

Getting Through the Shift
Navigating Moral Distress in Acute Care Nursing

by
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Bachelor of Arts (Honours), Trent University, 1999
Bachelor of Science, Nursing, Ryerson University, 2005

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Supervisory Committee

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Abstract

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With the corporatization of healthcare, combined with rapid advances in medical technology, frontline health care workers, especially nurses, are facing an increase in daily ethical dilemmas, with potential increases in moral distress. The contributing factors and negative effects of moral distress are well researched, in particular as they impact nurses in specialty areas. However, understanding how nurses navigate moral distress, specifically in general medical and surgical units, is not as well understood. The purpose of this study was to understand and articulate the processes that nurses carry out when navigating moral distress, by exploring their interactions with the health care environment. Using grounded theory methodology, a substantive theory was developed to explain the process. The participants in this study were all registered nurses from an acute care academic hospital, who worked on non-specialty medical and/or surgical units. Data collection consisted of audio-recorded face-to-face interviews that were transcribed post interview. All the events and situations that resulted in the experience of moral distress were primarily rooted in organizational structures, which often blindsided the nurses in this study, and led to a sense of feeling ill-equipped and unsupported to respond in the moment. Furthermore, the participants expressed their inability to be agents of change due to the established organizational expectations. The basic social process for navigating moral distress was “*Just getting through the shift*”. This theory is comprised of the

categories of Experiencing Moral Distress, Making Sense of the Situation, and Finding the Way. In working through these processes, the participants engaged in navigating moral distress. Making sense of the situation was an ongoing process that nurses engaged in whereby they sought out knowledge in various ways, such as exploring internal resources, and building relationships with their peers, their patients, and patients' families. Throughout this iterative process of making sense of the situation, the nurses were then able to find their way. Participants discussed positive outcomes such as reflecting and learning from the experience. However, despite this response, there was a feeling of powerlessness to make a difference. Therefore, they focused on providing the best care they could and getting on with their shift without experiencing closure.

Keywords: moral distress, acute care nurses, grounded theory

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Dedication

This thesis is dedicated to my family, and my closest friends.
This work would not have been possible with your unwavering encouragement, support, the occasional proof reading, grammar lessons, technical support and most of all your love.

And to the nurses, who despite the challenges they face everyday, continue to do their utmost to provide the best care, always.

Thank you very much

Chapter 1: Navigating Moral Distress in Acute Care Nursing

Let whoever is in charge keep this simple question in her head
(*not*, how can I always do the right thing myself, but) how can I
provide for this right thing to be always done?

Florence Nightingale, "Notes on Nursing: What It Is and What It Is Not", 1858

As healthcare evolves, hospital leaders are turning to corporate values and strategies in an attempt to keep pace with current economic pressures. Recent trends in healthcare management and leadership are embracing processes that emphasize efficiencies and productivity (Austin, 2012). With these shifts, hospital leadership is implementing new mission statements, values, and goals, along with changes to policy and procedures, with the purpose of aligning to this new industry-type style. With the corporatization of healthcare, combined with rapid advances in medical technology, frontline health care workers, especially nurses, are potentially facing an increase in daily ethical dilemmas, with possible increases in moral distress. Moral distress occurs when one knows the right thing to do, but institutional constraints make it nearly impossible to choose the right course of action or act accordingly (Canadian Nurses Association, 2008; Jameton 1984, as cited in Wilkinson, 1988). Hospital boards of directors and senior leadership teams are adopting both industry vernacular and behaviours that are significantly different from traditional healthcare philosophies, and that may be at odds with deeply held ethical values, surrounding nursing and patient care. Austin (2012) affirms, "the re-engineering of health care to give precedence to corporate and commercial values is literally demoralizing health professionals" (p.28).

Nurses practice in organizations that are characterized by cutting costs and resources. A commonly expressed frustration of nurses is that of being placed into a situation of having to "do more with less". Patient acuity is increasing, and with fewer resources available, nurses have less

time to offer to patients, thus, causing a significant source of tension between nurses, the organization, and patient needs (Beagan & Ells, 2009; Canadian Institute for Health Information, 2014; Corley, Minick, Elwick, & Jacobs, 2005; Ontario Hospital Association, 2016; Registered Nurses Association, 2016; Rodney, Doane, Storch, & Varcoe, 2006; Romanow, 2002). The impact of moral distress on nurses and other health professionals is multifaceted. Nurses are suffering from emotional distress, including feelings of guilt and anger, with increasing rates of both burnout and nurses leaving the profession. All of this has the potential to impact patient outcomes negatively (Erlen, 2001; Hamric, 2000; Ulrich, O'Donnell, Taylor, Farrar, Danis, & Grady, 2007; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012; Webster & Baylis, 2000; Wilkinson, 1988).

In what is considered to be a seminal work on moral distress, Wilkinson (1988), suggested that nurses often face moral distress due to their unique role of caring for a patient but being bound, as employees, to the rules and regulations of both the licensing bodies and the organizations in which they work. Erlen (2001) and Austin (2007; 2011), in their respective studies, identified that nurses experience varying conflicting loyalties, between a health care system that is focused on market-driven goals and internal nursing values. Nursing values are the ethical values that underpin nursing. They include providing safe, compassionate, competent, and ethical care; promoting health and well being; promoting and respecting informed decision-making; preserving dignity; maintaining privacy and confidentiality; promoting justice; and being accountable (Canadian Nurses Association, 2008a; College of Nurses of Ontario, 2002a; 2009). As a result, nurses suffer from moral distress because they are placed in a situation whereby they feel ineffective to enact many or most of the nursing values, as well as to be strong patient advocates.

At the current time, the shift in direction and priorities within healthcare means a shifting to quality indicators and an increasingly corporate culture, resulting in more rigid external constraints impacting the ability of nurses to deliver quality holistic care (Austin 2012; Storch, Rodney, Pauly, Brown & Starzomski, 2002). For example, when patients are treated as objects that fit into hospital and physician metrics, such as wait times or surgical quotas, nurses are likely to experience moral distress as a result of not being able to care for the patient from an individual, holistic perspective (Corley, Minick, Elswick, & Jacobs, 2005; Wilkinson, 1988). Situations such as this can contribute to the amount of moral distress nurses experience, as well as affect the available resources and support systems accessible to nurses to navigate their moral distress as hospital leaders attempt to minimize expenditures and reduce costs by cutting various positions, both at the point of care and support roles. Ultimately these situations create an environment where nurses are faced with competing priorities, and they may find that they are unable to practice ethically or provide the necessary level of care that they believe patients require (Hamric, 2000; Rodney, Buckley, Street, Serrano & Martin, 2013; Rodney, et al., 2006; Rodney, Kadyschuk, Liaschenko, Brown, Musto, & Snyder, 2013). It is this inability to practice ethically that further contributes to moral distress (Rodney et al., 2006).

Moral distress in health care is defined as the outcome of a situation in which health care professionals find themselves unable to choose the proper course of action, as a result of either internal or external constraints (Canadian Nurses Association, 2008a; Erlen, 2001; Hardingham, 2004; McCarthy & Deady, 2008; Webster & Baylis, 2000; Wilkinson, 1988). Moral distress is often caused by incongruence between nurses' loyalties to their patient and to their employer (Doane & Varcoe, 2013; Erlen, 2001; Rodney, Kadyschuk, et al., 2013; Wilkinson, 1988). External constraints are routinely associated with organizational operations such as resource

availability, policy, decision-making processes, and traditional patriarchal roles in healthcare (Erlen, 2001; McCarthy & Deady, 2008; Rodney, Buckley et al., 2013; Wilkinson, 1988).

Accordingly, due to the role nurses play in typical healthcare settings, they find themselves at the mercy of external constraints leading to moral distress.

Internal constraints are most often associated with the nurse's own moral identity and personal values, such as how they have been socialized within the profession as well as to a particular unit (Doane & Varcoe, 2013; Erlen, 2001; McCarthy & Deady, 2008; Rodney, Buckley et al., 2013; Wilkinson, 1988). Further examples of internal constraints experienced by nurses are self-doubt, fear of repercussions, or learned helplessness from what may be perceived as past personal failings (Doane & Varcoe, 2013; Erlen, 2001; McCarthy & Deady, 2008; Rodney, Kadyschuk et al., 2013; Wilkinson, 1988).

Subsequently, I argue nurses are facing an increase in the number of challenging ethical situations leading to moral distress. An ethical situation is understood to be situations where there are conflicts between two or more values along with uncertainty about the correct course of action, this can occur at the individual, interpersonal or organizational level (Canadian Nurses Association, 2008). This is different than an ethical dilemma that the CNA (2008) defines as situations where there are equally convincing reasons to take two or more courses of action, and when choosing one course of action means something else is given up. Therefore, more than ever, nurses are requiring wide-ranging organizational supports to prevent and assist in navigating the increased moral distress that they may be experiencing. As mentioned previously, the research is limited on how nurses navigate moral distress; therefore, to ameliorate moral distress, it is important to understand the process by which nurses navigate moral distress in this increasingly complex environment.

Purpose and Research Questions

The purpose of this study was to understand and articulate the processes that nurses enact when navigating moral distress. In order to do so, I explored their interactions with the health care environment such as the relationships with peers, leaders, patients and families. The outcome of this research is that I provide an understanding of how nurses are able to navigate moral distress. The focus of this study was on the adult acute care medical-surgical nurse in a large academic teaching center. This group is under-represented within the literature on moral distress. That is to say, frequently the focus of research on moral distress is on highly specialized areas within health care, such as palliative care, oncology, critical care units, and paediatrics (McCarthy & Deady, 2008).

As advances in medical technology occur, patients in acute care medical-surgical units are increasingly complex, not only as a result of improved medical techniques, but also in terms of presenting co-morbidities, the result being that nurses on these units are facing ethical dilemmas related to the presence of technology previously only seen in critical care areas (Ontario Hospital Association, 2016; Registered Nurses Association, 2016; Rodney et al., 2006; Romanow, 2002). This includes, for example, dealing with invasive monitoring such as arterial lines, supporting non-invasive positive pressure ventilation systems, and managing complex post-operative patients who previously would have been admitted to the critical care areas for a few days prior to being moved to the inpatient units. Thus, the changes and external influences of the health care system, from a macro, greater political level down to a micro unit culture level, are contributing to the nurses' experience of moral distress.

My research objectives were to:

1. Describe morally distressing situations as experienced by nurses on medical surgical nursing units.
2. Create an explanation of the process of navigating, or attempting to navigate, moral distress, including barriers that nurses experience while attempting to resolve moral distress both clinically and organizationally.
3. Explain organizational factors that contribute to, or ameliorate moral distress in these situations.
4. Describe supports; both existing and desired, that would alleviate moral distress.

My specific research questions were:

1. What morally distressing situations for acute care nurses (non-critical care) exist related to the current healthcare practice environments?
2. What is the primary cause for these morally distressing situations?
3. What organizational factors contribute to, or ameliorate, moral distress in these situations?
4. What is the process for navigating moral distress? What is the impact of these strategies?
5. What other organizational strategies would help to ameliorate moral distress effectively?

To be able to explore the interaction between nurses and their environments (agency and structure), I used a grounded theory study design to understand these processes. Grounded theory was originally identified as a way to understand how people manage basic social problems. (Schreiber & Stern, 2001). It focuses on a shared basic social problem and provides a mid-range theory to explain the process used to solve the problem (Schreiber & Stern, 2001). The benefits of a grounded theory study include examining the relationships between and among the nurses, the organizational constraints, organizational values, and the nurses' own values. By

understanding the way in which nurses interact with their environment, and learning how nurses navigate moral distress, the outcomes of my study provide insight as to the resources and supports needed for nurses to cope successfully with moral distress. Providing a concrete understanding of the process of navigating moral distress is necessary if we are to provide nurses with a work environment in which they can practice ethically.

From my experience as both a front line nurse and in administrative type roles, I argue nurses are facing an onslaught of rapid organizational change, exacerbated by a focus on measurable outcomes and the downsizing of budgets. The nurse participants in this study were recruited from a large teaching hospital where groundbreaking medical technology is utilized. Consequently, these nurses were caring for patients with high levels of complexity and acuity, the likes of which have not been seen before on general medicine and surgical units (Canadian Institute for Health Information, 2014; Rodney et al., 2006; Romanow, 2002). As a result of this combination of factors, the resounding theme heard from nurses in this study was that they are being asked to do much more, with much less.

Advances in medical technology, such as minimally invasive surgery, video assisted laparoscopic surgery, and improved treatment regimes have changed diseases, such as cancer or renal disease, once considered terminal, into chronic diseases. It can be argued that patients such as this would have been previously considered palliative but are now receiving active, curative treatments, contributing to increasingly acute and complex care needs. In addition, these patients are also presenting with complex co-morbidities, furthering the need for increased complex levels of care. Consequently, those in hospital are often sicker than in the past.

It is the combination of the changing face of Canadian health care that is demonstrated by the trend in the corporatization of healthcare, subsequent complex organizational constraints, and

an increase in patient acuity that contribute not only to the increase in moral distress, but to all the challenges nurses face to navigate moral distress adequately. Therefore, the benefits of this research may provide opportunities for healthcare organizations to support nurses in navigating moral distress. In addition this research may offer learnings for nurses in terms of better strategies for navigating moral distress, such as self-care and resiliency.

Chapter 2 Literature Review

Definitions of Moral Distress and Moral Residue

Jameton (1984, as cited in Wilkinson, 1988) provided the foundational definition of moral distress: “moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to propose the right course of action” (p. 16). Lützén and Kvist (2012) further expanded this definition to include the nurses’ experience of these external constraints, combined with the awareness of the incapacity to act in accordance with internal values. The Canadian Nurses Association (2008a) elaborated on the concept of moral distress by including the compromise of nurses’ integrity, stating that moral distress occurs when nursing obligations are constrained by external factors that affects nurses’ identity and moral agency.

The negative impact of moral distress has been well documented throughout the literature. For instance, in her work on moral distress and its effects on nursing, Wilkinson (1988) clearly identified the negative impact moral distress can have on nurses’ emotional well-being. Wilkinson (1988) found that moral distress could lead to unsuccessful coping behaviours, resulting in damage to nurses’ sense of wholeness, decreasing their ability to provide care, and thus, leading nurses to leave the profession. Nurses commonly experience feelings of guilt, frustration, distrust, anger, and powerlessness as a result of moral distress (Austin 2007; Beagan & Ells, 2009; Erlen, 2001; Hamric, 2000; Hamric, 2012; McCarthy & Deady, 2008; Newton, Storch, Makaroff, & Pauly, 2012; Olson, 1995; Pauly, Varcoe, Storch, 2012; Rodney, Kadyschuk et al., 2013; Schluter, Winch, Holzauer, & Henderson, 2008; Ulrich, et al., 2007; Wilkinson, 1988).

The negative impact of moral distress not only affects nurses, but can also contribute to patient safety issues, and potentially poor patient outcomes (Newton, et al., 2012; Schluter et al.,

2008). For example, Rodney, Kadyschuk et al., (2013) articulated that moral distress caused by external constraints can “threaten the well-being of nurses and the well-being (and likely also the safety) of patients and families” (p. 169). In addition, moral distress can affect recruitment and retention of nurses, the quality and safety of care delivered, and patient outcomes (Corley et al., 2005; Hamric, 2000; McCarthy & Deady, 2008; Newton, et al., 2012; Pauly, et al., 2012; Schluter et al., 2008; Wilkinson, 1988). With fewer nurses providing care to more acute patients, without adequate resources, ultimately there are increased opportunities for patient safety risks such as medication errors, preventable falls, or transmission of hospital acquired infections, all of which can be attributed to fatigue, lack of time, and distractions.

In addition, an equally important consequence of moral distress is moral residue. Moral residue is defined by Webster and Baylis (2000) as “that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised” (p. 218).

The Canadian Nurses Association (CNA) recognizes moral residue as a significant impact of moral distress, but also suggests, along the same lines as Webster and Baylis, that moral residue can be used as a learning opportunity. The CNA suggests that nurses can reflect on past experiences and use their moral residue to consider what they might do differently in similar situations (Canadian Nurses Association, 2008a). Besides personal reflection, Webster and Baylis argue that examining moral residue can provide clarity as to personal moral identity and boundaries (Webster & Baylis, 2008). However, in contrast, moral residue can have a devastating effect on an individual. Moral residue can “lead to the erosion and fragmentation of their sense of meaning in the world” (Webster & Baylis, 2000, p. 224). By examining this long term, negative impact on nurses, researchers can highlight the importance of understanding how

nurses can navigate moral distress and either avoid the experience, or reduce the negative effects of moral residue.

Causes of Moral Distress

Contributing factors to moral distress include both internal and external drivers. It is important to recognize that internal and external drivers are related. External factors, such as senior leadership directives, policies, or budget limitations can contribute to the environmental culture of a unit, thus, influencing the social norms of the staff. As a result, nurses can experience internal conflicts, whereby, their personal values and morals are in conflict to how they must practice. Furthermore, nurses can also struggle with internal drivers when these are in conflict with patient care requirements or patient and family beliefs. Nurses may face situations where there is an experience of moral distress as a result of deeply held personal values, such as a cultural or religious conviction, that is challenged when care is in opposition.

Although internal drivers are an equally causative factor of moral distress, it is the external factors that are most important to this research study. The rationale for this was the changing healthcare environment in Ontario, and throughout Canada, an environment that is experiencing a shift in focus related to budgetary constraints and an uptake in corporate philosophies. (Austin, 2012; Rodney et al., 2006). This change is recognizable in terms of organizational climate where policies and practices are changing to reflect corporate values. (Austin, 2012; Storch et al., 2002). Such policies and practices can include systematic decreasing of staff, increased workload, which in turn creates environments that have become “simulated marketplaces” (Austin, 2012, p. 27). External causes of moral distress are more difficult to control because they are related to organizational policy and procedure, mission and value statements, as well as internal organizational culture, and often entrenched historical attitudes.

Varcoe, Pauly, Webster, and Storch (2012) contend that the relationship and interaction between the system and the individual is a contributing factor to moral distress. They further explain that the culture of the health care professionals within the organization/system contributes to the overall health care culture; thus, the profession and the system are interconnected (Varcoe, Pauly, Webster & Storch. 2012).

Along with these traits, the corporatization of healthcare, and hospital leadership's tendency to impose decisions based on budget, further contributes to the increase in moral distress. For example, external constraints that may stimulate the experience of moral distress identified within the literature are issues of increased patient acuity, along with staffing shortages (Beagan & Ells, 2009; Corley et al., 2005; Rodney et al., 2006; Schluter et al., 2008). Nurses frequently cite nursing shortages and staffing ratios as contributing to moral distress (Corley et al., 2005; Erlen, 2001; Hamric, 2012; Varcoe, Pauly, Storch, Newton & Markroff et al., 2012). It is important to understand the external constraints nurses experience when trying to practice ethically, because nurses do not practice separately from the organizations in which they work.

Organizational climate. As mentioned previously, the corporatization of health care, and the appearance by hospital leaders to reduce patients to objects with measurable outcomes, is increasing the risk for occurrences of moral distress. The current trends in healthcare leadership behaviours are touted as being necessary to continue to deliver quality healthcare in the present economic climate in Canadian society. The common model being adopted by hospital leadership is that of industry or rather a customer service focus. As Austin (2011) explains, hospital leaders are using the customer service model as a way to focus on patient satisfaction, safety, and quality patient care. Along with the industry focus, there is also a need to adjust to the rapid advances in healthcare technology, which continues to have a predominately biomedical and curative focus.

Subsequently this need is supported by a shift to corporate practices. This, more often than not, results in a reduction in resources such as staffing and other supports, because of reorganized priorities, and in the end leaving nurses to do more with less (Austin, 2007). This shift in healthcare enhances the external constraints that impede the ability of nurses to practice ethically. In other words, nurses are adapting their practice as a result of the changes in organizational culture, such as a focus on wait times, length of stay, metrics, quality based procedures, and budget constraints. Trends such as these are only becoming more prominent as health care environments shift to an increasingly corporate focus.

Lützén, Blom, Ewalds-Kvist and Winch (2010) assert that the capacity for nurses to navigate moral distress is directly related to the climate of their practice setting. In a health care environment where senior leadership is concerned with efficiencies, downsizing, and other corporate philosophies, nurses find themselves experiencing moral distress to the extent that doing the right thing is challenged by the emphasis on technology and cure. Furthermore, this is compounded with the need to account for the care they have provided through tools, such as workload measurement, that reduce care to a measurable number (Austin, 2007; Austin, 2012; Corley, 2005; Beagan & Ells, 2009; Rodney, Buckley et al., 2013).

Environments such as these, which are themselves strongly influenced by external constraints, are producing healthcare climates that are at odds with nursing values, and in turn are leading to a decline in job satisfaction and the inability of nurses to practice ethically (Austin, 2011; Storch et al., 2002; Vanderheide, Moss & Lee, 2013; Ulrich, et al., 2007). To articulate not only what organizational constraints are responsible for moral distress, but also what facilitates or prevents its resolution, has implications to improving ethical practice from a

broader systems perspective, thus, providing nurses with the ability to navigate moral distress successfully.

Organizational constraints. The corporatization of healthcare brings new policies, rules and regulations that, as mentioned previously, may be in conflict with traditional nursing values. Policies implemented within an organization are what guide nurses in their practice, and ideally should ensure nurses can provide safe and effective care. However, policies may not have a positive impact on nursing, and can either be viewed as a barrier to enacting ethical nursing care, or as creating tension for staff who are attempting to navigate a moral dilemma (Beagan & Ells, 2009; Corley, et al., 2005; Pauly, et al., 2009). Policies are adjusted to reflect the current healthcare environment, and with the evolution of Canadian healthcare, they are changing to meet the new corporate visions. There is also a need to adjust to the rapid advances in healthcare technology, which continue to have a predominately biomedical, curative, and efficiency focus; subsequently this is supported by a shift to corporatization.

Schluter, et al. (2008) suggest in their 2008 report, in which they state, “inadequate staffing and time constraints inhibit nurses’ ability to provide appropriate patient care” (p. 306). Furthermore, as Erlen (2001) writes, “issues are mandatory overtime for nurses, unsafe staffing practices, and nurses caring for an increasing number of patients with high acuity level” (p. 76). Staffing issues can be attributed to the change in health care organizations having a focus on benchmarking, streamlining, and efficiencies. Austin concurs in her (2012) article, where she maintains that the consequence of the restructuring of health care to corporate principles is the demoralization of nurses and other health professionals. This is equally challenging when there is a lack of negotiability in the policy interpretation, and rigid bureaucracy that excludes nurses from the decision making practices (Austin, 2012; Newton, et al., 2012; Ulrich et al., 2007).

The combination of organizational climate and constraints can have a serious impact on the ability of nurses to provide quality care because these influences can contribute to practice scenarios that will increase the experience of moral distress. Therefore, it is essential to understand how nurses navigate moral distress, in terms of organizational structure, in order to assist nurses to be able to practice ethically (Hamric, 2012; Schluter et al., 2008).

Conflicting loyalties. The organizational climate, and the imposed external constraints within healthcare organizations, as discussed, generates the behavioural norms for how nurses practice. In the current healthcare culture, nurses following the organizational policies, procedures, or values that may be in tension with to their own personal ethics, thus, causing a conflict in loyalties. The notion of conflicting loyalties is a reoccurring topic throughout many significant works on moral distress (Corley et al., 2005; Lütznén, Blom, Ewlad, Kvist, & Winch, 2010; Lütznén & Ewalds-Kvist, 2012; Rodney, Buckley et al., 2013; Wilkinson, 1988). As expressed by Wilkinson (1988), nurses are susceptible to moral distress as a result of their unique relationship and conflicting loyalties to both their patients and the organization for which they work.

Nurses are guided by an intrinsic desire and vision of how to care for patients. However, this is often times at odds with the goals of the organization for which they work (Austin, 2012; Erlen, 2001; Lütznén & Kvist, 2012; Newton, et al., 2012). As Lütznén and Kvist (2012) articulate, the organization socializes nurses to act in accordance with rules and regulations to ensure employment; this in turn generates norms for behaviour in the workplace. Organizational constraints, such as policies that limit resources, an unawareness of policies due to poor implementation, inadequate policies in regards to end of life care, resource allocation, or staffing guidelines, are examples of the tension that can occur between the nurses' and organization's

values, impacting how nurses are able to act (Austin 2012; Beagan & Ells, 2009; Corley et al., 2005; Rodney et al., 2006; Schluter et al., 2008; Storch, Rodney, Pauly, Brown & Starzomski, 2002).

Within the theme of conflicting loyalties is the concept of power imbalances, and the effect of social hierarchy of health care organizations emerges. Power imbalances occur between nurses and physicians, nurses and unit leadership, and nursing/nursing leadership and senior leadership. These differing roles and historical perceptions of power within healthcare have led to a social hierarchy, which can create an inability for nurses to navigate moral distress successfully (Austin, 2012; Corley et al., 2005; Hartrick Doane, 2002; Erlen, 2001; Hardingham, 2004; Newton et al., 2012; Storch et al., 2002).

Experiences of moral distress are not always directly related to unethical events or situations within an organization. It is important to note, particularly in health care, that although a situation leads to moral distress, it may not be inherently unethical. Rather, it is the combination of the influence of the external constraints and the culture of both the health care professionals and the organization that can give rise to the experience of moral distress (Rodney, Buckley et al., 2013; Storch, 2013). Moral distress is the sense of feeling compromised in fulfilling a duty of care, and in the current health care climate this can be an ongoing challenge for many (Storch, 2013). Nurses face day-to-day ethics in their every day practice, and it often these small decisions, or situations, which are a result of decisions made at senior leadership level, that can contribute to significant moral distress.

The corporatization of health care has led to a shift in focus of efficiency, with subsequent care restructuring, and although that is not inherently unethical, it contributes to situations that may warrant nurses making decisions regarding how and what care is completed,

thus, nurses having to compromise one of their firmly held nursing values. The outcome of such situations is the experience of moral distress. For example, Rodney, Buckley, et al. (2013) suggest that “the corporate ethos” leads to nurses not having time to communicate, that their contributions to patient care are not valued, and they must now care for more patient as quickly as possible, meaning they cannot do what they feel is right. In other words, they cannot enact their moral agency. Meaning they are not able to direct their actions to meet what they believe to be the right course of action; the result is a potential negative outcome for the patient, and consequently moral distress for the nurse. Further ethical situations arise when there is conflict between the frontline staff (including frontline leaders) and the organizational mandates, when what they may view as unjust practices become the norm. This results in nurses finding it increasingly difficult to “maintain their moral integrity” in the current health care environments (Rodney, Buckley et al., 2013).

As previously mentioned, there is a clear lack of understanding of how nurses navigate their moral distress, despite the extensive research and literature on moral distress in nursing over the past three decades (Corley et al., 2005; McCarthy & Deady, 2004; Varcoe, Pauly, Webster, & Storch, 2012). Researchers have identified many contributing factors to moral distress, as noted above, and have recognized potential roles for nurse leaders and policy makers in intervening, but without understanding the process behind how nurses navigate their experiences with moral distress, it may be difficult to implement solutions to prevent it successfully. As Varcoe, Pauly, Storch, Newton & Makaroff (2012) posit “surprisingly little attention has been paid to how nurses experience and respond to what they see as morally distressing experiences or the effects of moral distress on patient care” (p. 490). Corley et al. (2005) and Schluter et al. (2008) called for further research to understand how to reduce moral

distress, and to identify what organizational interventions can be put in place to assist with working through such issues. The purpose of my research was to gain an understanding of the processes by which nurses navigate their moral distress. In the research, I paid particular attention to the effect of organizational factors, both as causative and assistive factors to navigating moral distress.

Chapter 3 Methodology

In this chapter, I present a brief overview of grounded theory from its philosophical underpinnings, the different perspectives within grounded theory, and finally which methodology I have chosen. I also provide a description of the participants, data collection, and analysis. To conclude, I review the ethical considerations of this study.

Qualitative research is characterized as research that generates knowledge that is based on the actual lived experience of human beings (Denzin & Lincoln, 2011; Sandelowski, 2004). Researchers who engage in qualitative methodologies are able to gain an understanding of the phenomenon in question by further comprehending the context in which the experience occurs, thus, capturing the meaning of the experience from the perspective of the participants. Before one can determine the appropriate interventions to address an existing problem, or to mitigate potential problems, one must truly understand the issues at hand. It is this initial understanding of the phenomenon in question that creates the foundation for all interventions to come (Sandelowski, 2004).

Using qualitative research methods allows participants to share their stories, provide context and meaning to their experiences, and at the same time, it positions the researcher in the environment in which the participant lives (Denzin & Lincoln, 2011). In reading and reviewing the literature on moral distress, it is evident that experiences are individual, and often situated within a particular context. Accordingly, because the purpose of this study was to discover the process by which nurses experience and navigate moral distress, using a qualitative research method was applicable.

Considering the purpose of this research study, I employed a constructivist grounded theory methodology. A primary tenet of constructivist grounded theory is to form a theory that is

rooted in the social reality of the participants, thus, allowing for a practical application to the practice environment (Charmaz, 2014).

Philosophical Underpinnings of Grounded Theory

Grounded theory is a methodology of qualitative research developed by Anselm Strauss and Barney Glaser in the 1960s, with the purpose of generating theory from the explanations of social processes (Baker, Wuest, & Stern, 1992; Glaser, 1978). Foundational to this methodology is the philosophy of symbolic interactionism. Symbolic interactionism is a theoretical perspective to explain the meaning that individuals assign to events and situations they experience and the symbols they use to convey that meaning (Charmaz, 2014; Corbin & Strauss, 1990; Milliken & Schreiber, 2001). Benoliel (1996) and Charmaz (2014) further articulate the goal of symbolic interactionism as a way to describe the influence and interconnectedness of social circumstances on the behaviours, interactions, and the perceived reality of the population being observed. Central to symbolic interactionism is the notion that individuals respond to social influences by thinking and interacting according to each situation.

Traditional grounded theory methodology, as developed by Glaser and Strauss, is situated ontologically on post-positivism and epistemologically on objectivity (Higginbottom & Lauridsen, 2012; Mills, Bonner & Francis, 2006). From this traditional foundation, Kathy Charmaz developed constructivist grounded theory, which differs from the original methodology both epistemologically and ontologically. Constructivist grounded theory is based on the premise that one can “give voice” to the participants, and the focus is on the importance of the relationship between the researcher and the participant (Mills, Bonner & Francis, 2006, p. 11). Researchers using a constructivist grounded theory methodology use a relativist ontology in which there is no one single truth, but rather truth is relative to the social, cultural, or

environmental context; thus, there may be multiple truths, and truth is socially constructed by the participant (Higginbottom & Lauridsen, 2014; Mills, Bonner & Francis, 2006; Schreiber & Martin, 2013). In terms of epistemology, constructivist grounded theorists also employ a constructivist lens focusing on the researcher and the participant and how they co-construct a reality or truth (Higginbottom & Lauridsen, 2014; Mills, Bonner & Francis, 2006, Schreiber & Martin, 2013).

Grounded theorists examine a basic social problem from the perspective of those experiencing it. In my study, the basic social problem was the experience of moral distress as caused by a variety of situations. The complex social relationship that exists between nurses and their employer can be understood from a theoretical perspective of symbolic interactionism. Nurses will act according to the current workplace climate that they are experiencing, and will readjust as necessary. In their work on organizational climate and nursing, Malloy, Hadjistavropoulos, McCarthy, Evans, Zakus, Park, Lee, and Williams (2009) suggest that, in order to understand fully the relationship between nurses' ethical practice and the organization in which they work, it is imperative to understand the meanings nurses give to their actions and interactions within the health care environment. Having been a staff nurse on an acute surgical floor, I have experienced moral distress and acknowledge that my "truths" were socially constructed, and changed based on the context of immediate situations and previous experiences. As nurses, how we understand, and consequently define ourselves, in terms of where we practice, by extension defines how we practice within that environment (Austin, 2011). I believe that my personal experiences have allowed me to co-construct a reality with my participants, not only as a past front-line staff nurse, but now as an informal leader in health care, I can relate to the experiences of the participants. Although moral distress, and how different individuals

navigate their experiences, is deeply personal, it is also influenced by various social constructions at a moment in time, and using a constructivist grounded theory methodology allowed me to place the nurses' experience in the shared social context when moral distress occurs, and thus, give meaning to the social process of moral distress.

Sample

The sample population for this study was drawn from Registered Nurses (RNs) and Registered Practical Nurses (RPNs) who work on inpatient acute care units with an adult patient population (Please refer to Appendix A for summary of demographics). Inclusion criteria included being a registered nurse/registered practical nurse with the College of Nurses of Ontario, and actively working in an adult acute care medical or surgical unit. Exclusion criteria included working in paediatric, palliative, or critical care settings. As a result of the eligibility criteria, nine nurses, all RNs, participated in this research study; no RPNs were part of the study. This group included eight women and one man. Four of the nurses were from medical units, four were from surgical units, and one worked in both medicine and surgery as a full time member of a float pool. The majority of participants had similar educational preparation, however, experience was varied. Eight nurses were baccalaureate prepared; one was Master's prepared with a nurse practitioner (NP) certificate, but not yet practicing as an NP; one nurse was half way through a Master's program; and one nurse was diploma prepared. The participants ranged in age from 25 to 54 years old, with the average age being 32.3 years of age. The participants' nursing experience ranged from 18 months to 33 years.

Because this was a qualitative research study, the sample size was determined when I achieved theoretical saturation of the emerging themes. According to grounded theory literature, theoretical saturation occurs when the data no longer provide new ideas or theoretical categories,

ultimately when repetition occurs within data collection and analysis (Charmaz, 2014). I used purposive sampling and snowball sampling to begin with, and then theoretical sampling of both the participants and the data as the study progressed, which was consistent with constructivist grounded theory. Theoretical sampling is a form of sampling whereby the researcher has identified a preliminary theoretical category from the data and pursues further participants or information to further the theory (Charmaz, 2014). Glaser (1978) defines this sampling as “the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory” (P. 36). In other words, a key precept of theoretical sampling in grounded theory is to direct next steps in data collection and analysis based on the emerging categories from this concurrent process.

Participants were able to express their current practice in relation to the larger health care system and articulate the challenges that organizations are facing in a time of health funding reform, such as Ministry-mandated quality based procedures (QBPs), and the current climate within provincial and federal political systems. For instance the Ministry of Health and Long-Term Care (MOHLTC) in Ontario announced health care funding reforms in 2012, with the legislation of the Excellent Care for All strategy (Ministry of Health and Long-Term Care, 2016). This includes health system funding reform, a particular focus on quality improvement, and standardized quality care supported by best available evidence. Funding reforms are centred on funding Health Based Allocation Model and QBPs that will comprise 70% of the funding, and the remaining 30% will be global funding. The Ministry implemented this new model over the past three years and completed the transition in 2015/2016. With QBPs, the patient must meet treatment milestones and follow a transfer/discharge pathway, all of which are reported to the

MOHLTC, with agency funding directly tied to meeting these targeted milestones. This has resulted in a significant shift in how care is provided for patients across the continuum of care. Furthermore, as the population ages, and there are more occurrences of comorbidities and multiple chronic illnesses, the patients are often more complex than the pathways envisioned. I provide detailed discussion of the nurse participants' experiences of moral distress later in chapter four.

Data Collection

I recruited the majority of participants through the advertisements placed throughout the organization, and approximately one third of them through word of mouth using snowball sampling. I placed advertisements on the internal electronic bulletin board and sent electronic advertisements to the clinical educators and coordinators associated with medical and surgical units, who then distributed them via their internal email lists. Participants were directed to contact me via phone or email if interested in participating in a study on moral distress. This yielded the majority of initial contacts, and six participants were recruited in this manner. When potential participants contacted me, I provided greater detail and asked a series of questions to determine eligibility. If the participant was eligible and agreed to participate, I arranged a time and place to conduct the interview.

I gave a copy of the Draft Interview Guide (Please refer to Appendix B for the sample interview guide) to the participants prior to each of their interviews, either via email or when they arrived to the interview; therefore, they were able to see the questions that would be asked and have an understanding of what would be explored. I explained to the participants that, although there was an interview guide, I might ask other questions as the interview progressed, to explore their experience further or to generate discussion. The interviews were semi-structured

and averaged between 45 and 55 minutes. I conducted all interviews in person. In alignment with the grounded theory methodology, I adjusted the interview tool as data were collected, and I analyzed the data to reflect emerging categories. For example, after the first few interviews I identified emerging categories as “getting on with the day/shift” and “building relationship”. Consequently, I added questions to explore these categories for subsequent participants.

Data Analysis

As mentioned previously, grounded theory involves the concurrent process of data collection and data analysis. A key element in data analysis in grounded theory is coding. Glaser (1978) suggested, “*the code conceptualized the underlying pattern of a set of empirical indicators within the data. Thus generating a theory by developing the hypothetical relationships between conceptual codes*” (p. 55). As Schreiber (2001) discusses, coding is more than a technical task, but rather a way to see and understand the data. Coding allows for the researcher to elevate raw data to theory; by coding data and comparing codes with the data categories, eventually a theory emerges (Schreiber, 2001).

Coding occurs in various stages. The first level of coding involves examining the data and using words as close to the participant’s words as possible (Charmaz, 2014; Schreiber, 2001). This level of coding includes examining the raw data with a line-by-line analysis and labeling sections with the participants’ own words. Glaser (1978) described this level of coding as substantive coding, or open coding, with the purpose of generating an “emergent set of categories and their properties which fit, work and are relevant for integrating into a theory” (p.56). This process creates a large volume of codes that require further analysis.

Once the first level coding is complete, the second level coding begins. The purpose of second level coding is to examine the first level codes and collapse them into categories

(Schreiber, 2001). It is more than just studying or assessing the initial codes and picking interesting codes. Rather it involves concentrating on what the initial codes are saying and comparing them to one another. This exercise is an integral part of the constant comparative process whereby the researcher compares initial codes with the data, and codes to codes. By engaging in second level coding, the researcher is able to bring the data to a higher level of abstraction (Schreiber, 2001). Regardless of what this stage of coding is referred to, the ultimate goal is to take the data to a higher level of abstraction and begin to unearth the relationships between the codes, and work towards an emerging theory.

The final step in this process is third level coding. In third level coding, the researcher now turns the focus to understanding the relationships between the categories (Charmaz, 2014; Schreiber, 2001). The researcher continues to employ the constant comparative method, in that the researcher moves back and forth between data collection and analysis. This level of coding is also referred to as theoretical coding. Glaser (1978) defines theoretical codes as those that “conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into a theory” (p.72). It is important to understand that, although this is described in a linear fashion, the process of coding is dynamic and fluid. The researcher moves back and forth between the different levels of coding as new data are collected, and analyzed, and new categories emerge. It is this constant comparative method that provides direction for further data collection.

As described above, data collection and analysis were concurrent processes. I started the process of data analysis by examining the data using line-by-line coding. In keeping close to the participants’ language I identified codes based on their experiences. I continued to examine new data along with the previously collected data. During this iterative process of collection and

analysis I used the constant comparative method, whereby I was able to go back and forth between new and previously analyzed data to uncover, shape, and inform emerging theory (Baker et al., 1992; Charmaz, 2011).

As a novice grounded theorist, I began with line-by-line coding to review the data carefully. In using constant comparison, I consistently analyzed and collected data together throughout the interview process. During this initial phase of data analysis I developed codes that were in keeping with the participants' own words. During this stage of coding I amassed a large number of codes. I began second level coding when I began to merge my initial codes into higher-level concepts. By using constant comparison, I compared the line-by-line codes and collapsed them into and/or incorporated them into higher conceptual codes, thus, ensuring a higher level of abstraction. As new data came in, I compared first level codes from existing data to the new data and codes, identifying similarities in the concepts. For example, codes such as "asking for help" and "relying on my team" and "talking to each other" eventually became the core category "finding the way". As explicated by Charmaz (2006), the initial comparison between data is centered on similarities and differences, both within and between interviews.

As categories emerged I used theoretical sampling to assess concepts within the data and decide upon next steps. Glaser (1978) defined theoretical sampling as the process of data collection "whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them" (p.36). Engaging in this process allowed me to adjust the interview tool to guide the questions to reflect the emerging categories that came from concurrent coding and recoding. As well, I continued to examine further the emerging categories against previous transcripts. Subsequently, I was able to develop increasingly abstract categories that demonstrated a conceptual framework (Charmaz, 2011) of how nurses are attempting to

navigate situations of moral distress. By using this process I ensured a dynamic interview progression, and also that I was raising the level of abstraction and avoiding the risk of only describing the categories and basic relationships (Schreiber, 2001).

Essentially the first level codes were collapsed into categories or “higher level concepts” (Schreiber, 2001). The third stage of coding, theoretical coding, involved exploration of relationships within the categories. For example, the categories such as “experiencing moral distress” and “making sense” and “finding the way” do not always occur in a linear or predictable fashion; rather nurses move back and forth through the stages in different patterns, yet the end goal for the nurses as they navigated these categories was always to “just get through the shift”. It is important to note that the coding processes I engaged in were occurring at the same time; this was an iterative and dynamic process (Schreiber, 2001), thus, ensuring that I kept the codes and categories that emerged grounded in the data and informing the direction of my ongoing data collection and analysis.

As Schreiber (2001) describes, a common mistake made by novice grounded theorists is to describe the findings in a linear fashion, rather than discovering how the participants work through the process and what actions they take. By being diligent with the constant comparison and allowing an organic process of interviewing and coding, I was able to construct the theory from the data.

A key component of grounded theory is the use of memo writing. Charmaz (2014) identifies memo writing as “the pivotal intermediate step between data collection and writing drafts of papers” (p. 162). Memo writing serves as a way to explore the data early on in the research process. By writing memos, I had a fluid and permanent collection of ideas, data, codes, questions, potential directions, and relationships within the data. I made memos by hand

throughout this research study, which took the form of hand written and typed notes, along with informal memos such as post-it-notes, and they were often adjusted and advanced as I collected and analyzed more data.

I utilized diagramming as another strategy throughout data collection and analysis. Frequently, I mapped out possible ideas and relationships not only to help with directing the interview process, but also to tease out categories and potential emerging theory. Putting the categories into a visual representation further enhanced my ability to conceptualize the emerging theory and see the relationships between the categories (Charmaz, 2014; Schreiber, 2001).

Rigour

Rigour refers to the strictness of the process by which the study was conducted to ensure that there is quality, believability, and trustworthiness in the results (LoBiondo-Wood, Haber, & Singh, 2013). For qualitative research in particular, rigour is ensured during the methodological research design, data collection, and analysis. As LoBiondo-Wood, Haber, and Singh (2013) explain, the goals of qualitative researchers are to be able to account for the method and data in such a manner that a second researcher would be able to come to the same conclusion following the same process of data collection and analysis (p. 324). Rigour also ensures the researcher produces a “credible and reasoned explanation of the phenomenon under study” (p. 324), in other words to demonstrate rigour.

However, when considering a specific qualitative research methodology, it is necessary to understand the key components that contribute to rigour for that method. In the case of grounded theory, Glaser (1978) states that a strong grounded theory has fit, grab (relevance), works to explain the phenomena, and must be modifiable, all of this combined allows for the theory to be evaluated for credibility. Glaser (1978) states that “fit” means that the categories of

the theory fit the data; all of the categories of a grounded theory are created directly from the data, or rather that the categories emerged from the data. Within fit are the properties of refit and emergent fit (Glaser, 1978, p. 4). Refit is the process where the researcher returns to the data and adjusts the categories to reflect the new data. A grounded theory works when it can be used to explain what is occurring in the data and predict what will occur. Work is achieved by ensuring data are gathered by a systematic process (Glaser, 1978). A grounded theory must have grab or relevance in order for it to work. Glaser (1978) states that grounded theory achieves this because it focuses on a core problem and allows for a process to emerge, therefore, demonstrating its relevance.

The final component is that of modifiability. In Glaser's view "though basic social processes remain in general, their variation and relevance is ever changing in our world. The theory can never be more correct than its ability to work the data – thus, as the latter reveals itself in research the former must constantly be modified" (1978, p. 5). In essence a grounded theory needs to be modifiable as more and new data becomes available. In order to ensure adherence to grounded theory techniques my supervisory committee included a member with expertise in grounded theory to provide guidance and feedback throughout the process.

Throughout the data collection and analysis, I engaged in the following methods to ensure rigour. In relation to credibility, during the data collection process I audiotaped the interviews. The recordings were transcribed verbatim, and the transcriptions compared to the audiotapes. I took detailed notes during the interviews. I sought out feedback from my committee members during the data collection phase by sharing my ideas and initial coding outcomes, along with my initial drafts of the emerging theory. Furthermore, I shared my progress of the emerging theory with a seminar group of grounded theorists and other graduate students to seek feedback

and input. Keeping detailed notes, memos, and interview transcriptions ensured that my theory met the criteria for work, fit, grab, and of course this process contributed to the rigour of the theory. As well, I have intermittently shared my findings with colleagues who have an interest in the topic of moral distress in nursing to determine if the findings resonated with their experiences. Their response was one of being able to relate and identifying with the findings.

Ethics

Research ethics is an important aspect of any research project, thus ensuring that participants are respected, that no harm is done, and that the well being of the participants is foremost throughout the process (Oberle & Storch, 2013). There are commonalities between the code of ethics for nurses and the basic ethical principles of research. The CNA (2008) outlines that nursing values and ethical responsibilities include respect, justice, and providing safe competent care. In other words, beneficence, which is the obligation to do no harm, justice, so that subjects are treated fairly, and that people have the right to self-determination (Haber & Singh, 2013). As a researcher, these cornerstones of research ethics and nursing values were foremost in my mind while I conducted this study.

As a researcher, it is critical to adhere to the principles of research ethics, in particular that of consent and voluntariness. Participants must have the ability to make an informed decision as to the risks and benefits of participating, as well as have the ability to determine when and if they want to participate and for how long. (Haber & Sing, 2013, Oberle & Storch, 2013). In particular in this study, participants were sharing stories of moral distress that often involved intense emotion, thus there was a potential for them to experience a period of vulnerability during their interviews, therefore, I needed to ensure that I paid attention to the notion of beneficence, consent and voluntariness to ensure the participants' well-being.

Ethical approval was received through the Human Research Ethics Board (HREB) at The University of Victoria in October 2014, and through the Ethics Review Committee associated with the organization where the recruitment was occurring in April 2015. Prior to the interview I provided a letter of information (Please see Appendix C for the letter of information) to the participants whom I outlined the purpose, procedure, requirements, and the risks and benefits of participating in the research study prior to the interview. I established informed consent prior to the interviews, and in that discussion, allowed the participants the opportunity to ask questions and discuss any concerns they had. At which time, each participant signed a consent form. Informed consent is “the legal principle that requires a research to inform individuals about potential benefits and risks of a study before the individual can participate voluntarily” (Haber & Singh, 2013, p. 122). By guaranteeing informed consent, the participants have the ability to agree to participate or not in a study, at any given time throughout the process. Participation in the study was voluntary; I made the participants aware, and I included in the consent form, a clause explaining the participants’ right to withdraw from the study at any time without consequence. Anonymity was protected in that all interviews were individual; I used no identifying or personal information during the interviews, transcripts, or findings. In order to ensure anonymity I used pseudonyms for each participant, as well as changing gender and masking details of events as necessary to prevent identification of participants and units. I did capture specific unit location during the interviews but this was not used in the findings; location was identified as “medicine/medical” or “surgery/surgical”.

I discussed with the participants, at the time of obtaining consent, that by participating in the research they might re-surface their moral distress by talking about their experiences. I had a

plan in place should this have occurred. The plan involved providing the participants with the brochure and contact information for the employee assistance program offered through the hospitals. As well, I gave them the option to withdraw from the study if necessary. Although two participants experienced an emotional response, they did not require assistance and declined the offer.

As multiple REB approvals were required, there is variation in the duration of record retention. Therefore, all material, data, and information pertaining to this research will remain locked in a secure location, and all electronic files will remain encrypted and secure for five years from completion, which was the longest retention period required from the various approval bodies.

Chapter 4: Findings

In this chapter, I introduce the basic social process of *Just Getting Through the Shift*, together with the comprising categories, all of which emerged from the data. As well, I describe the concepts that make up each category, along with their relationships to each other and how the participants moved through the process of moral distress.

The basic social problem in this study was the experience of moral distress. It is important to understand that situations of moral distress were often directly related to larger organizational decisions and therefore, perceived to be beyond the immediate control of the participants. Throughout this chapter, I will provide examples of these larger systems issues, such as organizational and/or unit culture. For instance, the majority of participants' stories were examples of budget decreases resulting in the reorganization and reduction of resources, both human and physical, leadership not being viewed as supportive, or a singular focus on admission and discharge metrics.

As noted previously, the participants worked in a variety of medical and surgical settings, with one participant who was part of the full-time float pool and worked on both medical and surgical floors. With one exception, all of the situations leading to moral distress described by participants were patient care situations resulting from the current organizational direction. The one case that differed involved the devastating impact of a nurse experiencing a serious health crisis while on shift.

Grounded theory is understood as having a focus on process and trajectory and identifying a basic social process (Morse, 2001; Schreiber, 2001). The basic social problem that is the focus of this research is the experience of moral distress. In particular, my focus is to

understand the experience of moral distress from the perspective of nurses in acute care settings, and elucidate the process participants used to navigate it.

Moral distress, as discussed previously, is what arises from a situation whereby healthcare professionals find themselves in conflict between their own values and beliefs and the direction they are being asked to take by their organization, leaders, and in some cases, patients and families. Because of this, they are unable to make the choice or act in the manner that they would prefer (Canadian Nurses Association, 2008a; Erlen, 2001; Doane & Varcoe, 2013; Rodney, Kadyschuck, et al., 2013; Wilkinson, 1988). When nurses are facing these situations of moral distress, they embark on a journey to reconcile their personal and professional values with the outcomes of the morally distressing event, and attempt to resolve and mitigate any further negative outcomes. In the following sections I describe in detail the substantive theory of *Just Getting Through the Shift*, with the categories of Experiencing Moral Distress, Making Sense of the Situation, and Finding the Way.

Just Getting Through the Shift

In this section I introduce the basic social process of *Just Getting Through the Shift* and the comprising categories. I begin by providing an overview of the process. I then provide a detailed description of the major contextual influences on moral distress. It is important to understand these various contextual influences on the experience of moral distress, to understand the backdrop in which the experience of moral distress occurs. Finally, I describe how the process emerged and explain how the participants moved through this basic social process.

Basic social process. Participants navigate moral distress through the basic social process of *Just Getting Through the Shift* (Figure 1). It is the process by which the participants carried out their day-to-day practice. *Just Getting Through the Shift* is the core category that emerged

from the data as a consistent pattern of behavior described by the participants. It is comprised of the categories: Experiencing Moral Distress, Making Sense of the Situation, and Finding the Way, all of which are informed by the contextual influences on the experience of moral distress.

Just Getting Through the Shift is illustrated in Figure 1. The contextual influences on moral distress are represented in the outer ring. *Just Getting Through the Shift* occurred under the backdrop of these three influences: (a) Organizational Influences, (b) Patient and Family Influences, and (c) Unit Influences.

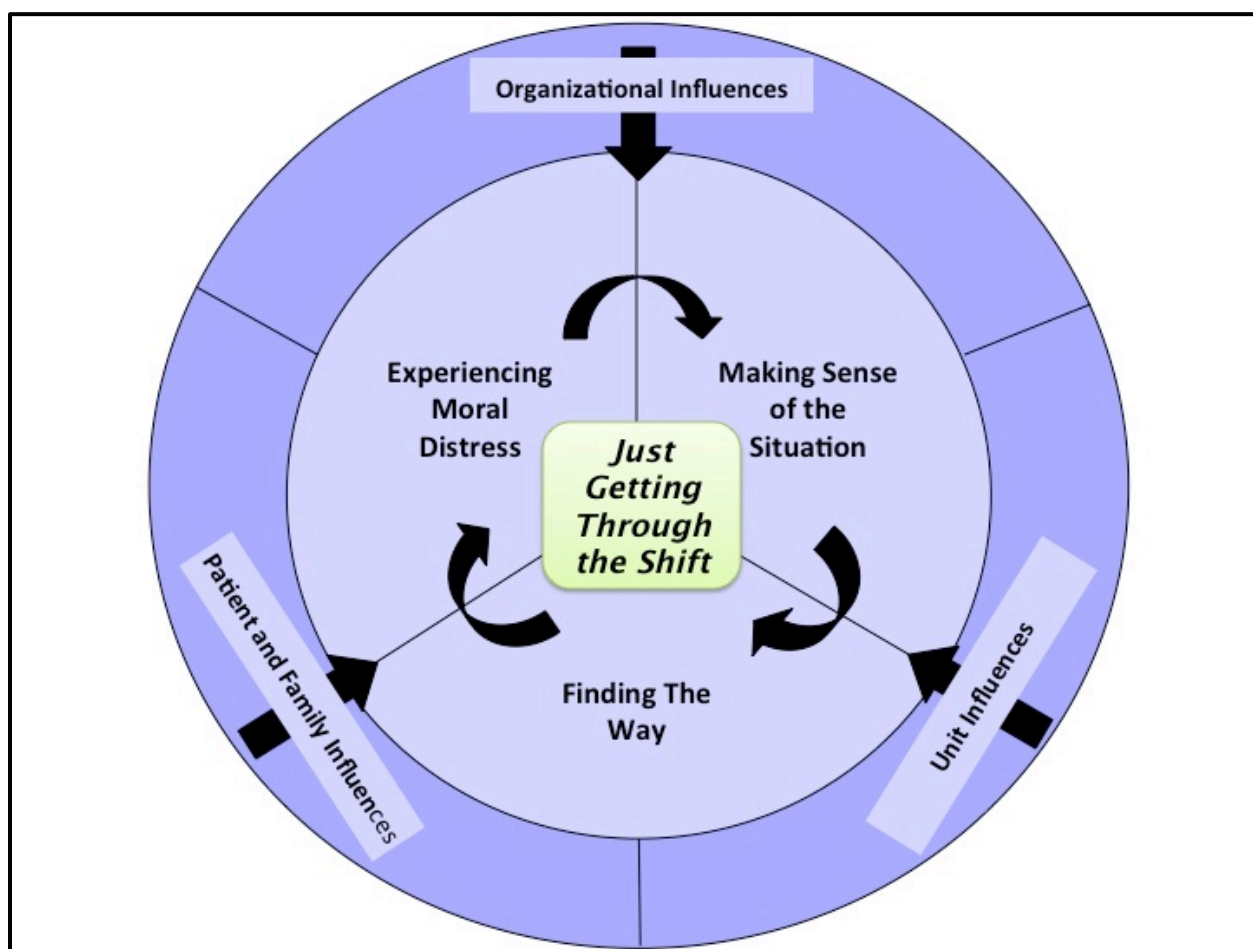


Figure 1 - Just Getting Through the Shift

Moving through the process. The process of *Just Getting Through the Shift* according to participants began with Experiencing Moral Distress. A morally distressing situation occurred,

and the nurses were left asking, “*What do I do now?*” To answer this question and address their moral distress, participants started a complex journey of exploration, Making Sense of the Situation, and eventually Finding the Way, the other categories of *Just Getting Through the Shift* (Figure 1). As the nurses moved through this process, it was noticeable that it was a dynamic and fluid process. During this process they were attempting not only to reconcile their professional and personal values within the context of the organizational climate, but also to remain focused on the needs of the patient and accomplish basic patient care tasks, such as medication administration, treatments, and ambulation, all within the best of their ability.

Amy articulated this internal struggle when she discussed how she did not feel she had enough time to complete all the tasks required for her patients, when trying to cope with the amount of work she had, and deciding what would be completed and what would not. When asked if she felt she could advocate for things to be different, she replied, “*There’s not enough time in the day to stand around and be angry about something when you know you can’t really change it. [Y]ou just have to go with the flow or else you’re the cog in the wheel*”. This example illustrates the difficult choices that nurses have to make every day when faced with scenarios where they are frustrated or uncomfortable with a situation but feel powerless to change it. Moreover, it exemplifies that nurses are faced with competing priorities on a regular basis: providing patient care in a timely manner, which includes making decisions as to what care/tasks are completed and what is not, and in some situations, making a choice to take time away from their busy shift to advocate for what they believe needs to be changed. These decisions impact how they carry out their daily practice and interactions, as well as how they reflect on ethical commitments to those for whom they are caring, in other words what the CNA defines as everyday ethics (CNA, 2008a).

Emerging theory. In this section I describe the emergence of the theory as well as how the participants moved through the basic social process. *Just Getting Through the Shift* emerged as the participants described their goal to get on with the day and get through the shift instead of dwelling on the external causative factors they either felt powerless against, or that would involve more time or effort than they could afford in the moment. This was not always a conscious or purposeful decision, nor did they always specifically articulate that this was their way of coping. Rather it emerged as the necessary action because there were “*other patients to care for*”; participants needed to “*keep focused and keep working*” and they “*just wanted to get home*”. The participants described elements, such as trying to remain patient-centred, focusing on providing the best care for the remainder of the day, trying to build trust and therapeutic relationships with the patient and/or family, and, arguably the most concerning, keeping the patient and nurses/themselves safe.

Furthermore, the participants’ experiences and descriptions of how they navigated moral distress revealed a degree of frustration and helplessness. They used phrases such as “*sink or swim*”, “*making it happen*”, “*needing [the shift] to be over*”, “*not having enough time or staff to get it all done*”, and it was from these statements and other examples they conveyed a sense of getting by that led me to identify the basic social process of *Just Getting Through the Shift*. The participants described incidents where their attempt to provide patient-centred care¹ was challenged by organizational and unit expectations that led to Experiencing Moral Distress.

For most of the participants, there was little possibility of an immediate solution. Resolution was not often achieved; rather, the participants described a resignation to their

¹ Patient centered care is defined as providing care that is holistic in its approach, whereby the health care provider is respectful, compassionate, and endeavors to work in collaboration with the patient and/or family to identify mutually agreed upon goals that reflect the patient’s personal values and beliefs (Registered Nurses Association of Ontario, 2015)

inability to change the situation from a larger systems perspective. Participants spoke of organizational level factors, such as budget influences and senior leadership mandates, against which they felt powerless. Participants described these system issues as forces beyond their control, often feeling defeated and powerless toward them. This inability to find resolution is well articulated by one of the participants, who had spent 14 years in various medical-surgical units:

I think coping with the actual nursing skills was more difficult in the earlier days, which makes sense. Now I find myself having trouble coping with the external factors mainly... So I find it more difficult to cope, not with the actual nursing tasks anymore, because those have become easier as time had gone on. It's just the politics. (Laurie)

Laurie described her evolving and deeper understanding of the multifaceted contributing factors that led to morally distressing situations. As her experience deepened, so did her appreciation for what she had control over.

To conclude, when the participants discussed the events that contributed to the experience of moral distress, they also articulated the need of *Just Getting Through the Shift*. The nurses described this concept in a variety of ways such as “*just keep moving*”, “*go with the flow*”, and “*making it happen*”, all of which they presented in the context of continuing to deliver patient care and completing work that needed to be done, with the subsequent tasks of putting the moral distress aside. Essentially, the participants compartmentalized the experience. They found it necessary to avoid the experience if they were to continue to concentrate on their patients. Cathy articulated this need to compartmentalize her experience when she explained “*You have to put on the face the whole day.*” Cathy further shared “*It's stressful. I feel stressed but I – I do*

try to keep going because I don't have any choice either. No one's going to cover me if I don't do my stuff."

The participants were consistently focused on ensuring that their patients remained safe, that they themselves remained safe, and that they continued to provide as much care as possible, despite the challenges they were facing. Most often the participants cited the primary reason for needing to continue to focus on the remaining patient work and daily tasks was because of the "other patients" they were still assigned to, and the work that would pile up.

Contextual Influences on Moral Distress

As mentioned previously, the situations that precipitated the moral distress were often associated with larger systems influences. Specifically, these situations were the downstream impact of Health Care Funding Reforms and the resulting restructuring of budgets and roles, a concentrated attention on patient access and flow, as well as a perception of prioritizing invasive medical techniques over quality of life. As a result of circumstances such as these, the participants described situations where they felt they were unable to do the right thing, or were fearful to do the right thing, when decisions were being made about the direction of patient care. In Amy's view "*you have a voice but the ultimate decision isn't up to me...I don't feel supported. I feel that there's pressure on the managers and coordinators from higher ups and things are out [of our] control*".

Experiencing moral distress is caused by three different types of influences: (a) organizational level influences, (b) unit level influences, and (c) patient care and family influences (Figure 2). Participants identified numerous combinations of these subcategories within their descriptions of the events, with occasional overlapping in root causes. It is these issues that create and give rise to situations of moral distress. It is important to note that these

contextual influences are at times morally distressing, but also, there are situations where the issue or situation is not unethical, but led to a morally distressing outcome, and therefore, were viewed as morally distressing. For example, the death of a patient is distressing but not always morally distressing. However, if the patient is placed on a unit that is not able to provide specialized care due to a lack of knowledge, certification or resources, and the patient passes, the nurses may feel moral distress. This moral distress is related to lack of ability to transfer the patient to a specialty floor or to provide the best care for the patient at the end of life. Thus, the contextual influence of patient access and flow policies, leadership support, and the lack of resources all contribute to the moral distress.

Organizational level influences. Organizational level influences are external constraints that, despite being distant from the bedside, have a significant impact on how nurses carry out their work. Organizational influences consist of senior leadership decisions, as well as the board of directors, the mission, vision, and values of an organization. As well, these influences can also include the metrics and targets set by the government that the organization is mandated to meet. The organizational level influence that was the single most referenced was the organization's primary focus on patient access and flow. Participants described the pressure to clear wait lists, which entailed either rushing discharges, or transferring a "*stable patient*" to an off-service floor to make room for sicker or more acute patients. In Cathy's words, "*It's business and this person – this person, they're just...in for their service and they're back out. Get them out as fast as you can. They [senior leaders] don't really care about anything else*". With hospitals being scrutinized for meeting Ministry-mandated surgical wait time targets, and decreasing bottlenecks for admissions, there is a focused attention on admission and discharge metrics, all of which are reported to the MOHLTC.

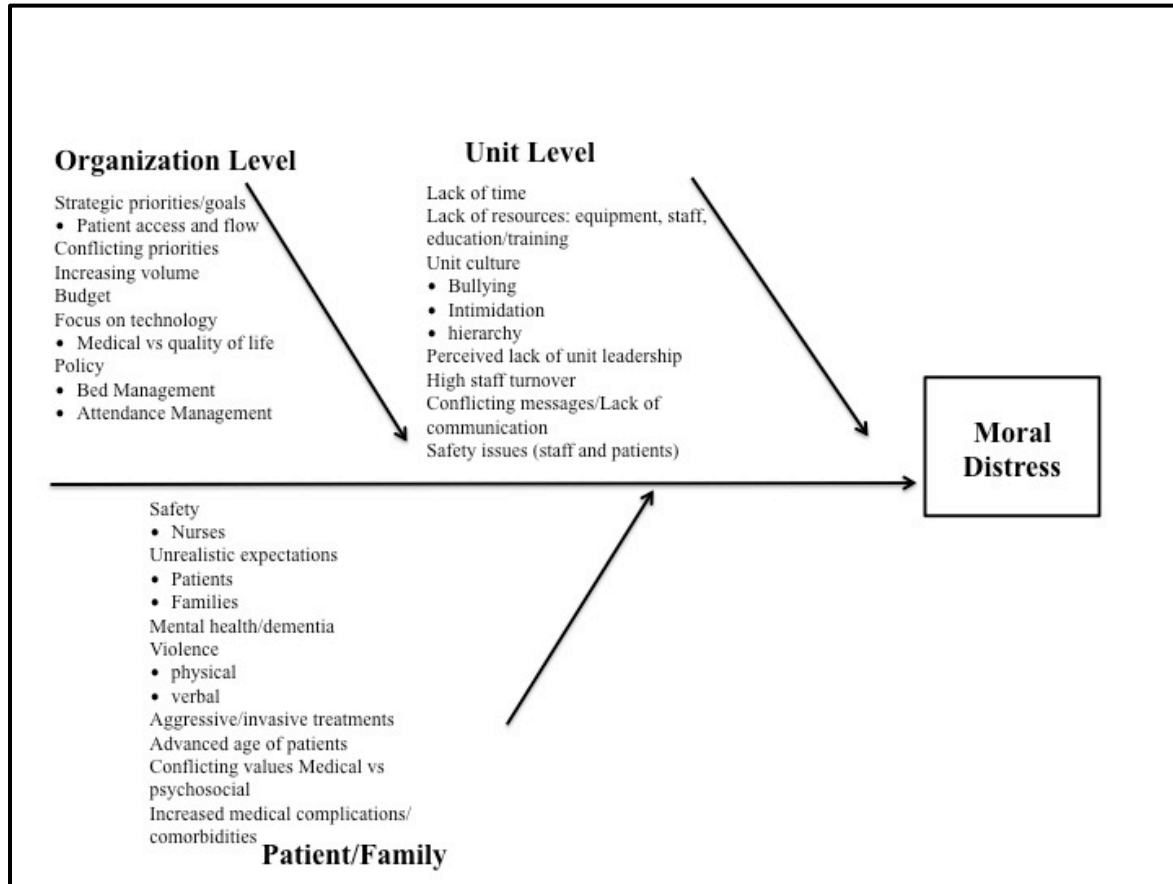


Figure 2 Contextual Influences on Moral Distress

An additional organizational level influence was budget constraints. As an illustration, participants shared examples of point-of-care staffing levels being decreased by one full-time equivalent; the evening eight hour shift being removed; nurse-to-patient ratios increasing from 4:1 to 6:1; and support services, such as unit clerks and housekeeping staff, being cut. This was accompanied by new departmental policies outlining replacement strategies, including that sick calls would not be replaced. As Cathy explained “[t]hey’ve done all this restructuring on all the roles outside of nursing to save money, but I find it’s just really affected nursing really because we’re the only ones who can’t say it’s not our job”. Cathy raised an important point because she highlighted the downstream affect of “off loading” work onto nurses in the wake of

restructuring and roles being made redundant. As support roles, such as weekend unit clerks, housekeeping, charge nurse/resource roles, or clinical educators decline, the work must be absorbed by those remaining, and in most cases that work falls to the point of care nursing staff. Nurses believe they cannot refuse this work because it has direct impact on patient care and therefore, must be completed.

When the participants were exploring these situations of moral distress, they frequently referenced the feeling of conflicting messages or priorities between what the stated mission, vision, and values of the organization were, and what was reflected in the actions taken by leadership at all levels. To take a case in point, participants described their concern with patient safety as it related to the decrease in staffing, supports, and patient access and flow, and how that was in direct conflict to the mandate of patient safety. As articulated by Amy:

[I]s it really in their best interests to be moved? For the hospital and for the flow, yes, for the new patients coming in, but for the patients that we've invested time in and...healed and now we're ready to say here's your wings and you get to go home...it always gives me [an] awful feeling when I have to go in and tell somebody.

The situations involving premature discharges or early transfers caused the nurses to question if those actions were truly reflective of an organization that claims to value patient-centred care.

The organizational management philosophy was identified throughout the interviews as a contributing influence on experiences of moral distress. Participants often spoke of the impact of this philosophy as not only being a root cause of the moral distress, but also the impact on the ability to navigate the distress. Participants identified that the current leadership structure within the organization involved the rotation of frontline leaders on a frequent basis through various units, intended to provide a breadth of experience in different programs to enhance leadership

development. Participants perceived that, in some cases, leaders were not invested in the staff or unit, because they knew their time there was limited. Participants identified that the downstream effect of this model was that leaders can be rotated as often as every 18 months. Laurie spoke directly about the leadership model and challenges it created in terms of continuity and feeling a connection to the leader:

It's been really frustrating because we had a coordinator for a long time and then we've had two within a very short period of time...it hasn't led to much continuity or the feeling that there's approachability because you don't have a relationship with the person because they're only there for such a short period of time.

Accordingly, the leaders do not stay long enough to get to know the unit, the staff, and the culture. Participants stated that they felt disconnected to their leaders and that they did not have a strong, established relationship with them due to the high leader turnover.

The effect of organizational decisions can have a serious and lasting impact on nurses. The downstream effect of senior leaders focusing on access and flow, and making decisions with a budget-first perspective, both of which have the outcome of appearing to contradict the stated values of patient-centred care, is that nurses are experiencing an increase in moral distress, and navigating everyday ethics multiple times a shift.

Unit level influences. The experiences of moral distress shared by the participants not only exposed the organizational level influences, but also the unit level influences. It could be argued that these two are intricately connected because unit level leadership is acting upon senior leadership and organizational directives. However, the way in which the unit level leadership responds to the situations should be negotiable; that is to say, frontline leaders should have the ability to adjust their responses to ethical situations on the unit to achieve the best outcome for

the patient and staff, and not always default to the organizational mandates. It appeared that the leaders were not always empowered to work with the staff, but rather were under pressure from the senior leadership. Participants described being fearful of leaders, being unable to speak up, or speaking up and not being heard. This common thread was illustrated throughout the various situations where the participants viewed leaders as not approachable because they were fearful of being dismissed, or being viewed as obstructive/disruptive, and in some situations, being blamed for negative patient outcomes.

In addition, there are unit level influences that were more than just leadership, but linked to leadership such as unit structure, nursing workflow, availability of resources, and unit culture. In these examples, unit structure refers to the model of care delivery, the number of nurses, allied health, clinical educators, and support roles such as unregulated care providers and unit clerks. Nursing workflow denotes the way in which nurses complete their work, the steps they take to complete tasks. The availability of resources refers to both human resources, such as allied health, housekeeping, and educators, but also equipment and supplies. Unit culture in this case refers to the social norms and hierarchy that nurses follow. I go into greater detail about these influences of unit culture throughout this paper.

The most significant unit level influence repeated throughout the interviews was that of the perceived lack of leadership support. Participants described this lack of leadership as leaders not being present or accessible, and in some situations, participants described leaders not being helpful when approached. As Cathy explained “*They [the leaders] don’t really care...they want to go on to the next thing. So they’re going to come in and do their job 8:00 am to 4:00 pm, do the tasks and get out*”. Furthermore, participants reported that they believed that leaders would not, or could not, advocate for nurses and patients. Participants interpreted this as a result of both

the current leadership structure along with poor leadership styles. As an example, Cathy expressed how leadership styles have become “*very authoritative and very business like and not [very] humane*”.

As discussed previously, the management philosophy of rotating leaders to enhance their leadership development has contributed to this perception of a lack of leadership. Laurie and others described feeling there was not a sense of approachability to the leaders because they transition to another area or move up to a more senior position so quickly. Other examples included participants discussing leaders not being able to follow through with quality improvement because they transition off the unit before the work is complete.

Participants reported that poor leadership support, regardless of the reason, not only contributed to the experience of moral distress, but also prevented resolution. Poor support was often illustrated by examples of leaders not being accessible or available to staff, leaders downplaying or not acknowledging the issues, or refusing to assist staff in reaching a solution.

In addition to a perceived disconnection with their leaders, nurses in this study at times were fearful of their leaders. Participants expressed feeling hesitant to approach their leaders out of fear of potential negative recourse, for being labeled as a troublemaker. One participant described being fearful of reaching out to the leader with her concerns about the rate of patient turnover, the increasing acuity, and feeling unprepared to care for the patients, fearing reprisal: “*I’m always a little concerned and I just don’t want to go on the bad list. Like the black list*” (Chris).

The experience of bullying within a unit is often described as horizontal violence because it is usually referring to conflict between peers. However, bullying can also occur between staff and leaders, and can contribute to the toxic unit culture. The experience of nurses being bullied

by their leaders, however subtle or overt it may be, is a contributing factor within the experience of moral distress from the perspective of unit influences. When faced with leaders who bully, nurses can be placed in situations where they are unable to enact their moral agency due to being afraid to speak up, or being dismissed and prevented by their leader from acting morally.

Furthermore, a leader's behaviour contributes to the unit culture and climate, creating the social norms for how the unit functions. In such situations, nurses are not able to practice in a moral climate where they feel their values, and voices are heard. (Storch, 2013).

The other significant component of unit level influences on moral distress is the effect of the unit culture. Unit culture refers to the beliefs, values, meanings and social norms of the nurses, physicians and leadership (Malloy et al., 2009). The unit culture is reflected in unwritten rules of how staff interacts with peers, and what is the "collective perception of what is ethically acceptable" (Malloy et al., 2009). It is this culture that influences how nurses are able to find support and guidance in navigating moral distress, as well as contributing in some situations, to the experience itself. Nurses spoke of how the unit culture contributed, not only to the experience of moral distress and the ability to resolve the situation, but in some situations also compounded the experience because nurses felt alone and isolated. This notion of being isolated on a unit is reflected in Reese's experience:

I don't have much say. There's not a lot of people sitting here that can, like, kind of be on my side and can feel kind of the as [I do] ...in that sense, not feeling a part of the majority....I kind of felt helpless.

A morally distressing event was compounded for Reese by the contributing influence of the unit culture. In other words, not only was the situation itself, and the way the nurse did not provide

care for the patient, morally distressing for Reese, but the inability to find support from his colleagues and being openly viewed as an outsider were also morally distressing.

Reese's example leads to another important aspect of unit culture, that of poor collegial relationships. It is important to understand that at times participants felt fearful towards their co-workers and the impact on day-to-day unit culture. For instance, Wendy shared a scenario where, as a newer graduate and new to the unit, she was working with senior staff, when her patient passed away. Wendy was told by her senior team member to get the body to the morgue as soon as possible because the bed was needed. She resisted because she wanted to notify the family and give them time to come to the hospital and say their goodbyes. Her colleague became angry with her and told her to do her job and get "*the body off the floor*". She proceeded to start to prepare the patient to be transferred to the morgue. She stated while doing this "*[she] felt it was wrong*" and enlisted the support of another nurse to assist her to push back and do what she believed was right. An argument ensued between the nurses, and eventually Wendy was able to notify family members and give them time with the patient. The residual effect was that she received the "*silent treatment*" from the nurse she challenged and he continued to treat her dismissively for a few months. Her perception was "*He wasn't so happy with me. Like I said, I was still pretty new so he probably thought I was, like, over stepping him.*" These examples illustrate the challenges that nurses can experience with their own peers, in particular how senior staff treated junior staff led to situations where participants felt that they were unable to carry out their practice in ways that reflected their own personal ethics and nursing values.

Unit culture can be attributed to the broader organizational culture because it directly affects decisions that are made at the unit level, the leadership model, and individual leadership styles, all of which influence the social norms of a unit. As an example, it is an often-referred to

phenomenon of nurses eating their young; recent graduates often experienced lateral bullying in the workplace, at the hands of senior nurses, that led to toxic unit cultures, and perpetuated a normalizing of bullying. Further examples were the challenges between disciplines and the disrespect and mistrust that was expressed between and among allied health, nursing, and physicians, which impacted the ability to work as a high functioning, cohesive team.

As discussed beforehand, the organizational climate and the subsequent unit environment generate the behavioral norms for how the unit functions, and socializes the nurses to act in accordance to their environment (Lütznén & Kvist, 2012). The combination of unit culture, a lack of leadership support, and organizational pressures contributed to the helplessness that participants felt when they knew what the correct action was, but out of fear of repercussions by others and further alienation, chose not to act.

Patient care and family influences. The final contextual influence of moral distress is the patient experience, as understood from the nurses' perspective and as reported to the nurses by the patient and/or family. Examples of morally distressing situations related to patient and family care were ones that involved direct patient care that staff did not always feel comfortable with, decisions made by the physician team, or in some cases, the behavior of the family. Nursing values and ethical responsibilities, as outlined by the CNA, include providing safe, compassionate care, respecting informed decision making, preserving dignity, and promoting justice (CNA, 2008a). According to participants, there were times when these values were challenged by the health care system and by the decisions made regarding treatment plans. All of the participants detailed the increasing acuity of the patients, and the increasing level of invasive and aggressive procedures that were being performed. Some discussed that patients and families were not always prepared for the outcomes and the intensity of the recovery that was

required. What is at the core of this contextual influence is the tension that arises between patients/family and the nurses when there are differing opinions as to what constitutes safe, compassionate and ethical care. The undercurrent in the participant's examples highlighted the issue of informed consent. In particular, there is no clarity about the role of the nurse in ensuring that the decisions being made, regarding the direction of care, are informed, as well as, who and what decides is informed consent.

Participants reported that patients, families, and physicians often held unrealistic expectations of the treatment outcomes and nurses' roles. Consider the reflection provided by Cathy, where she articulated the challenges that nurses were facing with an increase in access to healthcare information:

I don't know many other work places where someone can walk into an office and watch everything you do. "Are you sure you're going to do that? Put this there first..." I'm supposed to be the expert in their care with them...you're defending your actions all the time.

The situation described by Cathy is an illustration of an increasingly common challenge that nurses are facing as patients and families are coming into hospital with information they have researched themselves regarding their diseases and treatment. This increase in health literacy can be positive, however, the challenge is that patients and families are not always accessing up-to-date, or for that matter, correct information.

The participants described patients and families being unprepared or unaware of the recovery needs and potential complications, and at times patients and families stated they had not understood what they consented too. As a result, the nurses questioned how informed the consent was, based on the responses of the patients and families post-operatively. The participants asked

these questions to the team when they felt confident in approaching them, and when they were not confident, they discussed amongst their peers. Amy described a situation with a patient who had end stage metastatic prostate cancer and how the physician team would not discuss with the family that he was dying, “*He was bleeding... basically almost in a coma... He was so close [to death] but the doctors just wouldn't ...meet with her [Daughter] We didn't say the D word. Like he's dying*”. Amy went on to say that the daughter insisted on blood transfusions and the doctors agreed, despite the fact the patient was bleeding unstopably. “*One of the doctors walked by and he laughed... 'You know you're hanging blood on a dead person'*”. Amy had to step in to talk and spend time with the daughter, because the daughter had not understood what the extent of the situation was. What the participants have described is that the overall patient and family influence on the experience of moral distress is a combination of having a lack of information, and/or having inaccurate information.

In conclusion, the multitude of influences that are affecting nurses' ability to provide safe, holistic, and ethical care can be obvious or subtle, but regardless, they are complex and most often interconnected. The examples that the participants provided had elements of organizational influences, such as policy, and budget; unit level influences, such as frontline leadership or unit culture; and finally patient and family influences regarding care decisions, all of which can be seen in context of the others. Due to these complex relationships, nurses felt helpless at times to act in accordance with their personal and professional values, and were often in a position where the solution was to focus on *Just Getting Through the Shift*.

Experiencing Moral Distress

Experiencing moral distress is the initial step in the basic social process of *Just Getting Through the Shift*. (See Figure 1) *Experiencing Moral Distress* is comprised of two

subcategories: *Being Blindsided*, and *Naming*. *Being Blindsided* is the experience and feeling of being caught off guard by the event. *Naming* is the process that the participants undertook to label the experience as distressing.

It is necessary to explore the participant's experiences of moral distress and their contextual influences in order to understand how the nurses in this study navigated moral distress. The CNA states moral distress "*...arises in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm*" (2008a, p. 6). It is this definition of moral distress that echoed throughout all of the participants' interviews as exemplified by stories of not being able to speak up to leaders and physicians, or feeling powerless against the pressures of patient access and flow. Throughout this research, participants described situations where they felt unable to enact their moral agency due to organization and unit influences along with patient and family influences.

It is important to keep the contextual influences in mind throughout the experiences of moral distress. The effect of external constraints far outweighed the effects of internal constraints for all of the participants in this study. With the shift in priorities within the Canadian healthcare system, to achieve measureable and reportable metrics and adopt industry standards and processes, nurses have had to broaden their understanding of their clinical environment to include these external influences. The experience of moral distress was almost always triggered by an organizational decision or an outcome from a decision that contributed to the nurses experiencing a morally distressing situation. The contextual influences of organizational decisions, unit culture, and patient and family influences shaped not only the experiences of

moral distress, but also how the participants enacted the basic social process of *Just Getting Through The Shift*

An emotional example of moral distress was provided by Chris, who shared a story of a young patient, who was actively dying, and was admitted to a temporary medical floor known as a holding unit². In this example, the patient came into the emergency department (ED) alone and was quickly sent to the holding unit, and because the emergency room leadership wanted to avoid the patient dying in the ED, had her placed in the first available bed. This patient was also dying alone and had no family member present with her. To complicate matters, this patient was still considered an active patient in her specialty service and had not been transferred to palliative care. As a result, her care needs were complex and specialized, and the unit was not equipped to provide the level of invasive and intense care, or appropriate palliative care, both from a human resource and equipment perspective. Furthermore, there was no support available from leaders or the specialty unit to assist the staff in providing safe care. The unit functioned with a bare minimum of staff and resources because the goal was not to provide care longer than a few hours. *“I was just so scared and I kept thinking, like, what should I do?... I still sometimes think that I don’t know what help I could have got at the time”* (Chris).

Chris’s experience of moral distress demonstrates the downstream impact of organizational decisions, such as how to manage ED patient access and flow, and unit level influences, such as a lack of leadership and resources. The combination of not being trained in a particular specialty care and not having the resources, in terms of adequate staffing plus appropriate patient care equipment, created a morally distressing situation. Moreover, this

² A holding unit is used by the organization to alleviate the backlog in the emergency department. It is used for short term holding when patients are admitted from the emergency department and are waiting for a bed on the specialty service. This unit will hold a patient for a few hours to assist in the flow of patients in the emergency room and attempt to prevent the bottleneck in admissions.

example demonstrates how nurses are caught off guard by morally distressing situations, and the lack of support demonstrated by the leadership.

Being blindsided. *Being Blindsided* is the first sub-process of *Experiencing Moral Distress*, and is the feeling that participants experienced of being unprepared, caught off guard, and/or not knowing what to do in response to a morally distressing experience. *Being blindsided* emerged as a shared response to the experience of moral distress by all of the participants, and they spoke of being caught unprepared to either manage or make sense of the situation at hand. All participants described their next step after experiencing a morally distressing situation as asking, “*What do I do now?*” The question occurred regardless of the underlying cause of the event, whether the situation was concerning an organizational directive, an episode of aggression towards the nurse, a lack of leadership, or an unexpected and devastating patient death. All of the situations presented left the nurses asking what they needed to do next to address the immediate situation, to prevent an adverse event, as well as to continue on with their shift and provide quality care.

Wendy exemplified being blindsided when describing the experience of an unexpected and questionable discharge that she was unable to prevent: “*You go through a situation like this and the patient has left and you’re not feeling great about that decision and it’s kind of sitting with you, what do you do?*” By asking this question, participants shared in the common experience of not being prepared to cope with the moral distress. This questioning of “*what do you do?*” or “*what just happened?*” speaks to the disconcerting nature of moral distress. Being blindsided appeared to be the necessary trigger for nurses to begin the intuitive process of reflecting on the situation and exploring why they were caught off guard. By acknowledging being blindsided, the participants began the complex and dynamic journey of identifying the

situation as distressing, and determining how to get through the shift. It is this query that allowed the nurses to engage in the initial stages of problem solving by focusing on particular components of the situation and starting to confront the compounding influences. The experience of being caught unaware and not having confidence in one's own abilities was unsettling and further contributed to the emotional stress experienced during these situations. The participants were consistently surprised by the contradiction between what participants believed should have happened, and what actually occurred. It is important to note that not only were they blindsided by the event, but also that they were unable to act according to their professional and personal values and therefore, they were not able to enact their moral agency.

Some participants were placed in situations where patient or staff safety was put at risk. Decisions that are made under the premise of the patient's best interest, but in actual fact were sometimes creating tremendous risk, led to the participants not only being blindsided, but also experiencing an added level of stress with the introduction of fear. For example Morgan, a float pool nurse who was newly floating to the unit was instructed by coworkers to withhold information from the abusive partner of a patient. During an interaction, the partner became verbally aggressive towards the participant. The participant was unsure as to why the information was being withheld, and faced the additional challenge of not being familiar with the history of the patient and the current safety plan in place on the unit. This information was not found on the care plan, or in the chart. The nurses familiar with the patient were not forthcoming with details or documentation; rather they dictated to Morgan what was to be done. Morgan described being unprepared and lacking confidence to navigate the situation, as well as not experiencing a supportive team of colleagues, *"I wasn't sure what to do, so I was trying to do the right thing, but at the same time, like I don't know exactly what was needing to be done...what*

do I do?” In other words, Morgan, as a new member floating to the unit, was placed in a highly emotional and volatile situation without any background or preparation, and therefore, was caught off guard, not only by being asked to withhold information without any explanation or documentation, but also by not being supported by the other nurses.

This participant described being unsure about lying to a family member, and did not have information available on the chart as to what was in place regarding power of attorney/substitute decision maker status, and privacy agreements for this particular. This situation is an example of the nurse being blindsided by the interaction with the patient and family, and also by not being provided the information and supported by peers. Fear was also a contributing factor in this situation; the nurse was worried about both the safety of the patient, and the safety of the staff due to the aggressive behavior of the partner. Furthermore, the nurse was fearful of repercussions if the actions taken violated organizational policy. The fear that is experienced during morally distressing events can be multifactorial, in that it is not only about immediate safety for the outcomes of those involved, but also about larger ramifications to practice.

The experience of being blindsided and the fear that accompanies this feeling, similarly extended to unsafe patient situations and potential negative patient outcomes, not knowing what is their perceived role or responsibility for any adverse outcomes, or, at the very least, not being able to care for a patient competently. Participants described a sense of fear of negative patient outcomes because they were caught off guard and unprepared for the situations.

As described previously, Chris was blindsided by the admission to the holding unit of the dying patient. She was left asking, “*what do I do now?*” Chris was dismayed and surprised that there was no discussion between the unit staff and admitting as to the suitability of the admission, and there was no assistance from leadership despite her efforts. Chris felt alone and

unprepared to care for the patient properly, which led to Chris' experience of moral distress. The participant was faced with not knowing how to care for the patient and questioning the appropriateness of the admission, yet not being able to say "no" to the admission. To put it another way, Chris was unable to act according to her personal and professional values.

Moreover, the unit was experiencing high patient turnover, with patients being admitted with conditions the nurses did not have the knowledge and skill set to care for. Chris was facing multiple challenges in resource allocation because of not having a full complement of support staff, allied health, and equipment. In addition she needed to manage competing patient needs, and competing priorities, such as the need to provide comprehensive care versus acting as a temporary holding unit with a focus on admitting and transferring patients. The resolution for Chris was to rely on her peers to assist where they could, and to focus her attention on the dying patient, with the acknowledged risk of delaying care for the other patients.

A contributing factor to being blindsided was the perceived lack of leadership support. Being blindsided was not only related to the experience of having an off-service patient placed on the floor, but also discovering that there was no one to turn to help advocate for a solution. Participants discussed feelings of being alone, and the realization that there was no one to support them, in particular their leadership and/or the physician group, and they made statements such as "*having to carry the burden alone*" and "*making the decision on my own*". The nurses found this sense of isolation was often surprising because it was in stark contrast to being part of the patient care team/unit and working for an organization that claimed it promotes patient-centred care and a healthy work environment.

Accordingly, the next step after being blindsided was to start by asking what happened and why. This next stage of the process involved exploring the factors that led to the event

occurring, and how to manage the outcomes as best as he or she can. When faced with the question, “*What do I do now?*” the participants started the dynamic process of navigating moral distress. After being blindsided, participants started to enact their agency by initially naming the event in order to make sense of the moral distress.

Naming. *Naming* is the other sub-process of experiencing moral distress and is the process of identifying and labeling the situation as morally distressing. *Naming* is comprised of applying a label to the event, both in the immediate and long term. Participants identified and labeled a situation as being wrong or distressing, and upon further reflection named the event as *morally* distressing. It is important to note that all of the situations identified throughout the previous section, were in fact identified as morally distressing by the participants at the onset of their interviews, although in the moment they may not have identified the experience as morally distressing because they needed to reflect further. Furthermore, naming also included acknowledging the emotional and/or physical responses to the situation. *Naming* occurred as a natural extension of *Being Blindsided*. Most often the question “*What just happened?*” was closely followed by a recognition of the feelings that accompanied the experience. In classifying what had occurred, and paying attention to their own responses, nurses were able to *Name* the situation using the feelings they had. For instance the words most frequently used by the participants to describe what they were experiencing were distressing, upsetting, unsettling, and frustrating. For example, one participant stated “*I just felt so distraught...I just, it felt, it hurt me*” (Reese). It is this action of naming the event that allowed the nurse to identify that what has occurred caused moral distress, and to start to examine potential contributory factors, thus, beginning the journey of navigating moral distress.

An important component of naming is the process of reflecting on personal, emotional, and physical responses to the event. By focusing attention on these feelings and responses, participants were able to identify those situations where they were feeling unable to act in accordance with personal or professional values. For some, they were able to name the experience as moral distress, whereas for others, they may not have applied the label of moral distress, but yet they described the experience of moral distress by my assessment in relation to the CNA definition of moral distress.

It was this acknowledgement by the nurses, and their subsequent reflection on how they responded, that assisted the process of naming the moral distress. Participants indicated that they experienced a varying array of emotional and physical responses to their experiences. Participants talked about feeling that something was wrong, whether it was a subtle gnawing, a feeling in their gut, or an obvious conflict in values; they knew that what was happening was wrong on some level. In some of the examples the participants shared, it was the subtle shift in practice on the unit that evolved over time that left them feeling that a situation was wrong; the new normal had settled in and created continually morally distressing situations.

Responses ranged from feeling tremendous pressure, being overwhelmed and overburdened, to anxiety, shock, and feeling hurt. Moreover, this often included physical responses such as crying, shaking, and sleeplessness. For example, Amy shared her experience with discharging and/or transferring patients off the unit too soon, and stated, *“You don’t get to see the process through. I think that’s what gnaws at me”*. For her, the ongoing practice to rush the discharge of these patients was in stark contrast to what she believed was best for the patients. This realization over time, that this practice had subtly changed and become the new norm, occurred without anyone really noticing and having the opportunity to fight against it, and

now “*it is too late*” to push back. Amy expressed “*feeling guilty*” and always worrying about the safety of patients when they were discharged home or sent to another floor where they might not get the care they required. Other participants shared similar stories, and spoke about the lack of closure with these patients, adding to their own distress, because they believed they contributed to a potentially unsafe situation, or let the patient down.

In other situations, the feelings were more evident and the recognition of something being wrong was immediate. Participants shared experiences where they described feeling instantly unsettled. In these situations, participants described feeling distraught, afraid, or anxious; participants had a direct response to the situation in the moment. For example, Eric described the sensation as being “*at loose ends*”, and went on to say, “*I was really out of my element...that was just a very strange place to be in*”. The circumstance leading to this experience for Eric was directly related to an unsafe working environment, along with a lack of leadership support. This particular unit was staffed with only two registered staff on nights, and in the middle of the night his co-worker started to suffer a serious health crisis. Due to current staffing levels, there was no relief staff able to assist him; the on-call operational leader was new and unsure how to assist and directed him to the regular leader for the unit, who was not responsive to his call. Eric was left to care not only for the patients on the unit, but also trying to care for his co-worker without support. It could be debated that the events that led to a response such as this were easier for nurses to identify as morally distressing. However, these situations were often more crisis-like in nature, and therefore, the focus was on immediate tasks and survival. This meant the nurse did not have time to reflect until the crisis was over. This could be minutes to hours later, and in some situations even longer, depending on the circumstances of the event.

Participants also provided examples of situations where they experienced a physical response to a morally distressing event. Participants described feeling sick, shaking, crying, and having nightmares. These physical responses occurred both as an immediate response, and in some scenarios occurred hours to days to months after the event. What was important was that the ability of the nurse to make the connection between the physical response and how the circumstances of the situations contributed to the identification of moral distress. In her interview, Amanda explained:

I'm shaking. Like I can't even – like it was bothering me even though I was so used to it. I worked so long that day. I couldn't believe it. I was like – my arm was shaking and I'm like okay. Like I – I got to go – like it's getting ...I feel like there's a pressure building up in me.

Reflected in this narrative is the complex and debilitating impact of moral distress. Amanda provided an emotional description of being in a stressful situation with a very confused patient for whom the staff was struggling to care for. When she stepped in to provide assistance, she had a physical response to having to restrain the patient chemically and physically in order provide care. Amanda had discussed earlier in her interview how she struggled with having to restrain patients in situations where staff were attempting to manage confused and aggressive patients, and in her perspective, the patients were not being managed in a comprehensive way by the physician team. In addition the reliance of the physician team to default to practices, such as chemical and physical restraints, were in direct conflict to her personal values and what she believed as her nursing ethics of not harming a patient. She discussed having to “*remove herself*” from the patient and “*see them as not a person anymore*” in order to carry out some of

the care and interventions orders by the team. In this example, all of the efforts to compartmentalize and ignore the moral distress had not been successful.

Chris had a similar experience when attempting to provide adequate care for a dying patient whose care requirements were beyond the expertise of the nurses and the unit (see details previously discussed):

I would just come out crying so bad that other families, other patients' families would ask, like what happened...I was crying so hard and at the end, what happened, the patient ended up dying...I had to go away and I cried and then I came back. Other nurses took over.

Chris's story further illustrates the serious and negative impact of experiencing moral distress. In caring for the patient to the best of her ability in the moment, she had to put the care needs of her other patients onto her coworkers, and continue to advocate having the patient transferred to the specialty unit. She knew the patient was dying and did not want her dying alone, yet she knew she was not meeting the needs of her other patients, and putting her coworkers in a difficult position with an increased patient care assignment. This happened while she was not receiving support from leadership to expedite the transfer or provide additional resources.

Participants reported that the overwhelming emotional responses caused by these experiences required them to step away, and to collect themselves before they went back to providing care. The environments in which these events occurred were not structured to provide nurses with the opportunity to address the emotional responses. Participants stated they got a few moments to settle and then immediately returned to providing care for other patients. Therefore, contributing to the fact that the nurses were feeling disempowered to advocate for patients and for changes to the system.

This combination of being placed in an ethically challenging situation, being denied the opportunity to address the emotional response, and having to remaining focused on the tasks at hand contributed to the nurses' distress and could lead to moral residue (Rodney, Kadyschuk, et al., 2013). Moral residue, as defined by Webster and Bayliss (2000) and the CNA (2008), as the lasting impact nurses experience when they have been compromised in their values, and is carried with them as they move forward. Other participants discussed this issue, and often talked about "*taking it home*" with them. Cathy explained how she "*put on the face...I used to – I cried sometimes when I drove home - until I got home*". Others talked about having sleepless nights and nightmares. Chris became emotional when sharing her experiences, "*I have had times when I can't eat after I come home. I have had times when I am going back the next morning and I still can't sleep at home*". The lasting emotional effect of these experiences was evident throughout these stories, contributing to the moral residue the nurses were grappling with.

Once the participants had named the experience, they were able to situate both themselves and their practice within the context of the clinical environment and the aspects leading to these unethical situations, thus, framing the situation, which may happen concurrently for some nurses. The examples of moral distress provided by the participants illustrated the impacts of multiple institutional influences, including budget reductions as a result of funding changes, strategies to reducing inefficiencies in workflow, and a focus on patient access and flow, all of which impact the everyday ethics of nurses where they feel they are "*not able to preserve all interests and values at stake*" (Kälvemark, Höglund, Hansson, Westerholm & Arnetz, 2004, p.1083), likewise, as the CNA describes "when values and commitments are compromised in this way, nurses' identity and integrity as moral agents are affected and they feel moral distress" (CNA, 2008, p. 6). In other words, the participants could perceive what was

within their span of control related to their own values and their own practice, what was beyond their control, and where the influences on the situation were derived from. When the event was framed within a specific context, it informed the nurse as to how he or she might problem solve the immediate situation. On the other hand, it exposed that the problem, and subsequently the solution, were beyond the current situation, thus, the focus became getting through the shift.

Making Sense of the Situation

An important element of *Just Getting Through the Shift* is for the nurse to make sense of what has transpired to cause moral distress. The category *Making Sense of the Situation* is the process that the participants engaged in to understand fully the situation. Furthermore, when nurses engaged in the process to make sense of the situation, this provided them with information to help determine what actions they could take to resolve the moral distress. *Making Sense of the Situation* involves the participants exploring the root causes and influences that shaped the morally distressing event, and subsequently determining what actions they needed to take to get through the shift. *Making Sense of the Situation* is comprised of *Framing*, *Consulting with Peers*, *Building Knowledge*, and *Locating Self*.

Making Sense of the Situation begins with responding to the question the participants asked when being blindsided: “*what to do I do now?*” Throughout the study participants discussed how they were blindsided and left asking, “*What do I do now?*” or “*What next?*” after their experiences. The process involved in answering these questions began in earnest after the participants identified the experience as morally distressing, or naming, as discussed previously. To move beyond naming, the participants needed to frame the situation by giving it context. Next they engaged in personal reflection, as well as discussing next steps openly with peers, and made efforts to start to navigate their experience of moral distress. It is important to note that this

was not always a linear process; there was a dynamic and fluid quality to *Just Getting Through the Shift*, whereby participants moved within the categories and continually adjusted their behavior and actions based on new experiences and learnings.

Making Sense of the Situation is a broad category that encompassed multiple strategies that the nurses moved back and forth between. This process included framing the event in terms of the contextual influences, building a knowledge base to be able to make informed decisions, locating themselves within the disarray, and consulting and relying on relationships with others. The nurses described the importance of their relationships with their peers, as well as building and maintaining therapeutic relationships with their patients and families throughout this category. This is an iterative and dynamic process that typically involved an active process of reaching out to others, not only to validate what they were experiencing, but also to ask for help in answering questions and determining what the best course of action should be.

Framing. *Framing* is the act of constructing an understanding of a situation by providing a framework, which the morally distressing event occurred within. This category, *Framing*, is the process that the participants used to provide context to their moral distress. This is an important stage of the process because it allowed the nurse to understand and view the experience in relation to him/herself in addition to the environment of the unit and organization. *Framing* is the bridge between *Experiencing Moral Distress* and *Making Sense of the Situation*. In the experiences shared by the participants, *Framing* occurred once the participants had identified the event as morally distressing; they proceeded to locate the event in relation to contributing factors. For some participants, it was clear from the outset what the influences contributing to the experience of moral distress were. For example, in situations where nurses were experiencing

bullying from peers on a unit that was known for a toxic culture, the connection between unit culture and the event were evident immediately.

Laurie spoke to this when she stated “*There comes a point where you think, well, when it comes down to it, they’re the doctor and I’m to do the orders.*” In her story, the physician wrote orders that she disagreed with for the patient. When she asked for clarification, the physician gave her a rationale and told her not to question but to follow the orders. Shortly thereafter, the physicians came back and wrote new orders that were contradictory from the first set; again she asked for clarification and was told “*not to question*” the physician and to complete the orders. The patient experienced a medical emergency shortly after. Laurie described that point when she realized it was beyond her control, that advocating was not working, and that despite disagreeing with the orders, she felt she had no other choice but to carry them out.

The influences illustrated in this case were a combination of the physician’s forceful decision and refusal to hear her concerns, the nurse not being in a position to change the outcome, and a subsequent clash in values related to patient-centred care. Laurie continued to discuss further issues of working in a team and needing to trust all members of that team, and how difficult it was when that trust is lost. For this participant, the moral distress came from feeling powerless against the physicians, losing trust in her team, and questioning her own place in the team structure. This process of identifying one’s emotional and physical responses, and locating oneself within the context of the events, was a necessary step in navigating moral distress. Without engaging in these steps to identify moral distress, the nurses could not effectively determine what the best course of action should be.

In recognizing internal and/or external influences as the causal elements, the nurses could subsequently determine what course of action could be taken to resolve the immediate situation

or to mitigate further occurrences. This process involved identifying whether the cause was larger systems based (organizational), unit based, or patient care related. For example, as a result of patients and families feeling more informed, they also had increased expectations and demands on frontline staff. The outcome was families and patients constantly questioning and observing nurses.

Nurses are in a position where they are trying to educate patients and families, as well as to defend their actions and care. In addition, participants reported that they were working harder to establish a therapeutic relationship because they were starting from a place of mistrust from the patient and families. As an illustration, Cathy shared the worry she experienced for herself during these situations, *“I worry about my license, I worry about my practice”*; the risk is not only limited to adverse outcomes for patients, but nurses worry about the risks, in fact, to themselves. The lasting impact of these situations was that nurses sometimes started to doubt themselves, and their confidence could be shaken. Participants talked about the increase in verbal abuse from families that can occur as a result of these interactions. However, identifying the influence of patient and family expectations as the causal factor moral distress helped participants to frame the situation, and provided insight as to how to navigate the situation.

The importance of being able to situate this experience in relation to the root cause allowed nurses to seek validation from others, because they were able to articulate not only what happened, but also to explore other possible causes and either work independently or as part of a team to address the situation. For example, Laurie, in talking about her various experiences on different units, identified how framing the situation provided her with an understanding of how a particular unit functioned and why:

The doctors on [this particular] service didn't tend to answer their pages. It was just kind of a very different atmosphere. There was no – I don't think there was as much urgency to a situation as...we were used to on [another service]. You called. They answered... You acted. And I think this - mentality played into this situation.

In other words, the behaviour of the physicians influenced the unit culture, and subsequently the patient care. Once this participant was able to frame this, she was able to adapt her practice to approach things differently when interacting with this particular team. As Reese posited “*Experience and observation ...will guide me in the future if I see that situation*”. Participants essentially were describing how reflecting back on previous experiences and context, and applying them to current situations, would allow them to navigate the events better.

Furthermore, by framing the events, the nurses could respond appropriately by adjusting to the different influences they were facing in that particular moment.

Reese shared a further example of how a morally distressing event was framed within the context of the unit culture; in this situation, the moral distress was exacerbated by the lack of support from his peers. Reese described a situation where a patient was experiencing respiratory distress and none of the nurses, including the patient's primary nurse, responded to the situation in a timely manner. Reese framed the situation as being the outcome of his position on the unit: he was newer to the unit, and was not the primary nurse. He did not feel safe to speak up in the hierarchical culture of the unit, let alone offer assistance. “*I felt powerless...I don't have much say. There's not a lot of people sitting here that can, like, kind of be on my side.*” (Reese). He went on to describe other situations that contributed to the sense of not being able to speak up out of fear of repercussion. When he reflected on the situations, he was able to frame the event in the context of the unit culture and how that contributed to his decision and subsequent responses.

He had become fearful to speak up against the actions of those she perceived to be senior staff and part of the core group on the unit; for her there was a significant risk of negative repercussions.

Although participants described being faced with a morally distressing event that they were often blindsided by, they were occasionally able to draw on similar past experiences to assist in navigating the waters. All of this would not be possible without having named the experience as morally distressing and framed it by situating the particular event in the context of the influencing factors/situation. The participants' experiences provided the understanding of their place within the larger context of the health care system. Participants reported that this often left them feeling vulnerable and defenseless against the organization's mandate. That being said, the nurses did engage in problem solving and attempting to resolve the immediate issues.

Using the process of framing, nurses were able to decide what to focus their efforts on. Working through the process of framing provided clarity and helped the participants to prioritize their actions, and identify what was within their immediate control, and what was a larger systems issue. By engaging in this reflective process, participants were able to identify their own nursing beliefs and personal values. Chris and Cathy both shared experiences where they were faced with morally distressing situations and both were able to reflect on what they would want if they "were in their shoes". Both clearly identified the need to put the patient first; "seeing them as a human" and not just a bed, or a number, was the most important thing to them as nurses. This was in tension to the direction from the leaders and decisions being made regarding what the priority was for the unit: patient access and flow. From there, they could examine them in relation to the situations they faced and begin to understand what was leading to the feeling of moral distress, and their subsequent emotional and physical responses. In understanding their

own perspectives that influenced their responses, participants were, in essence, positioning the experience within the background of causal factors, specifically in relationship to the organization, the unit, and/or the patient experience. Ultimately, by engaging in the process of framing, the nurse was able to gain insight by locating self within the context of the factors that contributed to the experience of moral distress, and therefore, beginning of the process of Making Sense of the Situation.

Consulting with peers. A fundamental component of *Making Sense of the Situation*, and ultimately navigating moral distress, was *Consulting With Peers*. *Consulting With Peers* involved discussing the situation; seeking feedback, opinions, and information; and asking for help. After the participants had been able to label the event and understand the contextual factors surrounding it, they were able to ask questions to understand the event further, validate their experience(s), and ask for assistance. This process involved relying on and using existing professional relationships. In the context of this research, the primary focus that participants identified was on the importance of collegial relationships. Being part of a high functioning team, where they could rely on one another, was instrumental in *Just Getting Through the Shift*. In feeling part of a team and being connected to peers, the participants were able to draw on others for assisting with tasks or patient care, knowledge building, and emotional support.

All of the participants provided multiple examples of how important team cohesion was, and the value of having peers to turn to when faced with challenging and distressing situations. There were frequent references to asking for help in terms of sharing work, asking for information and input, and relying on emotional support to cope. Laurie described how much their team members relied on each other to get through the shift:

[T]he people that we work with, in terms of nursing, like the day-day night-night crew that we have. If it weren't for them, things would just not get done. Like if we weren't working as a team and helping each other out, it would be – it would feel a hundred times worse.

Laurie had been discussing the impact of increased workload on the team, with the change in staffing ratios, and having support roles restructured out of their unit. Furthermore, she shared that the level of acuity on the unit had increased dramatically with the new practice of transferring the “more stable” patients off the unit. Some days, the combination of fewer staff, increased patient turnover, and higher acuity patients left the nurses feeling that they were not able to provide comprehensive and safe care. For Laurie, having a strong team that she valued allowed her to gain strength and reassurance that she was not alone when faced with having to prioritize care needs and make decisions, such as what tasks she was not going to be able to complete.

Many other participants shared examples of their strong bonds with their teams. Amanda exemplified this when she stated, *“[h]onestly, like if I worked anywhere else and I didn't get that support I probably...I probably would have moved... I work with such good people. It's amazing actually. Just how we've come together and worked together”*. Amanda described the emotional support and reassurance she received from her team, and described how they shared the burden of workload when faced with increasingly acute patients requiring intensive care. For this participant, the relationship she had with her peers continued to be the constant, as the resources and patient care needs changed on the unit. Both of these participants described the support they received from their peers when they had to advocate for patients to stay on the unit, or when trying to argue against further staffing cuts.

Along the same lines, Morgan described the importance of relationships with peers, as a member of the float pool. For this participant, building relationships and relying on other nurses were critical in navigating these situations, because Morgan was often unsure of details of the plan of care and the history of the patient's admission, along with the normal practices and routines of the units. As previously discussed, Morgan had experienced a situation where information had been withheld, and she perceived herself as being treated poorly because she was an "outsider". For Morgan, the need to establish and rely on peer relationships was critical to be able to find that one core staff member who would provide her with the information she needed to care safely and comprehensively for patients. As well, as a float nurse on a unit that was also facing decreased staffing levels and increased acuity, there were times when the patients were beyond her expertise, or she was unfamiliar with the typical recovery pathway, and would therefore, be unsure about how to manage situations. For this participant, the need to be able to build rapport quickly, and establish a reliable peer, was instrumental in navigating challenging situations.

As previously mentioned, there were a few examples of situations where there was a lack of peer support. For some, this was a result of moving to a new unit, being a new graduate, or being in a negative work environment (unsupportive unit culture). In situations where there was a lack of team cohesion, the nurses described a compounding effect on the severity of the moral distress. Reese experienced the challenges of a unit culture where there was a lack of team cohesion and relationship building was a difficult task:

I find that even though it's a hospital and it's a workplace, there are cliques. There is a certain group ...that [is] always together and if somebody tries to talk to them it just doesn't work out or they look down upon you.

The lack of support amongst certain groups can lead to distressing and unsafe situations. AS briefly mentioned previously, Reese experienced a situation in which a patient's respiratory status was compromised. When he stepped in to offer assistance when the patient was experiencing a decline in status, the other nurse dismissed his suggestions for how to approach the situation, and the patient experienced a significant respiratory crisis. As he stated, *"I think she should have seen when I was telling her that maybe you should turn the feeds off, but she sort of undermined my judgment at that point and – I don't know. Maybe she didn't think I was right"*. Reese believed that, as a newer nurse and new to the unit, he had not established credibility with the team. The compounding issue for this situation was that Reese's assessment was accurate, and this patient had aspirated a large volume of tube feed. The moral distress the participant experienced was difficult for him because he was able to articulate that his lack of action was a direct result of the unit culture and a poor relationship with this peer. Furthermore, he acknowledged that, on reflection, he would act differently now, despite the unit culture. He stated that now he would stand up for his assessment skills; he would intervene and not back down, to ensure the patient received prompt treatment. The lack of support contributed to the feeling of being alone, and internalizing the emotional impact of the situation increased, thus, the importance of quality relationships.

When discussing the importance of peer relationships, the participants identified another important reason for needing peer support in the moment: the feeling of only other nurses truly understanding what it is like to be a nurse. This was important because their perception that only nurses understand the experiences of other nurses created a sense of separation from others: the idea that nursing is a unique profession and no one can appreciate what they *"go through"*. Participants were also conscious of the need to maintain privacy and confidentiality, took these

rules seriously, and strongly believed they could not discuss patient related events outside of work. However, they believed that, even if they could, non-nurses would not be able to understand what they were experiencing. The participants steadfastly believed that there is a connection and comprehension that can only be shared between nurses. As Laurie articulated:

I think we're hesitant to go outside of ourselves too... I think, you know, we can hash it out with each other so many times and I think that's the best therapy...for one, you're not breaking confidentiality. That's a huge thing. You can pretty much talk about anything because they were all there for it. And the only ones that truly understand – it's fine to call somebody who's been trained in how to deal with people who are upset but if you haven't actually been doing the tasks that we do and working the hours that we work and knowing how that affects you as a person, but also your home life and other aspects of your life, you can't – I don't think you can truly be empathetic to it.

There is a perception amongst nurses that the relationship nurses have with patients is special, in that it allows the opportunity to be with patients and families during some of the worst times of their lives, and as such, understanding the depth and breadth of what nurses do when caring for patients and families is difficult for non nurses to understand. Nurses and patients can have complex, and, at times, contradictory relationships. Nurses are providing support and care while displaying confidence and professionalism, yet sharing in the emotional turmoil at the same time. The nurses described feeling isolated from others because of this perceived lack of understanding, in addition to the challenge of not being able to discuss situations outside of work due to confidentiality and privacy. Wendy reiterated this when she said, *“its hard...I can't really talk to my family or my parents about it because a) confidential, b) they won't understand...you can just say like, oh I had a really crappy day at work but that's it”*. The nurses described that

the frustrating and isolating part of this experience was the fact that a bad day for nursing is often very different from a bad day outside of healthcare, and they perceived the level of detail needed to explain required violating privacy and confidentiality.

Even though the main focus for the participants was on good collegial relationships, participants spoke about building and maintaining therapeutic relationships with patients and families in the face of challenging and distressing situations. Participants spoke of the need to establish trust with their patients, and how this need was heightened in the face of what they might deem questionable decisions regarding care. Cathy, in particular, addressed this when talking about the lengths she would go to understand the patients' experience and validate their feelings, despite the anger from the patient: *"I find patients are getting more upset with the care and you're trying to do your best and you're doing everything you can. You're building the trust"*. Establishing a trusting relationship and taking time to explain the rationale for decisions, giving the patient time to respond, listening, and being empathetic were part of the process for many participants. Consulting with peers was an essential component of the basic social process. By consulting with peers, participants identified knowledge gaps both for the individual and the team, and from this point, they were able to start to seek information and answers to their questions and subsequently build their knowledge base.

Knowledge building. *Knowledge Building* is the process that the participants underwent to gain information regarding the situation at hand, as well as regarding how to address the root causes of the situation. As mentioned previously, participants found themselves asking, *"what do I do now?"* or *"what happens next?"* after experiencing a morally distressing event. Participants often asked, *"what do I do now"* after being blindsided, however, in order to start

answering that question, the participants had progressed through labeling the event, examining the contextual influences, and were now establishing how to start getting through the shift.

There was a common theme throughout the stories of moral distress: a lack of preparedness; lack of resources; lack of training, and/or education; lack of credibility; lack of peer support; and in some cases not having previous experiences to draw from. For the participants, this lack of preparedness or experience was associated with the downstream effect of the corporatization of health care, such as the organization of health care and how it was carried out within the unit. With the increasing acuity, patient turnover, and restructuring, nurses were caring for patients that may be beyond their expertise, and in some case beyond the resource capabilities of the unit. The nurses perceived that they were experiencing situations where focusing on providing safe and comprehensive care was in tension to the organizational focus of patient access and flow, and nurses were reporting they had not had experience navigating such scenarios.

Furthermore, with the reduction in support staff, participants reported that clinical education had been reduced to essentials, if any at all, meaning nurses were not having the opportunities in the workplace to expand their knowledge and skills to match the increasing acuity. The nurses described multiple situations where they felt unprepared to provide care for patients because it was outside their typical practice or patient population, and they were lacking in educational resources to prepare them for how to manage the care of new patient populations. As mentioned above, the morally distressing events triggered the question, “*What do I do now?*” and participants often suggested this was due to a lack of preparedness as described above.

As a result of this lack of knowledge, participants attempted to answer the question of “*What do I do now?*” by turning to their colleagues, leaders, educators, or other experts to help

bridge the knowledge gap. For some, building knowledge was a self-directed process whereby they took the opportunity to seek out resources, such as policy, guidelines, practice manuals, and peers on the other units where the off service patients came from. That being said, participants did discuss how resources were difficult to locate, materials could be out of date, or just not available, for example procedure specific information for off service patients. They turned to their clinical educators, if there was one available to assist. Participants spoke of not having time to spend trying to locate materials, and that is why they often turned to their peers in hopes of a quick answer. Reese articulated this process of knowledge building when describing working on a unit where the majority of nurses had been working for five years or less:

I'll try to find the most senior nurse- [which] is probably like five years – as opposed to somebody, you know with just 30 years so – I mean I – we try to make the most of what we have, with the resources, and try to look up policies and seek out other resources, such as we have a resource nurse [that is] quite experienced – about 10 – 15 years – and coordinators and charge nurses which are usually senior nurses.

In a similar, but unique vein, Morgan, discussed the challenges she faced by not being part of the team, or being viewed as an outsider. There was a constant struggle to access information and resources, because these were not readily accessible or shared, and having always to seek out others and ask for assistance. This participant also discussed feeling alone, because the float pool staff was not always accepted into the team due to the transitory nature of the role, *“I don't see a lot of [float nurses] unfortunately on the floors because the units are so small...we might be on different wards or different sections so I don't really them frequently...I don't really talk to them”*. As well, she talked about overhearing disparaging comments about not being a core member of the unit, in particular Morgan shared how the nurses *“talk about us.*

Oh we don't like that [float nurse], or that one, or this one's ok". Furthermore, this participant discussed that, when it came to needing to reach out to leadership, she only felt comfortable to approach the resource team's leader because the unit leadership was perceived as not an option to turn to when needing support.

Finding the time to reach out to others and ask questions, and to access resources available to help fill in the gaps in knowledge or experience, was an important part of determining how to get through the shift. This action gave nurses the ability to make informed decisions and to validate their unpreparedness.

It became clear throughout the participants examples that engaging in knowledge building had long-term benefits from the perspective of basic professional development and immediate information gathering, but most importantly it bridged the gap of being unprepared. By increasing a knowledge base, the nurses were able to draw upon previous experiences and past learning when faced with future morally distressing situations. Gaining knowledge also helped the nurses to locate themselves in the larger context that leads to being able to make informed decisions about next steps and potentially to ameliorate further situations of moral distress.

Locating self. *Locating Self* is the process nurses enter to help understand their place in relation to the event itself and its root causes and influences; it is the final component of *Making Sense of the Situation*. *Locating Self* is an iterative part of the larger social process in that, as participants gained perspective and knowledge, and consulted with peers, their understanding of where they "fit" into the clinical environment evolved and became clear. By understanding where they and their practice were situated within the hierarchy of the system, the nurses were able to determine what actions they could take to resolve and/or prevent further moral distress.

Locating Self is a complex component of *Making Sense of the Situation*; participants entered this stage when they started to explore and understand their position within the context of the event and contributing factors. This stage is different than *Framing*, in that *Framing* involved putting context to the event and determining what influenced the outcome. In contrast, *Locating Self* is the process where the nurse gains insight into where he/she fits into the situation, and where his or her practice lies in relation to said influences. This was often a subconscious process that was subtle in its description. Participants identified understanding their relationship with the larger health care system, the hospital's organizational structure, the unit culture, and what their subsequent options for action were. *Locating Self* was also helpful for participants working towards determining where there were knowledge gaps and opportunity for further learning.

The concept that was most frequently discussed was the issue of leadership, and the participants tried to make sense of how they were able to work through issues of moral distress with leaders. For some, the leaders were a contributing factor to the moral distress. As discussed previously, responses from participants, when exploring fundamental causes of moral distress, involved a perceived lack of leadership support, which participants expressed as a perception that leaders were not accessible, or were dismissive when approached. Participants shared that not being heard, being dismissed, or feeling undervalued by the leadership were common problems. With a felt lack of leadership as the backdrop, the nurses were able to locate their role in relationship to the leaders' actions and the overall operational structure of the unit, in other words the chain of command. The participants were essentially describing the power imbalance between their leaders and the frontline staff. The organization, in their view, functioned as a top down organization, which contributed to their sense of powerlessness against their leaders and the decisions being made.

The current leadership structure in this organization was such that frontline clinical leaders were rotated through a variety of units on a regular basis. This created a situation where participants felt unable to feel connected to their leaders, and to be able to receive the supports they needed. This was either due to the leader being new to the unit, or the perception that the leader was not invested, because she/he was temporary. The participants located themselves as separate from their leaders due to this constant turnover. Interestingly, despite this clearly defined hierarchy, the participants expressed that they understood that their experience was often due to a larger systems issue beyond their control. Laurie spoke directly to this when she expressed her frustration with the organizations leadership practices:

[They] need to stop moving their management around so much...it just hasn't led to much continuity or the feeling that there's approachability because you don't have a relationship with the person because they're only there for such a short period of time. And also, the organization is giving too many areas/responsibilities/roles to their coordinators and managers ...our area just isn't getting the focus. More of the work is falling on the bedside nurses to do the management of the beds.

In saying this, Laurie was clearly aware that she did not have authority to refuse or challenge this transfer of work; rather she was powerless against those higher up the corporate ladder. She located herself as the recipient of direction rather than as a collaborator in the decision-making process regarding workload allocation. She went on to discuss how she needed to balance between caring for the patients and managing day-to-day operational issues, the problem being that there was not enough time for both. Therefore, she had to make a choice as to which role received her attention, and either one potentially put patient care at risk. If patient care was put to the side, there was risk to patients such as from falls, medication errors, and/or treatments being

delayed or missed. However, if patient care was the priority and bed management was put aside, then patients requiring admission may not get to the appropriate bed, there could be a backlog in the recovery unit, and surgical operations could be delayed. As a result, Laurie was torn between priorities. In particular in this situation, she not only felt unsupported by leadership at all levels, but also was aware of feeling powerless to challenge the leaders due to her place in the hierarchy of the organization.

Participants reported that, with the frontline leaders being overwhelmed with other priorities, the leaders were offloading responsibilities to the staff nurse. As a result, there was a perception of no support for the front line. In terms of support from higher levels of leadership, participants believed that decisions regarding resource allocation, such as staffing levels, frontline leadership coverage, and the subsequent delegation of work, was coming from the top down, and consequently, senior leaders were also not seen as supportive. The effect of understanding how one is located in these situations was that it provided insight as to what actions can be taken, and in this case, there was not much the nurse felt she could do within her span of control, leading to her doing what she can, simply to get through the shift.

Understanding where one fit into the chain of command was important in determining not only what actions to take, but how to carry out those actions successfully. For example, when Reese was faced with a serious negative outcome for the patient in respiratory distress when he attempted to provide input into the situation and was subsequently dismissed. He went on to explain that his position within the unit was influenced by the simple fact he was a newer graduate. His belief was, *“I think you have to be on a unit for a really long time to build that support”*. Other newer graduates described similar situations where they were aware of a unit

hierarchy heavily influenced by years of experience, both as a nurse and regarding the length of time on a particular unit.

Participants shared experiences of being wary to speak up due to the potential repercussions that they might experience due to challenging leaders and physicians. Laurie explained this when she said: *“You try to put up a little fuss to whoever’s making the decision. If it’s management or bed admitting, but most times you don’t win that battle and – or if you do, you don’t get treated very well for advocating for them [the patients]”*. The importance of understanding unit culture and where one fits within it was that the nurses could determine who to reach out to, and the best course of action to have a successful outcome.

Interestingly, some participants identified in their discussions how they appreciated the intense pressure frontline leaders were under to achieve their metrics for patient access and flow. The participants were fearful to speak up against the leader’s decisions, because the nurses understood that the negative reaction from the leader was related to the leader’s pressure to meet the program’s metrics, and consequently, there was little the leader could do. As Cathy explained, there is separation in the focus of care between what the leaders perceived as priorities and what the staff believed are priorities:

[w]e focus on the very patient-centred care, individualized care. The coordinator is on a business model. It’s business and this person [the leader] – this person, they’re just – they’re in for their service and they’re back out. Get them out as fast as you can. They don’t really care about anything else.

In acknowledging these pressures, participants perceived that they would be bothering the leaders if they approached them or spoke up and risked being reprimanded; hence, they avoided speaking up.

Locating Self provided the framework for nurses to understand what role they currently had in the events that led to the moral distress, but also what potential role, if any, they could have going forward. By extension, the framework also provided understanding as to their power to act on the situation, as well as where they were located in the professional hierarchy. Ultimately it provided direction to the nurses, by allowing them to understand the power dynamic between the front line staff and their leaders, in terms of how much support they had and what their place was in the structure of the unit. Furthermore, nurses were able to place their practice within a larger health systems perspective. For example, Amy noted:

We are big on patient access and flow, and especially in oncology – surgical oncology. There's a lot of a pressure in the cancer population to get patients in, in so they're not waiting, you know. Government mandated. So I know that puts pressure on the hospital system.

Amy proceeded to discuss how she appreciated that the decisions made by unit level leadership were influenced from organizational pressures, as a result of government-mandated practices, and in that case was beyond her influence.

The outcomes of such budgetary and patient access and flow decisions were often in stark contrast to the patient-centred values that nurses held. Cathy, who expressed her distress at such situations, provided an emotional description of this conflict in values:

You knew them [patients] very well. You knew their story. I looked at them like a human and I wanted to give them what I would want my grandmother to be treated like, and the system wanted them to be treated like the number and what the best outcome per system...and that's where it's very clashing to have that, where I feel like we wasn't

looked [at] like a human at all...it's very distressing to feel like people aren't being taken as individuals.

It is important to note that, not only was she discussing the current state, she was also reflecting back to a time when she thought she was able to give better care. Cathy had the ability to see that the issue was being driven by external factors beyond her span of control. With this understanding, she focused her attention on providing patient-centred care and supported the family as best she could.

It is interesting to note that various participants discussed being able to transition from addressing immediate concerns to becoming more aware of the larger system's influence. In doing so, the participants were demonstrating how, as they gained experience, their ability to locate their position within the experience evolved. All participants described how early career experiences had become easier to address. For example, they talked about increasing confidence when speaking up, asking for help, or interacting with a distraught family, but now they were aware of complex factors, such as governmental and organizational influences on the current health care environment within which they practiced. In other words, their experiences were perceived as more difficult to navigate as a result of gaining more insight into the external influences affecting their day-to-day practice. As Amy stated:

I think ...its harder the longer you do it because you're more apt to see...when you're more efficient at your job, you can see past so I think [coping with moral distress] gets harder. You're more aware. Aware...of the workings of the system in the hospital.

This last example also highlights how, as the participants gained awareness and understanding, they were not experiencing less resolution of morally distressing situations. Coupled with this awareness was a learned helplessness: “*there is no point in fighting anymore*” or “*you just give*

up trying”, which can contribute to lingering moral distress that is not fully resolved, and moral residue.

This ability of the participants to place themselves and their practice within the context of the organization and the larger political systems further highlights the scale of the moral distress they were experiencing. The contributing factors of moral distress are reaching beyond the walls of the hospitals. Participants were able to reflect on the details of the situation that triggered the moral distress, and were able to see the bigger picture and understand the various influences throughout the organization and the current health care climate. As one participant identified, the impact of decisions made at a government level, regarding health care priorities at a provincial and federal level, have a tangible trickle down effect that results in a shift in how hospitals conduct their business. As hospitals adjust their business models to meet funding changes, frontline leaders and nurses must make frequent decisions regarding resources, staffing models, and budget reductions, all of which can have a direct impact on patient care and safety.

An important outcome of locating self was the ability for the nurse to question his or her practice within the current situation and ask, “*Am I giving the best care?*” and “*Are we really patient-centred?*” From these two questions, the nurse considered all of the contributing factors and was able to determine what she or he felt was best, in terms of nursing practice and patient care, and what they needed to do to take action. These questions, and the consequent decisions for action, allowed the nurse to begin the process of Finding the Way and getting through the shift.

In summary, the process of *Making Sense of the Situation* provided greater understanding of the morally distressing event. By engaging in dialogue with peers, the nurses were able not only to access information and assistance, but they were also able to validate the experience and

subsequent feelings, therefore, gaining emotional support from their peers. The combination of gaining knowledge and being able to locate where they fit in the grand scheme of the situation gave nurses a more comprehensive understanding to allow them to make informed decisions as to next steps.

Finding The Way

Participants engaged in the last phase of *Just Getting Through the Shift* by *Finding The Way* to address the situation they were in. *Finding The Way* is the process that participants used to determine actions and responses to moral distress. This is the phase in which the outcomes of the previous categories culminate and the participants made choices as to how to navigate the experience of moral distress and get through the shift. Finding the Way is comprised of the subcategories: advocating, remaining patient focused, seeking resources, and becoming disengaged.

As discussed at the end of the previous section, nurses were asking themselves “*Am I able to give the best care?*” and/or “*Am I being patient-centred?*” It is through the process of *Finding the Way* that nurses were able to make informed decisions to address these questions. In essence, participants were asking, “Can I do *something* to improve this situation?” The resolution to these questions involved making choices as to what actions they would take to get through the shift. These actions may be at the patient level, by advocating to the patient and/or medical team, or at the unit level by engaging peers or the leaders. In contrast, there were situations when the nurse made the decision not to engage in addressing the moral distress; instead, the focus of energy became the tasks at hand and the remaining patients and their care. In other words, they internalized or compartmentalized the experience, along with the accompanying feelings, and moved on with their work. Interestingly, participants described trying to remain

patient-centred regardless of which action they took. The overarching principle guiding their actions was to keep the patient safe, and provide the best care they could, despite the challenges they were facing.

Advocating. Advocating is defined by the CNA as “*actively supporting a right and good cause; supporting others in speaking for themselves or speaking on behalf of those who cannot speak*” (CNA, 2008a). In the context of this study, advocating was a way for participants to speak up and ask for decisions to be made in the best interest of their patients. Participants engaged in this process once they understood what the influences were that led to the moral distress, and who was the appropriate individual or team to speak to. Participants expressed varying forms of advocacy, depending on their level of experience, both as clinicians and with the particular context of the situations at hand. It is important to recognize the vital role that nurses play in advocating for others. Advocacy is a key component of the nursing role; the College of Nurses of Ontario outlines advocating on behalf of patients as part of the Professional Standards (CNO, 2002b); the CNA (2008a; 2008b) also identifies advocacy as an important aspect of nursing as part of the Code of Ethics for Registered Nurses.

Throughout the participants’ stories, there were many examples of advocacy, ranging from subtle actions, such as asking questions, seeking clarification for orders, and engaging in dialog with physicians, to more overt actions, such as assertively speaking up against and/or vocally challenging decisions. Advocacy was the way in which the participants enacted their moral agency, by attempting to ensure safe and ethical care. Participants gave multiple examples of advocating in attempts to prevent premature transfers and/or discharges. Wendy described advocating to both the front line leader and the medical team not to discharge a patient, who was

not ready to be sent home, just to meet bed pressures. To ensure that she was successful with her plea, she provided a clear argument for the patient's safety, and was successful:

There were a lot of issues...especially with the medications. So the patient was supposed to be discharged...I double checked all the medications first and there was such a discrepancy between what was being sent home to the patient and what they were supposed to receive that I called – that I called the nurse practitioner looking after the patient and the nurse case manager and just said, this is what's going on. Look at this...I talked to both of them and then, we talked to our coordinator and we talked to the doctor

This nurse was successful with her advocacy as result of diligence, attention to patient safety, and insisting that the decision to discharge was wrong. More specifically, the nurse examined all the facts surrounding the proposed discharge, and presented them to a willing, yet influential audience who acted on her concerns. Participants expressed that advocacy became easier with experience in the sense that they found their voice and gained confidence in their ability to articulate a concise argument. For instance, Reese shared:

I'm able to advocate a lot more, but I'm also able to – before when I was able to advocate I would be able to say exactly why this patient needed to stay. But after – like I think a year and a bit, I'm able to exactly say why this patient needs to stay just a little bit longer in terms of the nursing point of view.

Most of the participants had similar perceptions of their ability to advocate and support their arguments, and they continued to hone this skill with further experience. In some cases they learned to anticipate potential risks and mitigate the situations.

The challenge with advocacy for most participants was feeling that their voice was lost to the system, *"It's the way the system now works and it's not – I don't know. I don't want to say it*

– *change can happen with one voice, but this is a bigger – it's a bigger problem that extends beyond [the unit]*" (Amy). This realization is connected to the process of locating oneself, in that the more practice experience the participants had, the better they were at advocating, but the more cynical they became, because they could see the bigger picture and understand where the influences were coming from. For some participants, this led to a sense of helplessness and subsequently giving up. Regardless of the outcome of advocating, the motivation the participants had was to ensure they were providing the best care possible, and remaining patient focused. Advocating was a way to enact their moral agency, and this centred on placing the patient in the forefront of their actions.

Remaining patient focused. *Remaining Patient Focused* means that the nurse continued to address and focus on the immediate care needs, and what was in the best interest of the patient, despite what challenges they were experiencing. *Remaining Patient Focused* is, in its essence, being patient-centred. *Remaining Patient Focused* often occurred within the context of organizational and unit level influences. As reflected in the following excerpt, the conflict between what organizational leaders claim and what the expectation of the staff was created ethical tension between what the participants believe to be the correct course of action and what they were asked to do:

We are always...told about, it's patient-centred care, and I think what ethically bothers me is that – is it really – is that really patient-centred? Because it really isn't the best – is it really in their best interests [for the patient] to be moved? (Amy)

Fundamentally, as reflected above, participants questioned how the organization could pride itself on having a patient-centred mission, when at the same time; the day-to-day actions appeared to reflect otherwise.

A further example of how the organizational priority, to meet discharge and admission metrics, was in contrast to the need to remain patient centred, was echoed by Wendy when discussing what she observed as rushed discharges:

We should discharge them and then, even though we know sometimes a patient might not be doing well or I'd hear some of my co-workers saying "this patient is [going to] come back within a week, why are we sending them off?" Or "why are they going home when they can't even walk by themselves or take care of themselves?"

Reflected in this narrative is the dichotomy nurses experience between meeting discharge targets and doing what is in the best interest of the patient. The nurses were often in a position of having to carry out discharge orders, despite their expressed concerns and valid questioning of the orders, as in this example, knowing the patient is not ready for discharge and thus, was at risk for a negative outcome. The nurse was caught between challenging the system, by refusing to carry out the order, or voicing his/her disagreement but ultimately following the order, and meeting the patient access and flow targets.

For some participants and/or situations, remaining patient focused was the lens through which the participants advocated for different decisions. However, sometimes participants believed remaining patient focused was the only option, when the nurses felt powerless and invisible against external constraints. For these situations, when the participants felt helpless to change the outcome, they could, at least for the time at hand, focus their energy on patient care and disengage from the moral distress. This alleviated some of the distress by knowing in the end, they stayed true to their values of patient-centredness. Cathy suggested that there were times when the best she could do was to attempt to be as patient-centred as possible for the short time she had with the patient.

Remaining Patient Focused involved keeping the patient safe, providing patient-centred care, and doing what was in their span of control to ensure the best care possible. Regardless of what was occurring on the unit, nurses remained cognizant of the care that was required for all of their patients; this was the most important action they took. In the face of challenging and distressing situations, patients remained the centre of attention, and continuing to meet their care needs often was a way to channel the frustration into a positive outcome. Chris exemplified this when she shared the story of being with a dying patient. Despite the chaos of the situation, “*At the end what happened, the patient ended up dying, I was there with her and that’s the thing. I am like, ok, at least there was somebody*”. Ensuring that this patient did not die alone became the primary focus for Chris, and she put all of the complex issues with this admission aside to remain patient-centred. The outcome was devastating nonetheless, but Chris took comfort from knowing that the patient was not alone.

Similarly, Eric faced a difficult situation when his coworker suffered a health crisis while on shift, and despite being left alone on the unit, he ensured that the patients were kept safe and attended to: “*I did my best. You know, everybody’s had their pills and they’ve been turned, repositioned*”. As well, he ensured that his coworker remained safe and the participant was able to get the co-worker assistance by the end of the shift. *Just Getting Through the Shift* for this participant meant balancing the needs of the coworker and the patients to ensure neither was neglected.

Keeping the patient safe was a recurring focus of the participants when they were making decisions on what actions to take. Keeping the patient safe was the driver for advocating, as well as for remaining patient focused. For some participants, worrying about patient safety was an aspect of the moral distress experience when it was related to early transfer or discharge. In

particular, participants often spoke about the fear they had in sending the patient to another unit, where the staff was not familiar with the diagnosis and procedures/treatments, therefore, not familiar with the care required. This would increase the risk for adverse outcomes. For many, this was an important patient safety issue, and caused significant anxiety. This concern became the driver for advocating against sending the patients off the units. Several participants shared examples of how patients were transferred or discharged, and ended up being sent back to the sending floor or readmitted; participants shared how they advocated against the discharges as a way to try and keep the patients safe. Patient safety for these participants was more than ensuring proper hand hygiene or preventing falls; it was about ensuring that patients received quality, skilled care that addressed their needs.

For Laurie, the challenge of maintaining patient safety was a combination of not knowing the nuances of care, but also about not having the knowledge about the need for proper equipment on the receiving unit:

...But with our chest tubes and that type of thing – that a lot of floors don't have portable suction so they [the patients] either don't get walked or they get walked off suction when they shouldn't be getting walked off suction. So all these things are on your mind³.

In this situation, the lack of specific knowledge and expertise available to care for particular patient populations, such as thoracic surgery patients, on an off-service unit, was the driving argument when advocating not to transfer or discharge the patients. The nurses on the receiving

³ For this example, it is necessary to understand that when a patient requires a chest tube that is maintaining the correct internal pressure of the lung cavity allowing for the lung to stay inflated. There are times when a chest tube system requires suction due to the lungs inability to remain fully inflated. The suction is applied by an external source, essentially creating the right internal lung cavity pressure; when this suction is removed, the lung is not able to stay inflated, thus it collapses and leads to respiratory distress, and potential further damage to the lung.

unit did not know that the patients could not be removed from suction, and as a result patient safety was compromised.

The compounding issue for early discharge was often a disconnection between what care was being provided in hospital and available community services. For instance, participants identified that the level of nursing care required was often greater than what would be approved and/or funded by homecare, resulting in patients either not receiving an adequate amount of support, or support provided by less skilled or unregulated care providers. In particular, there is a well-documented disconnect between hospital wound care and the wound care in the community, resulting in poor wound care and hospital readmissions (Southwest Regional Wound Care Program, 2011). This challenge exists from both a skill/education and wound care product standardization perspective.

One of the most arduous experiences that a participant shared was the impact of having to restrain patients. This example embodies the contextual influences of patient and family on morally distressing situations. The examples Amanda shared centred on caring for patients who were requiring restraints as a way to be kept safe, and to keep the staff safe. Amanda talked about the increase in patients experiencing severe cases of delirium after surgery or a prolonged period of time in the intensive care unit: *“from the unit ...they’re always going through that...morning/night confusion or from all the medications...They’re doing surgery on people that maybe...have a little Alzheimer’s or something that just triggers an event”* These patients were requiring restraints, because they were delirious enough to be violent or flight risks. This participant also shared that the increase in older patients with dementia, having aggressive and complex surgeries, was also causing an increase in patients needing to be restrained to prevent the accidental removal of tubes and equipment. Staff were not equipped or trained to address the

responsive behaviours,⁴ such as physical violence, which these patients displayed towards the staff because of their dementia.

The goal of the nurse is to keep the patient safe, and this becomes increasingly complicated when nurses are faced with aggressive, and/or responsive behaviours that they are not able to manage, and the only option becomes to restrain, which compromises the nursing value of preserving dignity. As Amanda described, *“like you feel kind of – it hurt in the beginning. Like I found that I got hurt by it because I felt like I was hurting them”*. It is this feeling of harming patients as a way to protect them that creates the conflict between nursing values and ethical responsibilities. In ensuring patients are safe and cared for, their dignity can be compromised. Additionally, participants discussed the increasing incidence of mental health comorbidities, in particular the inability to provide adequate holistic care, because the focus of the unit was surgical or medical and the resources to support the mental health needs were not available.

Being patient-centred and providing the best care are the same for many nurses, all of which, at its core, is keeping the patients safe. There is a quote that I have heard used in my own organization regarding the three things that patients want: *“Do not harm me. Heal me, and be nice to me”* (McLeod, 5, 2013); this is, in essence, what the participants were struggling to achieve with their practice in an environment that is asking them to do more with less. Consequently, the strong desire to remain patient-centred allowed the participants to identify and articulate the resources that they would find helpful to navigate moral distress.

⁴ Responsive behaviours refers to the actions demonstrated by persons with dementia to express something important in relation to their environment (Alzheimer Society of Ontario, 2016)

Nurses are challenged with rearranging their workload to attempt to meet all these needs or risk of adverse patient outcomes. For example, without a charge nurse/resource nurse role troubleshooting assignments, patient flow and/or sick calls may fall to a point-of-care nurse, taking time away from direct patient care needs. Therefore, decisions that are made at senior levels regarding restructuring have a downstream affect for those at the bedside. The underlying current throughout the participant interviews was the disconnection between the decisions made at a senior leadership level, when it came to setting and meeting budget targets, and what the staff, patients, and families believed are priorities for optimum patient outcomes and patient-centred care.

Seeking resources. *Seeking Resources* was a small subcategory of *Finding the Way*, whereby the participants identified what resources they were lacking to assist in navigating moral distress. Participants frequently discussed issues of lacking resources, both in terms of physical resources and knowledge and skill. Decisions and actions taken by the leaders that produce situations, such as increasing the patient to nurse ratio, decreasing allied health resources, or cutting the evening and weekend unit clerk role, contributed to situations where participants repeatedly referred to not having time to provide the best care, or the level of care they wanted to give, due to the lack of resources and resulting workload increase. For example, not having expertise in palliative care, units not equipped with the necessary resources, and not having the time to spend with the patients and families because the patient to nurse ratio did not reflect the needs of acute medicine or surgery left the participants feeling that they were unable to fulfill the care needs of those they cared for. Participants also discussed the impact of increasing technology, and invasive, aggressive procedures being performed on patients who may not have been the best candidates and who were experiencing significant complications.

Seeking Resources was often reflective of both organizational and unit level contextual influences. An example of unit level influences is reflected in the following narrative. Participants described being criticized for reaching out to leaders when needing assistance. For example, Eric's experience with a manager who was not only unsupportive, but also angry that the participant contacted her to provide guidance when one of the nurses suffered a serious crisis while at work. *"I called my coordinator...I had to leave a message saying that I needed to discuss a sensitive issue. So she called me back and she wasn't very happy... she redirected me back to the on-call coordinator"* The leader expected that the participant would deal with the on-call leader, despite Eric explaining why he was calling her directly. Due to the seriousness of the situation, and because it occurred outside of regular hours, the on-call covering coordinator suggested the participant contact her actual unit manager to assist. The on-call leader felt this situation was beyond her expertise and warranted direct involvement from the manager familiar with the staff. The nurse stated, furthermore, that the leader never followed up with him after the event, and went on to blame the nurse for the colleague's behaviours once she returned to work. When I asked if the leader had followed up with him regarding how he was coping, she responded with *"nope"*. I asked if he had been offered any supports and again he said no.

Participants expressed a desire to be able to debrief regarding situations. They spoke of how the current state of debriefing, if it occurred at all, was used to address critical incidents such as a fall, a patient that leaves AWOL, or medication errors. The focus of these debriefing sessions, when they happened, was to examine them from a quality improvement perspective and learn from the errors. This has important value, however, what the participants identified as missing was the ability to debrief regarding their emotional needs, and talk about how they were

feeling, how they were coping, and whether they were okay. Cathy illustrated this missing piece in the following narrative:

There's no – the management wouldn't ask you. She actually shuts her door after we've had codes lately and doesn't even come to the floor...there's no educator...maybe it was related to this incident but let's all learn what to do better next...there's no learning...there's no debriefing...there's no support for anything.

Coupled with the desire to have formal debriefing sessions, participants expressed the need to have time to work through and process the events. There was often reference to not having time to stop and reflect or talk to someone. All the participants expressed how they felt pressure to keep going, and not having time to dwell, because “*there is someone else who needs you*” or “*admitting is sending up the next patient*” and “*you don't really have time to think about what happened*”.

Along the same lines, participants Amy and Cathy talked about the need for leadership at all levels to think of upstream causes and solutions, instead of only focusing on the downstream solutions. Cathy stated that “*there's not much upstream – preventative thinking...rather than looking down the road and saying 'Well, I can prevent four or five admissions if I do this and this today'*”. Amy echoed this sentiment when she discussed the need to think upstream regarding processes for discharge; she shared the need to think about discharge planning earlier if they anticipated the patient would be discharged from another unit. That way, they could prepare both the patient and the other unit, and mitigate any delay in discharge, or complications due to a lack of information.

When I asked what resources were available to them to assist in navigating moral distress, the participants indicated their peers. When I asked if there were supports available

from the ethics consultant, or spiritual care, participants stated they were unaware of the services those departments could provide for staff. Participants associated these resources only with assisting patients. Amanda expressed surprise and was unaware that spiritual care had a service where they would come and debrief with the staff after a traumatic event on the unit. Laurie echoed this when asked if there were supports that staff could access, and she stated, *“I’ve seen something – there’s a number or something you can call, I think”* The resources within the organization were not widely used, and this may be due to poor communication and awareness.

Furthermore, participants identified access to online educational resources needed improvement. As Amy shared:

[I]f everything...all services were completely online...if we had an orthopedic patient I was sending home, I don’t really know about weight bearing restrictions for a tib-fib fracture or whatnot. So I would want to know that I could go to a computer and find that information.

The solutions the participants proposed, in terms of the resources they were seeking to assist in navigation moral distress, were small scale in terms of changing the environment and culture. They were looking for easier access to consistent and up to date information. They felt they needed to be made aware of the resources available and how to access them. They were asking for time to be heard and share their experiences, and suggestions of how to improve patient care and their own practice. Interestingly, none of the participants identified resources such as reaching out to their professional organization (Registered Nurses Association of Ontario) or the union (Ontario Nurses Association). When asked as to why they did not identify these resources as possible supports, Amy, Cathy and Laurie stated that they did not believe the union was not interested in helping with issues such as these. They felt the union was focused on

labour issues such as contract negotiations and wages. As for the RNAO, not being a member or being unaware of them as a resource were the responses. Consequently, the situation of not feeling that they had the opportunity to navigate or resolve the experience of moral distress, and lacking supports, participants expressed feelings of frustration and disempowerment. Subsequently participants described how in order to find resolve, they often “*internalized*” or “*pushed [the feelings] aside*” and “*got on with the shift*”. The perceived lack of resources, supports and resolution lead to being disengaged from the moral distress and the contributing factors.

Becoming disengaged. *Becoming Disengaged* is the process that the participants underwent to compartmentalize their feelings, with the goal of distancing themselves from the distress. Participants used words such as internalizing, distancing, building a wall, or pushing it away, to describe their psychological efforts to lessen the distress. For some participants, *Becoming Disengaged* was the only way to get through the shift. As a component of *Finding the Way*, *Becoming Disengaged* was a coping mechanism nurses employed as part of the process of Finding the Way through the shift.

Becoming Disengaged was a common response for many of the participants when dealing with moral distress. The justification for this was sometimes attributed to a lack of time to address the situation, because of workload pressures, and for others it was the only option because they felt powerless against the system. For some participants, becoming disengaged was a response to the larger system issues they felt powerless against, in other words the external constraints. Participants discussed examples of when a medical team would not have any discharges across the organization during the morning patient access meetings, but as soon as it was identified later in the morning that the access and flow metrics were not being met, teams

would round and suddenly there would be “50 discharges in one day” (*Wendy*). This incongruence, between what the teams decided during morning rounds, based on clinical presentation and/or concerns, and what was enacted later the same day, when the patient status had not changed, left the nurses feeling that they had no input into the decisions, nor, apparently, were the patients’ best interests taken into consideration. The nurses faced transferring or discharging patients they knew were not safe to leave. In almost all of the situations, the patients were moved despite the nurses articulating their concerns and advocating to frontline leadership.

Consider this example from Cathy, who shared that the resulting decrease in budget meant the patient to nurse ratio is now 5:1 on the floor, “*they’ve cut down staff on the floor so you have five people and it’s still an acute floor*”. She explained that previously, ten patients were divided between three nurses. In the step down unit the ratio remained the same, which is 2:1 due to invasive cardiac monitoring. Patients were now being moved out of the step-down unit a few days earlier in order to meet the demand of post-op admissions. This resulted in a patient that may have up to ten lines such as IV, patient care anesthesia pain pump, two chest tubes, a naso-gastric tube (for decompression), a gastric feeding tube, a urinary catheter, and various other drains that require care and attention, along with requiring three to four periods of ambulation a day being cared for a nurse who has four other patients, all whom are of equal intensity and complexity. The lower acuity patients have been transferred off service.

Consequently, nurses felt they were not able to meet all of the care requirements and could only ambulate a patient two times a shift⁵. In addition, there were decreases to the amount of physiotherapy hours to assist the nurses on the unit. Therefore, nurses were often reduced to focusing on tasks, and attempting to prioritize care by deciding what care can be completed and

⁵ The outcome of patients only getting two walks increases the risk of deep vein thrombosis, post-op pneumonia, slower healing and recovery time, and in some cases increased pain.

what would be missed. As a result of being reduced to focusing on tasks and trying to provide the basic level of care, nurses were at risk of *Becoming Disengaged*. The organizational and unit level influences have led to a situation where nurses did not have time to act as moral agents.

Becoming Disengaged was a way to compartmentalize their actions that were in contrast with their personal nursing values, such as having to apply restraints or carry out tasks related to the increasingly invasive procedures. In these scenarios, disengaging was a way to cope with internal constraints. Cathy shared when she attempted to advocate and speak up against a discharge, the coordinator “*squashed me down pretty good and [told] me that it was a terrible idea*”, at which point Cathy disengaged and stopped trying to advocate. Amy, Laurie, and Cathy all described coordinators who only worked “*exactly 8-4*” and were difficult to find because they always seemed to be busy “*or in a meeting*”.

Regardless of the reason for disengaging and internalizing the experience, it was a consistent practice that all participants engaged in, and was an essential part of the process of *Just Getting Through the Shift*. Participants expressed this in multiple ways, with phrases such as “*just go with the flow*”, “*sink or swim*”, “*just make it happen*”; despite the various connotations, the undercurrent was the same: just make it through the shift unscathed.

Within the context of patient and family influences, *Becoming Disengaged* occurred as participants described the increasing situations of aggressive behaviours directed towards them by patients and families. These experiences shed a small amount of light on the issues of nurses feeling powerless against this type of behaviour. In these cases, the nurses were often the recipients of aggressive and abusive behaviour from families, receiving blame and having their skill, knowledge, and abilities questioned. To compound these situations, leaders and physicians were often not supportive of the nursing staff, who described, “*feeling alone*”, “*being hung out to*

dry”, and “*carrying the burden*” of these outcomes. As Cathy expressed “*I find everything comes back to us. They’re not blaming the doctors. They’re blaming the people that they can see the most*”. The threat to professional integrity that nurses experiences when families were blaming them for poor care contributed to the experience of moral distress and moral residue, leading to *Becoming Disengaged*.

Becoming Disengaged was also a byproduct of the notion of not being able to talk about morally distressing issues outside of work. Participants noted that there was often no outlet for them to work through their emotions, and many wanted simply to “*leave it at work*” when they went home. In other words, becoming disengaged became a coping mechanism to keep focused on the work at hand and not to take the issues home.

In light of the increasingly invasive procedures and treatments related to advancing technology, there were times when nurses found themselves at odds with the direction care was taking for patients. As discussed earlier, the acuity of the patents was increasing, as were co-morbidities. Participants discussed their experience caring for patients who required a higher level of care and increasing acuity. Some of the participants suggested that five or ten years ago, the level of intensive and invasive treatments they saw on their units would have only been seen in more specialized areas, and not on general medicine and surgical floors. Their perception was that, as technology advances, and patients were asking for, and receiving, more aggressive treatments. The outcome is that these specialty patients were now the norm. As a result, there was a greater risk of complications due to pre-existing comorbidities.

As mentioned previously, Amanda shared her distress with increasingly aggressive procedures being performed on elderly patients with cognitive impairments, and needing to restrain these patients as a way to keep them safe. For her, the challenge was reconciling her

dislike of restraints, but knowing it was a necessary intervention. She experienced a sense of helplessness at not being able to solve the problem of restraint use, and she resorted to internalizing the distress. For Amanda, the contributing factor was the fact that she believed the application of restraints in these situations became the default solution for the physicians. The hospital had adopted a Least Restraint policy, which was in alignment with the current Patient Restraint Minimization Act of Ontario (2001) and the CNO standards on restraint use. The actions of the physicians to default to restraining, rather than attempting to treat the root cause of the agitation, was in her perception, unethical. Her perception was that, instead of addressing the causes of delirium or agitation, or addressing the dementia, the physicians addressed only the symptom, which was the agitation, and ordered restraints. This internal conflict, coupled with being frustrated with the fact these situations were happening at all, led to her experience of moral distress.

The need to separate oneself from patients and make a conscious effort to stop seeing them as people was distressing and demoralizing to participants. These actions were in direct contrast to what is at the core of nursing, providing safe, compassionate, competent, and ethical care (CNA, 2008a). Nurses enter the profession because they are caring, and want to help and heal people. When situations arise that require nurses to act in opposition to those core values, the result is moral distress. Amanda found these situations caused her emotional pain. She shared that, "*It hurts me*", and for her, the only way to cope was to "*build a wall up*" and get through it. In addition, she explained that the pace of the unit contributed to needing to disengage because, "*You don't really have time to think about what happened*". Participants noted that lacking time was a frequent compounding factor, whether it was a part of the root cause of the moral distress, or a barrier to navigating through it. Amy touched on this when

talking about the pressure nurses faced to match the pace on the units *“There’s pressure coming at you from all different areas...from PACU or you’ve got pressure from management saying you’ve got to move this patient...There’s pressure to be – you feel to be efficient in your job...How do I deal with it? It’s really internalized”*.

Many participants shared similar stories of needing to disengage as a way to meet the expectations of their roles. As Laurie described:

You aren’t going to be able to do what you’re supposed to do if – if things upset you and then I think once you’re out of that situation, there’s just been so many incidences of that that you just think, okay it’s done.

In this response, Laurie also alluded to what participants described as feeling the need to leave it at work, not take it home. Participants articulated that distancing themselves from their workplace experiences was a necessary coping mechanism because it allowed them to try and “regroup” and be able to come back to work and start it all over again. This practice became a pragmatic way to Just Get Through the Shift.

What emerged from the data was that the process of internalizing moral distress and becoming disengaged appeared to increase the longer the participants were practicing. This occurred as a result of nurses being able to locate not only the external factors that caused the moral distress, but also locating their own practice in terms of larger system influences that, as discussed, are beyond their control. Laurie explained

It’s different than it was ten years ago... I don’t think the audience is as receptive as they might have been ten years ago and I feel nine times out of ten I’m just barking up – barking up a tree that nobody’s paying attention to.

For Laurie, her reaction to these situations has evolved as she located herself in the current health care landscape; no one was listening, one cannot make a difference, therefore, one stops trying and internalizes the experience and/or the response to the experiences, all with the goal of *Just Getting Through the Shift*. There was, as all the participants stated, another patient coming through the door, or other patients in your assignment, that all need care, and they are increasingly acute. In an environment where leadership was not viewed as supportive, technology is advancing, and increasingly aggressive treatments are being performed, decreasing wait times was the number one priority, and nurses were being asked to do more with less. Putting aside their moral distress and *Just Getting Through the Shift* had become the best option for many.

Summary

Together the categories of Experiencing Moral Distress, Making Sense of the Experience, and Finding the Way comprise the basic social process of *Just Getting Through the Shift*. As discussed previously, the basic social problem facing the nurses in my study was moral distress. Moral distress occurred within the backdrop of three contexts: (a) organizational influences, (b) unit level influences and (c) patient and family influences. These contextual influences were important, because they not only influenced the experience of moral distress, but they also influenced how the nurses navigated their experience of moral distress. Throughout the processes of naming, framing and locating self, the participants were evaluating the contributing factors to their experience, and by understanding those contextual pieces they were able to determine how they processed through the next stage.

The participants moved dynamically through these stages as they were attempting to navigate their experiences of moral distress. It is important to note that, although it appears to be

a linear process, these stages of *Just Getting Through the Shift* are fluid, and in some situations occur concurrently. Participants often moved back and forth between them, building and adapting as they gained new insight, knowledge, or experience. Furthermore, this process occurred with successive experiences of moral distress, where the nurse may reflect on previous experiences to help frame, locate themselves, and guide the decision making process. Nurses may, at some point in time, regress through the phases; however, they were doing so with new knowledge and experience that further deepened their understanding of the situations.

In the scenarios that the participants provided throughout this research, resolution was almost never achieved. Despite the variation in the events leading to the experiences of moral distress, participants consistently identified the central issues as a lack of preparedness, a lack of leadership support and/or presence, and a lack of time, all of which were a result of the current healthcare climate and the corporate culture within the organization. The nurses may have been able to solve a portion of the problem, or an immediate part of the moral distress experience, nevertheless the primary factor that contributed to the moral distress was beyond their span of control, and as a result complete resolution was not achieved. Therefore, *Just Getting Through the Shift* became the basic social process to cope with moral distress. By moving through the processes of Experiencing Moral Distress, Making Sense of the Experience, and Finding the Way, they were able to address what they could, and focus on the patients who were in their care, provide the best care possible in the moment, and move forward. In other words, these stages were essential for the nurses to understand the complexity of the situation and to get through the shift successfully.

Chapter 5: Discussion

Life's most persistent and urgent question is
what are you doing for others?
Martin Luther King Jr.

The purpose of this study was to understand and articulate the processes that nurses carry out when navigating moral distress, by exploring their interactions within the health care environment. My specific research questions were (a) What morally distressing situations for acute care nurses (non-critical care) exist related to the current healthcare practice environments? (b) What is the primary cause for these morally distressing situations? (c) What organizational factors contribute to, or ameliorate, moral distress in these situations? (d) What is the process for navigating moral distress? What is the impact of these strategies? (e) What other organizational strategies would help to ameliorate moral distress effectively?

In answering these questions I developed the grounded theory of “*Just Getting Through the Shift*”. Participants identified morally distressing situations and were able to view, not only the event of moral distress, but also their practice in the context of the external constraints that gave rise to the situation. The process that the participants engaged in to navigate moral distress was to Just Get Through the Shift, which involved focusing on being patient-centred and not always addressing the issues that were contributing to the situation of moral distress. Throughout the study, participants identified strategies they employed, such as peer support, reflection, and disengaging from the events. They discussed the need for formalized organizational supports, such as opportunities to debrief, better access to resources, and participation in decision-making process regarding patient care.

Limitations of this Study

The limitations of my research study are related to the particular practice environment in which I conducted the study. I recruited nurses from non-specialty medical and surgical units in an academic teaching hospital. Furthermore, because this particular hospital is an academic teaching hospital affiliated with a large medical school, it is a high-tech environment. As a result, the findings from this grounded theory study reflect the particular place and time in which the study was conducted. But others, particularly in high-acuity medical - surgical settings, may find the findings theoretically relevant.

A further limitation of the study was the participants average age was 32 years old and the more than half the participants had less than 5 years experience. The perceptions of more novice nurses may not be applicable to more experienced nurses. That being said, more junior nurses may have a heightened awareness of ethical issues and moral distress by virtue of their education and lack of experience.

Another limitation was the lack of discussion regarding the support that the local nurses' union would have been able to provide for the nurses in this study. Neither the participants nor I explored the potential role the union may have played in assisting the navigation process.

The Problem with Moral Distress and Moral Residue in Nursing

Andrew Jameton provided the foundational definition of moral distress, as what occurs when one knows the right or ethical action to take, but due to institutional constraints, it is almost impossible to do so (1984, as cited in Wilkinson, 1988). This definition has been broadened throughout the past three decades. Källemark et al. (2004) provided a more detailed and comprehensive revision when they described moral distress as “traditional negative stress symptoms that occur due to situations that involved ethical dimensions and where the health care

provider feels she/he is not able to preserve all interests and values at stake” (p.4). The Canadian Nurses Association (2008a) elaborated on the concept of moral distress by including the compromise of nurses' integrity, by stating moral distress occurs when nursing obligations are confronted by external factors that affect nurses' identity and moral agency. Furthermore, Lützén and Kvist (2012) expanded this definition to include the nurses' experience of these external constraints, combined with the awareness of the incapacity to act in accordance with internal values.

As discussed previously, it is important to differentiate between ethical issues and moral distress. Not every ethical issue is morally distressing, if those involved are able to work through the issue and move to a place of resolution. However, in situations where there is no resolution, an ethical issue can be accompanied by moral distress. Throughout this research, it was often the organizational climate, comprised of corporate mandates and/or leadership philosophies, which although not explicitly unethical, led to external constraints that prevented the nurse from enacting his or her own moral agency. The stories provided by the participants highlighted the complex interplay between and among the organizational mandates, the unit culture, patient and family expectations, and the ability to practice in an ethical climate. They also demonstrated how the external constraints placed on nurses on a day-to-day basis contributed to their ability to practice ethically and therefore, led to ethical issues and moral distress.

The examples provided by the participants demonstrated how, without being able to acknowledge and address issues they saw as ethical, participants experienced moral distress. For example, with an organizational focus on patient access and flow, and the achievement of budget targets, the nurses in this study described not having time to meet all of the patient care needs, as well having fewer human resources to support the work. The focus on efficiency and patient

access and flow is not itself unethical; it is the downstream effect of these priorities that led to challenges to practicing ethically. These decisions led to situations where nurses were having to re-prioritize care and make decisions about what would not be accomplished and what would wait, because participant did not have time or staff to assist. This is in line with the findings of other researchers, who identify that the “corporate ethos” means that nurses’ perception of what is necessary to provide quality patient-centred care is not valued (Rodney, Buckley et al. 2013). Thus, participants experienced moral distress because they were not able to act according to their professional standards, nursing code of ethics, or their own nursing values. In most cases this moral distress was not only unresolved, but also continued to occur because the system was not changing.

An outcome of unresolved moral distress is moral residue. Moral residue is defined as what “*nurses experience when they seriously compromise themselves or allow themselves to be compromised*” (CNA, 2008a, p.7). As outlined in the literature, moral residue can have a lasting effect on nurses, both positively and negatively. For those for whom moral residue can be a positive influence, engaging in personal and professional reflection on the events may lead to improved practice (CNA, 2008a; Rodney, Kadyschuk et al., 2013), and those who experience a negative impact of moral residue, can experience lasting emotional suffering, denial, or disengagement (Harrdingham, 2004; Pauly, et al., 2012; Rodney, Kadyschuk et al., 2013).

Various participants demonstrated moral residue when they shared stories of how their decisions about how to respond, and the subsequent outcomes of events, remained with them for long periods of time. Participants at times seemed to relive the experience, as if it happened only the day before; their memories were vivid and their sense of guilt, disappointment, and frustration were visible. The negative impact of moral residue can be subtle and long lasting, as

reflected in Amanda's story, while she described becoming emotionally overwhelmed during a procedure as a result of a memory being triggered. In the interview, she actually moved back and forth between the past and present tense, and it was hard to discern what time frame she was referring to; for her the moral distress was all encompassing.

In addition to the above example, Eric's story of his inability to reach a resolution led to his ongoing moral residue and contributed to his sense of burnout. Eric's experience, where he was not supported through the crisis of his coworker, carried a significant amount of moral residue, as illustrated by his comments, "*I do internalize it ...I'll go for, for a walk if I start thinking about...I have to do a lot of things before I got to sleep at night and have a good rest...reading, distraction, whatever*". Eric was not alone in the lingering effects. As discussed in Chapter 4, participants described having nightmares and difficulty sleeping, and being overcome with emotion. Moral residue is an ongoing concern for these participants, not only as a result for the initial experience of moral distress, but also because the situations that gave rise to moral distress were not diminishing, the participants continued to be compromised in their ability to enact ethical practice.

This enduring compromise and moral residue, in the cases of these participants, did not lead to situations of nurses leaving their unit, or leaving the profession; attrition, or conflict (Rodney et al., 2006; Rodney, Kadyschuk, 2013). Moral residue and/or the inability to enact moral agency, has been linked to nursing burn out and staff attrition as a result of the impact of feeling morally compromised, lack of supports along with the lasting impact of physical and psychological effects (Erlen, 2001; Hamric, 2000; Rodney et al., 2006; Rodney & Buckley, et al., 2013; Rodney & Kadyschuk, et al. 2013). Learned helplessness is the "belief that one has little control over situations", in other words, individuals perceive themselves as not being able

to change the outcome of a negative situation as a result of previous attempts that have not led to regular success (Bukatko & Daehler, 2001).

Nurses stayed on their units and continued to work. However, they portrayed frustration, disappointment, and cynicism, which have the potential to lead to negative patient outcomes, as nurses become disengaged from the patients and the care they are providing. Participants talked about going with the flow, not speaking up, or not bothering to argue, because the situations were now the new normal. The underlying current was a sense of powerlessness. The participants believed they were not able to make a positive impact or change the course of action, regardless of what they did, and subsequently they stopped trying. The concepts of learned helplessness and disempowerment discussed in this study are in alignment with the findings of other researchers and the work on moral agency (Austin, 2007; Corley et al., 2005; Rodney et al., 2006; Rodney, Kadyschuk et al, 2013; Rodney, Buckley et al, 2013; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012).

Moral agency is defined by the CNA (2008a) as “*the capacity of power of a nurse to direct his or her motives and actions to some ethical end; essentially, doing what is good and right*” (p. 26). In situations where nurses were feeling disempowered, or unable to fight against the system, their ability to act as moral agents was compromised. Rodney, Kadyschuk et al. (2013) discuss the importance of the relationship with the environment/system, because without a structure that empowers nurses to be able to make choices and be autonomous, their moral agency is constrained. The participants in this study were able to recognize and reflect on the various situations they encountered, and were able to identify how they should act, but were not able to make those choices because the choice was not theirs to make.

Implications for Practice

The participants in this research study identified challenges with enacting their moral agency. They described feeling unable to be agents of change, and to advocate successfully for what they believed to be patient-centred care. Situations that contributed to this were issues of feeling powerless, bullying between peers, bullying by leaders, and challenging interactions with patients and families.

With the increase in technology and more patients presenting with complex comorbidities, coupled with the increase in health literacy of patients and families, nurses are experiencing more challenging patient and family interactions. Equipping nurses with tools and resources to help educate patients and families, in particular to ensure they are accessing correct information, is essential. Nurses need to feel empowered and trusted by their leaders and physician partners to engage in dialogue and health teaching with patients and families. They also need time and space to have these conversations, and be supported in working with patients and families.

Understanding the resources that are available, both internally and externally, for support in challenging situations is essential for nurses to navigate moral distress, and enact changes. Internal supports, such as leaders, ethics consultants, spiritual care, union representatives, and professional practice consultants, need to be easily accessible, and nurses need not to be afraid to reach out to these supports. Furthermore, externally, nurses have access to professional associations, the College of Nurses of Ontario, and the Canadian Nurses Association. Becoming active in these associations could assist in nurses in gaining supports and resources, and will empower them to advocate for their patients and the profession.

Implications for Administration

The participants in this research study identified the importance of relying on their peers to assist in navigating the experience of moral distress. The participants described how they used their peer relationships as a way to validate their experiences and gain clarification or information from them. Moreover, the participants discussed the need to debrief and the absences of a formal debrief process; they, in turn, relied on their peers for this emotional support. The participants frequently described the strength of their team in terms of how they helped one another in the moment to achieve *Just Getting Through The Shift*, however, when questioned as to other resources they had access to for support, the participants were often unable to provide alternatives to their immediate peers. Perhaps part of the reason for this inability to identify organizational supports beyond their coworkers is a reflection of the moral climate of the organization, and possibly the health care system as a whole. I propose that, in conjunction with the corporatization of health care and the focus on efficiency, debriefing with staff has also fallen into the quality improvement paradigm and moved away from supporting staff. Therefore, if nurses are not able to discuss their moral distress in debriefing with their leaders, how can there be opportunity to improve the health care environment and allow for nurses to enact day to day ethical practice?

The moral climate of the organization is defined as the implicit and explicit values that drive the delivery of care and the form of the workplaces in which nurses practice (CNA, 2008a; Rodney et al., 2006). The moral climate of the hospital where the participants worked was one that values efficiency, corporatization, and meeting both internal and external targets. As a result, the nurses were not able to access supports, because they had been decreased or cut completely. Or participants were unaware of them because they were not considered a priority,

or they do not have the time to access supports. Organizations would be wise to invest in ways to enhance both awareness and access to support services, such as ethics consults, spiritual care resources, and employee assistance programs.

Furthermore, supporting staff in having time and space to discuss purposefully the issues and experience of moral distress may assist in ameliorating the events (Pauly et al., 2012). Having a forum where nurses can engage in dialogue with leadership to express their challenges in enacting ethical practice, and their experiences of moral distress, may contribute to changing the environment to start framing discussions in the context of both meeting the standards of practice and moral practice. The situations that are giving rise to moral distress are not separate from the organization and/or system. As discussed in the literature, nurses are not always able to enact ethical practice; it is not a simple decision of doing what is right, because the practice setting is where the ethical problems and constraints exist (Hardingham, 2004, Pauly et al. 2012). Organizations should provide opportunity in a safe way to explore the experiences of the staff, examine the staff's perceived contributing factors, and potential solutions. As well, the lack of awareness or uptake of clinical ethics support leads to the suggestion that more time and effort be given to ethics education for frontline staff.

A contributing factor to moral distress for participants in this study was the impact of transferring patients off their units, as well as receiving patients that were outside of the expertise of the unit. Participants discussed the lack of knowledge, skill, and physical resources (e.g. equipment, educational materials, and support staff,) to provide comprehensive and safe care for these patients. They expressed challenges with the admitting and patient access and flow mandates, which led to potentially unsafe situations, yet were unable to advocate for different outcomes. Organizations would benefit from focusing on bed-mapping practices, whereby they

evaluate the current allocation of beds for each service to determine if the physical space meets the volume needs of that patient population. In making up-to-date and accurate patient education materials, practice standards, and guidelines available to all staff, regardless of the department/program, nurses would have better resources to provide care when they are faced with a patient population with which they are unfamiliar. Creating greater collaboration between programs, and enhancing communication at the front line level, can support nurses in accessing resources and information.

The common thread amongst the contributing factors for moral distress was the impact of leaders and their actions as seen in the above discussion. The perception of the participants was often that their leaders were not supportive, and this contributed to the experience of moral distress, but as noted by a few participants, there was an understanding that the leaders were placed in a compromising position by not being able to act in an ethical manner. This highlights the need to discuss the need for ethical leadership and the challenges that leaders can face due to external constraints and pressures.

The moral climate of an organization is directly influenced by the leadership practices; therefore, ethical leadership is necessary to work towards a moral climate (Newton et al., 2012; Rodney et al., 2006; Storch, Makaroff, Pauly, & Newton, 2013). Ethical leadership includes the need to work collaboratively with frontline nurses, role modeling ethical behavior, and recognizing and encouraging the discussion of ethical decisions (Rodney et al., 2006; Storch, et al., 2009; Storch et al., 2013). The nurses in this study identified a lack of ethical leadership when they discussed being brushed off or “squashed down” when they spoke up, as well as a lack of accessibility to their leaders. Participants expressed the desire to be part of the decision making process, in particular when it came to decisions regarding discharges and transfers, and

felt left out of the process by the leaders. This echoes the issue of power that was identified in the findings. Nurses were locating themselves in terms of where they fit in the hierarchy of the unit, specifically related to their power relationship with their leaders. Consequently the power structures impact the nurses' ability to practice ethically and enact moral agency (Rodney, Buckley et al., 2013). It is necessary to acknowledge the power imbalances within organizations as it relates to nurses and nurse leaders in order to identify where there is opportunity for improvement in these relationships. The nurses in this study discussed the perception that they did not have a relationship with their leaders, and reflected an "us" and "them" attitude, that, it can be argued, is a result of the corporate ethos. As Newton et al. (2012) identified, "attending to power relations is an important aspect of building a positive ethical climate". It has been argued that the corporatization of health care has contributed to the power inequities within organizations (Rodney, Buckley et al., 2013). Nurse leaders have an opportunity to be a valuable part of facilitating discussions regarding ethical issues. This could ensure that nurses are able to raise concerns and work with their leaders to resolve issues, and enact moral agency (Newton, et al., 2012).

It is important however, to recognize that leaders may also be experiencing moral distress, or having difficulty enacting their moral agency. Just as nurses felt torn between what they believed was the correct course of action and what the leaders' decision was, nurse leaders may also feel torn between what they feel they ought to do and what the senior levels of the organization or other external influences are directing. Moral distress can occur for the nurse leader when their values are compromised as a result of having to set priorities and make difficult decisions related to resource allocation (Mitton, Peacock, Storch, Smith & Cornelissen, 2011). This was touched on briefly by a few of the participants when they expressed an

understanding that the leaders were experiencing pressures from above and they were unable to make different decisions.

The additional layer of complexity is that leaders may not have been able to express their distress to their staff with the decisions they were making, and thus they appeared to be unethical. Leaders are having to toggle between their personal values, their accountability to their staff and colleagues, and defending the decisions they must carry out that have been made in the best interest of the organization (Mitton, et al., 2011). The experience of moral distress in leaders can inhibit to their ability to role model ethical practice, and lead to the misconception that they are unethical themselves. I would argue that leaders should have the same opportunities as frontline staff to address moral distress and openly discuss ethical challenges with senior leadership. In doing so, a stronger moral climate can develop within hospitals. Organizations need to be aware that front line or mid level leaders may be experiencing moral distress, and the various influences causing moral distress. Therefore, it would behoove senior leadership to put in place strategies for leaders to prevent and/or mitigate moral distress. Furthermore, greater collaboration between all levels of an organization and a safe place to voice concerns would benefit all members of the health care team.

Implications for Policy

A considerable cause of moral distress for the participants in this research was that of contrasting values and priorities of the various levels throughout the health care system. As previously discussed, nurses in this study were able to recognize and appreciate the different influences at various levels contributing to the decisions being made regarding patient care at the bedside. There was an understanding of the pressures from both within and outside of the organization. For example, frontline leaders needed to meet their performance metrics, such as

decreasing average length of stay, discharge times and rates, all of which were being set by senior leadership. Furthermore, the pressures from outside the organization include such things as provincial wait-time targets; and above all else, the issue of funding allocation from the federal government down through to the local integrated health networks and on to the hospital itself. As a result, the priority of the organization's senior leadership and health system was that of efficiency, timeliness, and budget consciousness. Yet the nurses' priority was that of patient-centred care, continuity of care, and accountability to the patients they cared for, and this led to situations where the participants' nursing values were in opposition to the hospital administration's focus of resource and budget management.

The downstream effect of these external pressures led to the situations described by the participants where patients were routinely transferred or discharged when they were no longer deemed acutely ill, to make room for the new admissions, new post-operative patients, and those consider more acute. As a result, there was a significant fear that these patients would be readmitted (if discharged) with complications through the emergency department, or would not receive the level of expert care on the off-service units, and would suffer adverse outcomes as a result of these decisions. The lack of consistent and clear policies for admission, transfer, and discharge requirements contributed to the inconsistent approach by the frontline leadership. This also left the frontline nurses, who were attempting to advocate against these decisions, without supports to back their arguments. One participant shared how grateful she was that her unit had admission criteria for their step-down unit because it prevented misuse of those beds and ensured that the patients being admitted met the staff's knowledge and skill. In addition, enhancing collaboration between services across the organization would mitigate negative patient outcomes when these situations are unavoidable.

Beyond the issue of policy regarding patient access and flow, participants identified that there was a difficulty in accessing and finding policies, and in some cases, nurses not knowing if there were policies regarding patient care, human resource management, and other matters. This contributed to the sense of “not knowing what to do” in the situations participants described. As well, there were examples when policy was considered too rigid and led to situations where there was no opportunity for negotiation. The negative effect of a lack of policy, or constriction of policy, has been identified in other research on moral distress, as Storch et al. (2002) stated, “The organizational climate, including policy development and implementation in agencies, is problematic for nurses” (p. 9). As a result, it would be helpful for the senior leadership to develop a system that allows for better access to policies, and makes all staff aware the policies that are in place. Furthermore, having a system that allows for more frontline staff inclusion in the development of policies could have positive outcomes in this regard.

As discussed above, nurses stressed the need for opportunities to debrief and have time and space to be able to talk through their experiences. However, this often was not possible due to the organizational constraints, such as increased workload, decreased staffing levels, and the high rate of patient turnover. These constraints not only limited the ability for staff to engage in dialogue with peers and leaders, but also decreased their ability for self care related to experiences of moral distress. As Pauly et al. (2011) suggested, this current environment contributes to the sense of helplessness and powerlessness; therefore, having policy within an organization that allows for this ability to work through and achieve resolution is necessary.

Implications for Research

The focus of this research was to develop a substantive theory to outline the basic social process of how nurses navigate moral distress within acute care medical-surgical units.

However, another outcome of this research was identifying the need to understand further the role of nursing leadership in both navigating and mitigating moral distress. It is evident there is substantial literature on what is moral distress, its causes, and the impact to nurses. However, from the results of this research I identified three issues that require further research related to navigating moral distress: (a) the role of leadership and communication, (b) processes for addressing moral distress, and (c) what meaningful and practical actions nurses and leaders can take to work through moral distress. Participants consistently identified a lack of leadership and/or poor communication with leadership throughout the events of moral distress. The ripple effect of this was the inability of participants to know how to engage with their leaders to work collectively to resolve the situations. What is needed is further understanding as to the role of leaders at all levels, and their accountability and participation in navigating moral distress with the frontline staff. This includes exploring what is the process for raising moral and ethical concerns within an organization.

The CNA (2008) and the CNO (2002a & 2002b) discuss the individual professional accountability that nurses have to recognize and address ethical issues, however research is needed to determine how nurses can be supported to identify and raise ethical concerns in a collaborative and meaningful way with leadership. As well, having a better understanding of the role that nursing leadership, both formal leaders such as coordinators and directors, and informal leaders such as advance practice nurses, can have in navigating and mitigating moral distress is also needed, because nurses are not experiencing moral distress alone.

One of the findings in my research was the repeated request for debriefing sessions. There is literature on critical incident debriefing, and quality improvement debriefing, however, there is a lack of research to evaluate how to make debriefing sessions useful in alleviating and

mitigating moral distress. Furthermore there is a need to understand, from the perception of the nurses themselves, what is helpful and meaningful for them to navigate moral distress. Musto, Rodney, and Vanderheide (2015), also recognized this need for further research in this area.

Summary

This research adds to the body of knowledge on moral distress by supporting the idea that there is a direct relationship between the environment, or structure, and moral agency. The ability for nurses to demonstrate moral agency is directly related to context, situations, and the relationships between the nurses and others. Furthermore it supports the idea of having space and opportunity to engage in reflective dialogue with others, in particular colleagues, leaders, and patients. The purpose of this research was to describe morally distressing situations that nurses experienced, understand the contextual influences that gave rise to moral distress, and explore what the process was that nurses undertook to navigate moral distress. This involved understanding barriers to resolving moral distress, as well as strategies, both personal and organizational that assisted in alleviating the situations. Participants identified the inability to advocate successfully against the current organizational environment, and yet remain patient-centred, as the root cause of the experience of moral distress. The result was a necessity just to get through the shift. Participants identified multiple factors that contributed to the current organizational climate that led to their experiences of moral distress. The most commonly identified strategies that nurses identified to assist them in navigating moral distress was by asking “What do I do now?” and identifying and understanding the context of the situations, where they fit into the hierarchy of the organization and/or unit. Another key component of navigating moral distress was relying on a peer network and their teams, to validate, help gather information, and most importantly, be a sounding board and a moral support.

In order to create an organizational environment where nurses are able to practice ethically and focus on being patient-centred, organizational leaders need to create a supportive environment where nurses can feel safe to discuss their experiences. Organizations need to step back from a focus of corporatizing the health care delivery, and reexamine the notion of what it means to be patient-centred. Furthermore, ensuring that continuous quality improvement and striving for efficiencies, do not exclude the human emotions component of health care. Hospital leaders need to create time, space, and networks for nurses and leaders to acknowledge, reflect, and learn from these experiences, which includes understanding how the nurses are feeling, and coping, by engaging in positive debriefing sessions. In doing so, nurses will be able to work through their experience of moral distress, and potentially find resolution.

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Appendix A
Sample Demographics

Participant	Age	Gender	Education	Length of time in nursing at time of interview	Work setting at time of interview
1	30	F	BScN	8	Surgical
2	38	F	BScN, MN, NP	10	Surgical
3	25	F	BScN	2	Medicine
4	25	M	BScN	2	Medicine & Surgical
5	37	F	BScN	14.5	Surgical
6	27	F	BScN	2.5	Medicine
7	54	F	Diploma	33	Medicine
8	25	F	BScN	1.5	Medicine
9	30	F	BScN, MN(can)	5	Surgical

Appendix B
Draft Interview Guide

1. Tell me about a time when you experienced a distressing situation while working on your unit.

Potential follow-up prompts:

- Can you elaborate on that or tell me more about that?
- And then what happened?
- What specifically did you find distressing about this situation?

2. Would you say that this experience was “morally distressing” and/or did you feel that you were placed in an unethical situation?

If so, what made it morally distressing and why?

Potential follow-up prompts

- Were there organizational factors that contributed to the distress?
- Did new or advancing technology play a role in the situation, i.e. new procedure, new techniques, or new equipment?

3. How did you respond? What did you do next?

4. What did you see as available options for addressing this situation and your moral distress within the organization?

5. What did you not see as options for you to address the situation?

6. What would you have liked to see as options for you to work through this moral distress?

Appendix C



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Project Title: How Do Nurses Navigate Moral Distress

Principal Investigator:

Robert Sibbald, Clinical Ethicist, Medical Affairs,

Robert.Sibbald@lhsc.on.ca

519-685-8500 ext. 75112

Letter of Information

You are being invited to participate in this research study entitled, How Do Nurses Navigate Moral Distress that is being conducted by Elizabeth McMurray RN, BScN, MN(c) because you are a Registered Nurse/Registered Practical Nurse employed in a medical or surgical inpatient unit at London Health Sciences Center.

The purpose of this letter is to provide you with information required for you to make an informed decision regarding participation in this research.

Purpose of this Study

The purpose of this research project is to develop a pragmatic theory regarding the processes that nurses carry out when navigating moral distress. Furthermore, through this study, I will also gain an

understanding of how nurses are able or not able to navigate their moral distress and articulate what organizational supports could be implemented to alleviate the moral distress caused as a consequence of both advancing medical technology and the corporatization of our health care system. Research objectives include:

Describe morally distressing situations related to advancing medical technology.

- a) Describe organizational factors that contribute to or ameliorate moral distress in these situations.
- b) Obtain a description of what barriers exist for nurses to address and resolve moral distress both clinically and organizationally.
- c) Describe supports, both existing and desired, that would alleviate moral distress.

Specific research questions are:

- a) What are morally distressing situations for acute care nurses (non-critical care) related to advancing medical technology?
- b) What organizational factors contribute to or ameliorate moral distress in these situations?
- c) What organizational strategies are in place to address moral distress? What is the impact of these strategies?
- d) What other organizational strategies would help to ameliorate moral distress effectively?

Inclusion Criteria

Individuals who are a Registered Nurse/Registered Practical Nurse registered with the College of Nurses of Ontario and work on an inpatient medical or surgical unit working full-time, part-time or casual you are eligible to participate in this study.

Exclusion Criteria

Individuals who are currently working in a speciality area such as critical care, intensive care, paediatrics, multi-organ transplant, oncology or ambulatory care are not eligible for this study.

Study Procedures

If you agree to participate, you will be asked to participate in a face-to-face interview. It is anticipated that the entire task will take 45-60 minutes over 1 – 2 session(s). The task will be conducted in a location off hospital property and outside of work hours at a location of your convenience. There will be a total of approximately 15 participants as applicable. . All interviews will be audiotaped to ensure accuracy of the

information collected this collection method is not optional. Written notes will be taken during the interview and transcripts will be made. If you do not wish to be audio recorded please do not participate in this study.

Possible Risks and Harms

The possible risks and harms to you include a possible emotional response when recalling a difficult situation that led to moral distress. To prevent or to deal with these risks, the following steps will be taken: time will be given to you if you need a break, the interview can be suspended and rescheduled, or you will have the opportunity to withdraw from the study. I can also provide the contact information for the EAP program if necessary.

Possible Benefits

The possible benefits of your participation in this research include possible strategies that can be instituted at London Health Sciences Center to assist nurses in navigating moral distress.

Compensation

You will not be compensated for your participation in this research.

Voluntary Participation

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future employment.

Confidentiality

All data collected will be coded and no personal identifiers will be used. All research data will be stored in a secure manner, encrypted flash drive, password protected files on a password-protected computer, and all hard copy transcripts will be stored in a locked filing cabinet in the researcher's office. All data collected will remain confidential and accessible only to the investigators of this study. If the results are published, your name will not be used. If you choose to withdraw from the study you will be asked if the data you have provided may still be used in the study. If you choose not to give permission to have your data used, it will be removed and destroyed upon your withdrawal from the study.

Qualified representatives of the following organizations may look at your medical/clinical study records at the site where these records are held, for quality assurance (to check that the information collected for the study is correct and follows proper laws and guidelines. Examples include:

- Representatives of Lawson Quality Assurance Education Program
- Representatives of the University of Western Ontario Health Sciences Research Ethics Board that oversees the ethical conduct of this study.

Contacts for Further Information

If you require any further information regarding this research project or your participation in the study you may contact

Principal Investigator:

Robert Sibbald, Clinical Ethicist, Medical Affairs,

Robert.Sibbald@lhsc.on.ca

519-685-8500 ext. 75112

Co-Investigator/Student researcher:

Elizabeth McMurray

Elizabeth.McMurray@sjhc.london.on.ca

519-646-6100 ext. 47087

University of Victoria Supervisors:

Dr. Bernadette Pauly,

250-472-5915

Dr. Rita Schreiber

250-721-6462,

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics (519) 661-3036, email: ethics@uwo.ca or the Human Research Ethics Office at the University of Victoria (250) 472-4545 email: ethics@uvic.ca

Publication

If the results of the study are published, your name will not be used. If you would like to receive a copy of any potential study results, please contact Elizabeth McMurray.

Consent

Your written consent will be obtained in writing at the beginning of the interview. Furthermore, to make sure that you continue to consent to participate in this research, I will periodically throughout the study have you review the original consent form and initial it as documentation of your ongoing consent.

This letter is yours to keep for future reference.

Consent Form

Project Title: How Do Nurses Navigate Moral Distress

Study Investigator's Name: Elizabeth McMurray

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Child's Name: (if applicable) _____

Participant's Name (please print): _____

Participant's Signature: _____

Date: _____

Parent / Legal Guardian / Legally Authorized Representative (if applicable) Print: _____

Parent / Legal Guardian / Legally Authorized Representative (if applicable) Sign: _____

Parent / Legal Guardian / Legally Authorized Representative (if applicable) Date: _____

Person Obtaining Informed Consent (please print): _____

Signature: _____

Date: _____