distribution of qualification, out of 100 participants; there were people with nursing diploma 51.3%, BSN post RN 48.1% and people with other qualification were .6%

Question 1: Provide less than optimal care due to pressures from administrators or insurers to reduce costs.

Table 5 gives explanation about frequency distribution regarding Q-01. The result showed that 7.0% respondents are strongly disagree,18.4% are disagree,29.7% are neutral, 23.4% are agree, and 21.5% were strongly agree in out of 100 respondents.

Question 2: Follow the family's wishes to continue life support even though I believe it is not in the best interest of

Result of Table 6 shows that 3.8% are strongly disagree, 117.7% are disagree, 31.0% neutral, 21.5% are agree and 25.9% are strongly agree in out of 100 respondents.

Question 3: Witness healthcare providers giving "false hope" to a patient or family

Table 7 give explanation about frequency distribution regarding Q. 3. The result showed that 17.1% respondents are strongly disagree,32.3% are disagree,23.4% are neutral, 19.0% are agree, and 8.2% are strongly agree in out of 100 respondents.

Question 4: Follow the family's request not to discuss death with a dying patient who asks about dying

Table 8 gives explanation about frequency distribution regarding Q#04. The result showed that 5.7% respondents are strongly disagree, 18.5% are disagree,24.8% are neutral, 39.5% are agree, and 11.5% are strongly agree in out of 100 respondents.

Table 5: Provide less than optimal care due to pressures from administrators or insurers to reduce costs.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	11	7.0	7.0	7.0
	disagree	29	18.4	18.4	25.3
	neutral	47	29.7	29.7	55.1
	agree	37	23.4	23.4	78.5
	strongly agree	34	21.5	21.5	100.0
	Total	158	100.0	100.0	

Table 6: Follow the family's wishes to continue life support even though I believe it is not in the best interest of

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagre	6	3.8	3.8	3.8
	Disagree	28	17.7	17.7	21.5
	Neutral	49	31.0	31.0	52.5
	Agree	34	21.5	21.5	74.1
	strongly agree	41	25.9	25.9	100.0
	Total	158	100.0	100.0	

Table 7: Witness healthcare providers giving "false hope" to a patient or family.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	27	17.1	17.1	17.1
	disagree	51	32.3	32.3	49.4
	neutral	37	23.4	23.4	72.8
	agree	30	19.0	19.0	91.8
	strongly agree	13	8.2	8.2	100.0
	Total	158	100.0	100.0	

Table 8: Follow the family's request not to discuss death with a dying patient who asks about dying

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	9	5.7	5.7	5.7
	disagree	29	18.4	18.5	24.2
	neutral	39	24.7	24.8	49.0
	Agree	62	39.2	39.5	88.5
	strongly agree	18	11.4	11.5	100.0
	Total	157	99.4	100.0	
Missing	System	1	.6		
Total		158	100.0		

Question 5: Carry out the physician's orders for what I consider to be unnecessary tests and treatments.

Table 9 gives explanation about frequency distribution regarding Q. 5. The result showed that 3.8% respondents are strongly disagree,15.8% are disagree,36.7% are neutral, 33.5% are agree, and 10.1% are strongly agree in out of 100 respondents.

Question 6: Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support

Table 10 gives explanation about frequency distribution regarding Q. 6. The result showed that 3.8% respondents are strongly disagree,10.8% are disagree,25.3% are neutral, 41.1% are agree, and 19% are strongly agree in out of 100 respondents.

Question 7: Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.

Table 11 gives explanation about frequency distribution regarding Q. 7. The result showed that 11.4% respondents are strongly disagree,19.6% are disagree,25.9% are neutral, 28.5% are agree, and 14.6% are strongly agree in out of 100 respondents.

Question 8: Assist a physician who, in my opinion, is providing incompetent care.

Table 12 gives explanation about frequency distribution regarding Q. 8. The result showed that 3.2% respondents are strongly disagree,13.9% are disagree,31.6% are neutral, 38% are agree, and 13.3% are strongly agree from out of 100 respondents.

Table 9: Carry out the physician's orders for what I consider to be unnecessary tests and treatments

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	6	3.8	3.8	3.8
	disagree	25	15.8	15.8	19.6
	Neutral	58	36.7	36.7	56.3
	Agree	53	33.5	33.5	89.9
	strongly agree	16	10.1	10.1	100.0
	Total	158	100.0	100.0	

Table 10: Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	6	3.8	3.8	3.8
	Disagree	17	10.8	10.8	14.6
	Neutral	40	25.3	25.3	39.9
	Agree	65	41.1	41.1	81.0
	strongly agree	30	19.0	19.0	100.0
	Total	158	100.0	100.0	

Table 11: Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	18	11.4	11.4	11.4
	disagree	31	19.6	19.6	31.0
	neutral	41	25.9	25.9	57.0
	Agree	45	28.5	28.5	85.4
	strongly agree	23	14.6	14.6	100.0
	Total	158	100.0	100.0	

Table 12: Assist a physician who, in my opinion, is providing incompetent care.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	5	3.2	3.2	3.2
	Disagree	22	13.9	13.9	17.1
	Neutral	50	31.6	31.6	48.7
	Agree	60	38.0	38.0	86.7
	strongly agree	21	13.3	13.3	100.0
	Total	158	100.0	100.0	

Question 9: Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.

Table 13 gives explanation about frequency distribution regarding Q#09. The result showed that 7.6% respondents are strongly disagree, 6.3% are disagree,26.6% are neutral, 32.9% are agree, and 26.6% are strongly agree from out of 100 respondents.

Question 10: Initiate extensive life-saving actions when I think they only prolong death.

Result of question 10 showed that 8.9% are strongly disagree, 13.9% are disagree, 38% neutral,24.1% are agree and 15.2% are strongly agree from out of 100 respondents (Table 14).

Question 11: Be required to care for patients I don't feel qualified to care for.

Result of Question 11showed that 5.1% are strongly disagree, 17.1% are disagree, 45.6% neutral, 24.1% are agree and 8.2% are strongly agree from out of 100 respondents (Table 15).

Question 12: Witness medical students perform painful procedures on patients solely to increase their skill

Result of question 12 showed that 7.6% are strongly disagree, 16.5% are disagree, 34.2% neutral,27.8% are agree and 13.9% are strongly agree in out of 100 respondents (Table 16).

Table 13: Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	12	7.6	7.6	7.6
	Disagree	10	6.3	6.3	13.9
	Neutral	42	26.6	26.6	40.5
	Agree	52	32.9	32.9	73.4
	strongly agree	42	26.6	26.6	100.0
	Total	158	100.0	100.0	

Table 14: Initiate extensive life-saving actions when I think they only prolong death.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	14	8.9	8.9	8.9
	disagree	22	13.9	13.9	22.8
	neutral	60	38.0	38.0	60.8
	agree	38	24.1	24.1	84.8
	strongly agree	24	15.2	15.2	100.0
	Total	158	100.0	100.0	

Table 15: Be required to care for patients I don't feel qualified to care for.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	8	5.1	5.1	5.1
	disagree	27	17.1	17.1	22.2
	neutral	72	45.6	45.6	67.7
	agree	38	24.1	24.1	91.8
	strongly agree	13	8.2	8.2	100.0
	Total	158	100.0	100.0	

Table 16: Witness medical students perform painful procedures on patients solely to increase their skill

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	12	7.6	7.6	7.6
	disagree	26	16.5	16.5	24.1
	neutral	54	34.2	34.2	58.2
	agree	44	27.8	27.8	86.1
	strongly agree	22	13.9	13.9	100.0
	Total	158	100.0	100.0	

Question 13: Follow the physician's request not to discuss the patient's prognosis with the patient or family.
Result of question 13 showed that 5.7% are strongly disagree, 17.1% are disagree, 27.2% neutral, 39.2% are agree and 10.8% are strongly agree from out of 100 respondents (Table 17).

Question 14: Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.
Result of question 14 showed that 9.5% are strongly disagree, 16.5% are disagree, 20.3% neutral, 34.8% are agree and 19.0% are strongly agree out of 100 respondents (Table 18).

Question 15: Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.
Result of Table 19 shows that 8.2% are strongly disagree, 23.4% are disagree, 31.6% are neutral, 25.9% are agree and 10.8% are strongly agree out of 100 respondents.

Question 16: Work with nurses or other healthcare providers who are not as competent as the patient care requires
Result of Question 16 shows that 7.6% are strongly disagree, 15.8% are disagree, 27.2% are neutral, 34.2% are agree and 15.2% are strongly agree out of 100 respondents (Table 20).

Table 17: Follow the physician's request not to discuss the patient's prognosis with the patient or family.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	9	5.7	5.7	5.7
	disagree	27	17.1	17.1	22.8
	Neutral	43	27.2	27.2	50.0
	Agree	62	39.2	39.2	89.2
	strongly agree	17	10.8	10.8	100.0
	Total	158	100.0	100.0	

Table18: Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	15	9.5	9.5	9.5
	Disagree	26	16.5	16.5	25.9
	Neutral	32	20.3	20.3	46.2
	Agree	55	34.8	34.8	81.0
	strongly agree	30	19.0	19.0	100.0
	Total	158	100.0	100.0	

Table 19: Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	13	8.2	8.2	8.2
	Disagree	37	23.4	23.4	31.6
	Neutral	50	31.6	31.6	63.3
	Agree	41	25.9	25.9	89.2
	strongly agree	17	10.8	10.8	100.0
	Total	158	100.0	100.0	

Table 20: Work with nurses or other healthcare providers who are not as competent as the patient care requires

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	12	7.6	7.6	7.6
	Disagree	25	15.8	15.8	23.4
	Neutral	43	27.2	27.2	50.6
	Agree	54	34.2	34.2	84.8
	strongly agree	24	15.2	15.2	100.0
	Total	158	100.0	100.0	

Question 17: Witness diminished patient care quality due to poor team communication

Result of Question 17 shows that 7.6% are strongly disagree, 19% are disagree, 25.9% are neutral, 31% are agree and 16.5% are strongly agree out of 100 respondents (Table 21).

Question 18: Ignore situations in which patients have not been given adequate information to insure informed consent.

Table 22 shows that 12% are strongly disagree, 22.8% are disagree, 27.2% are neutral,27.2% are agree and 10.8% are strongly agree out of 100 respondents

Question 19: Watch patient care suffer because of a lack of provider continuity.

Table 23 shows that 7% are strongly disagree, 13.3% are disagree, 28.5% are neutral, 31% are agree and 20.3% are strongly agree out of 100 respondent

Question 20: Work with levels of nurse or other care provider staffing that I consider unsafe.

Table 24 shows that 12.7% are strongly disagree, 19.0% are disagree, 22.2% are neutral, 25.3% are agree and 20.9% are strongly agree out of 100 respondents.

Table 21: Witness diminished patient care quality due to poor team communication

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	12	7.6	7.6	7.6
	Disagree	30	19.0	19.0	26.6
	Neutral	41	25.9	25.9	52.5
	Agree	49	31.0	31.0	83.5
	strongly agree	26	16.5	16.5	100.0
	Total	158	100.0	100.0	

Table 22: Ignore situations in which patients have not been given adequate information to insure informed consent.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	19	12.0	12.0	12.0
	disagree	36	22.8	22.8	34.8
	neutral	43	27.2	27.2	62.0
	Agree	43	27.2	27.2	89.2
	strongly agree	17	10.8	10.8	100.0
	Total	158	100.0	100.0	

Table 23: Watch patient care suffer because of a lack of provider continuity.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	11	7.0	7.0	7.0
	disagree	21	13.3	13.3	20.3
	neutral	45	28.5	28.5	48.7
	Agree	49	31.0	31.0	79.7
	strongly agree	32	20.3	20.3	100.0
	Total	158	100.0	100.0	

Table 24: Work with levels of nurse or other care provider staffing that I consider unsafe.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	20	12.7	12.7	12.7
	Disagree	30	19.0	19.0	31.6
	Neutral	35	22.2	22.2	53.8
	Agree	40	25.3	25.3	79.1
	strongly agree	33	20.9	20.9	100.0
	Total	158	100.0	100.0	

Reliability Assessment

Present Cronbach's Alpha for fifteen scale use in research. Cronbach's Alpha is the normally used in measures of scale reliability (Cortina, 1993). Cronbach's Alpha above .70 is consider to be as acceptable indicator of the internal consistency reliability.

Table 24: Reliability Statistics

Cronbach's Alpha	No of Items
.846	20

Table 24 is showing the Alpha value in moral distress among nurses is above .846 and it is acceptable. It means the internal reliability of the scale is accurate.

Validity

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.686
Bartlett's Test of Sphericity	Approx. Chi-Square	335.714
	Df	36
	Sig.	.000

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.757
Bartlett's Test of Sphericity	Approx. Chi-Square	451.149
	Df	55
	Sig.	.000

The value of KMO is must be above .60 and Barlet table must be significant. Above table are showing the value of KMO that is .686 and .757. Barlet test is significant so this study is fulfill the criteria of KMO test and Barlet test.

Limitations

This study found many limitations.

- Time duration was too short.
- The study design is convenient sample technique.
- Likert scale questionnaire has been used in this study.
- Data collection was found lot of issues.

Discussion

The study was conducted to explore the effect of powerlessness and frustration on Moral distress among nurses in ICU; the study explores that how team climate, powerlessness and frustration influence employee performance. Data was collected from medical staff or Nurses' working in Intensive Care unit.260 Questionnaire was distributed among ICU staff. Total number of respondents was 260 From Services Hospital Lahore, Punjab Institute of cardiology Lahore, Fatima Memorial Hospital Lahore and Mid-City Hospital Lahore, was contributed in Research. The purpose of the study was to analyze the factors affecting the performance of nurses in ICU. In particular, this study applies has a relationship between the moral atmosphere of the association and level of good trouble. We did this study because we consider that moral distress was an important problem for nurses practicing in ICU and how powerlessness and frustration affect the situation is a potential source of confusion conflict and distress among care giver patient and patient family that is also a main source of moral distress. The impact of powerlessness and frustration experiences of moral distress on attitude about advance directives was not expected. In addition to description of specific patients and circumstances associated with great moral distress as well feelings of powerlessness hopelessness and lack of support emerged. It is extremely difficult to be in a situation you know is hopeless but all available measure are being implemented to prolong a patient's life and you are powerless to do otherwise no one really helps nurses. Events that involve workload uncooperative patients, criticism, negligent coworkers, lack of support from supervisors, and difficulties with physicians are also associated feelings of powerlessness and causes frustration which further leads to frustration and automatically behavior changes shown.

Conclusion

After the analysis of this study the factors affecting the moral distress among ICU Nurses highly effect on the performance of Nurses, powerlessness and frustration plays important role to influence the performance.

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