MORAL DISTRESS AMONG REGULATED AND UNREGULATED CARE PROVIDERS EMPLOYED IN LONG TERM CARE SETTINGS

by

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Abstract

Purpose and Research Questions

The purpose of this research was to describe the experience of moral distress among regulated and unregulated nursing personnel employed in Long Term Care (LTC) facilities. The specific research questions were: 1) Do regulated and unregulated nursing personnel experience moral distress? 2) What is the nature of moral distress in LTC facilities? 3) How do nursing personnel describe and perceive the experience of moral distress? 4) What are the organizational factors that participants perceive as contributing to or reducing moral distress in their workplace?

Methods

A qualitative, descriptive, study design was used. Semi-structured interviews were the method of data collection and analysis was conducted using thematic content analysis as proposed by Miles and Huberman’s (1994). A purposive sample of 16 participants was recruited from two LTC facilities.

Findings

Participants described work experiences in which they felt they were unable to do the “right thing”. There were four kinds of situations that gave rise to moral distress: end of life care, resident behaviours, other direct care provider behaviours and the work environment. The experience of moral distress was described in terms of an initial emotional reaction, followed by a response, with resolved or unresolved outcomes. Half of the examples described by participants as giving rise to moral distress, remained unresolved. Participants also identified organizational factors that prevented moral distress and assisted with its resolution such as, educational courses, administrative leadership and pastoral support.
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“It is curious - curious that physical courage should be so common in the world and moral courage so rare”

-Mark Twain
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Chapter 1

Introduction

The Concept of Moral Distress

Moral distress is not a new concept; it has been identified in the literature for more than two decades yet it remains a widespread problem in healthcare (Erlen, 2001). The term “moral distress” was originally coined by Jameton (1984) in his book on ethical issues in nursing. He defined the concept as a painful feeling or “psychological disequilibrium” arising when nurses are unable to implement the “best” course of action for the patient (Jameton, 1984). This inability to take action can be due to internal or external constraints, such as an individual’s personal belief system or organizational factors perceived as beyond their control (Wilkinson, 1987/1988).

Webster and Baylis (2000) added to the discussion with the statement that moral distress is a clash between one’s beliefs and what one does or what one fails to do. They discussed the idea of “moral residue”, which refers to the persistent feelings that follow from the sense that one has morally compromised their beliefs.

Moral Distress in Nursing

Moral distress has the potential to affect every nurse in every healthcare setting (Green & Jeffers, 2006). There is a growing recognition among researchers that moral distress continues to be a significant issue for nurses (Erlen, 2001). Nurses employed in a healthcare institution must uphold goals as determined by the administration (Corley, 1995). However, upholding these goals may conflict with nurses’ inherent sense of what is morally right. It is no wonder that conflict often arises as a nurse tries to balance organizational commitment, patient commitment and the commitment to his or her internal belief system. Moral distress occurs when this conflict arises and a nurse feels personally or professionally thwarted from taking “right” action (Corley).
Care providers have identified time constraints and heavy workload as giving rise to moral distress in their workplace (Jakobsen & Sorlie, 2010).

Some studies have found that moral distress leads to job dissatisfaction and “burnout”. In some cases, nurses reported that moral distress was a contributing factor in their decision to leave the nursing profession (Corley, 2002). Other care providers reported that in order to stay, they felt they had to suppress their conscience (Jakobsen & Sorlie, 2010). Moral distress not only negatively affects nursing personnel in terms of retention and attrition it may also result in negative feelings such as: anger, frustration, sadness and even physical symptoms for the care provider (Wilkinson, 1987/1988). Some nurses may attempt to cope with their distress by avoiding or distancing themselves from their patients (Raines, 2000). Moral distress affects the way nurses care for themselves, their patients and the way they deliver care in the institutions in which they work (Hanna, 2004).

**The Context of Moral Distress in Healthcare**

Ethical situations have been discussed in the literature as problematic for decades. In recent years there has been growing attention given to moral distress among care providers in healthcare environments. Some of this distress has been attributed to: the perception that patients are suffering (Raines, 2000), medical intervention that is perceived to prolong death (Corley, 1995), lack of financial resources (Pijl-Zieber et al., 2008), time constraints (Rittenmeyer & Huffman, 2009), inadequate staffing levels (Corley, 2000) and policy constraints (Redman & Fry, 2000). In Long Term Care, the number of older adults who require more complex care is increasing and the number of nurses able to provide that care is diminishing (Jakobsen & Sorlie, 2010). According to Pijl-Zieber et al., (2008), as healthcare providers continue to practice in complex and overburdened environments they remain vulnerable to moral distress. Therefore, the phenomenon of moral distress remains a relevant research priority.
**Moral Distress in Long Term Care**

Following a preliminary search of the literature, minimal research was found pertaining to the phenomenon of moral distress in Long Term Care (LTC) settings. Although unregulated care providers carry out most of the direct personal care for residents in LTC facilities, study of the experiences of these providers is virtually absent from the literature. Most studies of moral distress are primarily focused on Registered Nurses (RN) working in critical care environments such as Intensive Care Units. What we do know about Registered Nurses in acute care settings is that morally distressing situations are often related to disagreements between the nurse and physician regarding client care, particularly end of life (EOL) and quality of life (QOL) issues (Corley, 1995).

There is some indication that in LTC facilities, personnel also encounter ethically challenging situations. Smith (2004) points out in a report prepared for the Ontario Ministry of Health and Long Term Care (MOHLTC), that there is a persistent nursing resource deficit in the LTC sector (MOHLTC, 2004). She asserted that nursing resources are insufficient to meet the needs of the residents living in LTC and that these insufficiencies in the workplace often give rise to ethical dilemmas for both regulated and unregulated nursing personnel. The result is a work environment where caregivers face new and more difficult challenges in providing ethical care while maintaining the rights of residents (Smith).

**Unregulated Care Providers in Long Term Care**

LTC employers and employees have been under tremendous pressure as they are faced with fewer resources for delivering resident care. Pyper (2004) identified some factors which explained limited staffing resources for healthcare workers in Canada: an aging workforce that is fast approaching retirement, a declining enrolment in nursing programs throughout the 1990s and fiscal restraints. Compared to acute care hospitals in Canada, LTC facilities utilize unregulated direct care providers to provide the majority of direct care for residents. Since the late 1980s, in
order to control health care costs and address this chronic pressure, LTC institutions have encouraged the increased use of lower-paid unregulated workers such as, Personal Support Workers (PSW) (CNA 1995; CPNA 1999; RNAO, 1996).

As there has been limited research on moral distress in LTC facilities, little is known about the experience of moral distress among regulated and unregulated nursing personnel who work in these facilities. It is not clear if the experience of moral distress is different for regulated and unregulated care providers given the difference in educational preparation and the nature of the job responsibilities.

**The Purpose**

The purpose of this research was to describe the experience of moral distress among regulated and unregulated nursing personnel employed in LTC facilities. Direct nursing care provider groups included: Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).
Chapter 2

Review of the Literature

A review of the literature was conducted to describe the concept of moral distress and what is known about moral distress in health care and more specifically, in Long Term Care settings.

**Search Strategy**

A comprehensive search for articles was completed from 1980 through to 2010, using MEDLINE, EMBASE, AMED, PsycINFO, Cumulative Index for Nursing and Allied Health Literature (CINAHL) and Cochrane databases. Three combined subsets were searched; moral distress, nursing personnel and LTC. The keywords differed slightly from various databases in order to capture exact meanings for each unique database. The search was limited to the English language.

This search strategy yielded 1270 articles, of which 156 duplicates were removed to yield 1121 articles. Of these, most were excluded based on a title or an abstract review as they did not focus specifically on moral distress. Articles that were omitted focused on: stress, workplace and occupational stress, job satisfaction and dissatisfaction and emotional or psychological reactions to exhaustion. The thirty articles that were retained focused on: ethics and morals, distress, privacy, autonomy, integrity, consciousness and psychological well-being (Appendix A). These remaining articles included research reports and conceptual writings on moral distress. A search alert was used through 2009 and an update was done in July 2010. In addition, books on nursing ethics or health care ethics were identified that addressed the topic of moral distress.

**Definition of Moral Distress**

In 1984, a philosopher named Andrew Jameton first conceptualized the term moral distress. He explored the difference between moral knowing and moral action and discussed
these ideas in terms of the nursing profession. Jameton noted when a nurse knew the “right” thing to do, but was unable to implement that course of action due to institutional constraints, he or she often experiences a feeling of unrest. He further labeled this feeling of unrest as moral distress (Jameton). Jameton’s later works identified two types of ethical distress. These included initial distress and reactive distress (1993). Initial distress is the nurse’s emotional response to a morally distressing situation, including feelings such as, frustration, fear, anger and anxiety. A nurse may experience these negative emotions when faced with barriers or institutional obstacles. When the nurse does not take action that they believe to be the “right” action, he or she experiences what Jameton called reactive distress (1993). Jameton reported that when a nurse failed to act in the face of such constraints or obstacles, the nurses may experience both reactive distress as well as initial distress.

In 1987/1988 Wilkinson conducted a study of 26 Registered Nurses. Her findings furthered the discussion of moral distress, to be a response or emotion that resonates within an individual who is faced with an ethical decision and is unable to choose the most ethically appropriate action. This inability to choose may not only be due to institutional constraints, but also internal and external restraints (Wilkinson). An example of internal constraints could include the internalization of the traditional view that a nurse was a physician’s assistant, incapable of independent thought. Wilkinson’s examples of external constraints included the nurse’s interpersonal relationships with physicians, managers and even how the nurse interpreted the institutional policies.

In 2000, Webster and Baylis published a case study of nurses and other healthcare professionals which examined the residual effects of moral distress. They recommended that internal constraints giving rise to moral distress be expanded beyond Jameton’s and Wilkinson’s definitions. Webster and Baylis reported that internal constraints, also include when a nurse changes his or her perception of what was the “right” course of action to take. For example, originally a nurse may perceive themselves as taking the “right” course of action in the situation,
but upon reflection changes their belief and perceived themselves as having not pursued the ‘right’ course of action. Webster and Baylis described this change in belief of what was “right” as an internal barrier which also gives rise to moral distress (2000). In addition, the Canadian Nurses’ Association’s (CNA) code of ethics for Registered Nurses, echoed this view by stating when nurses are unable to implement what is believed to be the ‘right’ course of action, they fail to meet their ethical obligations or commitments (CNA, 2000).

Despite the academic advancements which build on or attempt to clarify the concept of moral distress, most researchers remain at an impasse when challenged with further defining the phenomenon of moral distress (Corley, 1995; Powell, 1998, Hanna, 2002, Repenshek, 2009).

**Differences between Dilemmas and Distress**

It is important to note that there are differences between an ethical dilemma and ethical distress as defined by the CNA (2002). An ethical dilemma can be a situation which arises that has two equally ethically compelling options in support of and opposing an action in a particular situation. A number of examples of ethical dilemmas have been described in the literature related to end of life and quality of life decisions. Dilemmas which were reported encompassed: do not resuscitate (DNR) or cardiopulmonary (CPR) orders, nutritional and hydration maintenance for patients, as well as equitable resource allocation (Gordon & Singer, 1995). Ethical distress can be illustrated with a situation when the nurse has already weighed the options and made the decision as to the ‘right’ course of action to pursue and is prevented from implementing that action due to barriers (CNA). More concisely, when a nurse observes that a patient is in need of incontinence care, but is unable to provide that hygiene care immediately, due to staffing shortages, the nurse may experience moral distress. This example illustrates how decreased staffing levels can manifest as a barrier for the nurse, since he or she is unable to perform prompt skin care for the patient. According to Webster and Baylis (2000), not only does moral distress ensue when a nurse is precluded from pursuing what is believed to be the right course of action, but also the nurse has a sense of having compromised his or her integrity. That compromise may lead to
moral residue that the nurse may carry for many years, and in some cases a lifetime (Webster & Baylis).

**Causes of Moral Distress**

Over the years philosophers, ethicists and nurse theorists have studied issues surrounding moral distress. Factors associated with moral distress include fiscal constraints, staffing retention rates, end of life care, as well as a lack of interdisciplinary collaboration with physicians (Corley, 2002).

**Limited Financial Resources**

Periodically institutional procedures compete with the nurse’s individual value system. Examples of this type of conflict include the availability of supplies. For example, a certain type of dressing may be used for a particular type of wound by the facility, despite the fact that there is a superior product available; it is not utilized due to cost saving measures. In this case, moral distress has the potential to arise when nurses perceive that they must put the institution’s needs for fiscal efficiency above that of the residents’ care needs (Mauleon et al., 2005). In the event that these constraints conflict with what the nurse believes to be the ‘right’ course of action, moral distress often ensues (Pijl-Zieber et al., 2008).

**Limited Staffing Resources**

Nordam, Torjuul and Sorlie (2005) found that nurses in LTC settings felt that they were unable to provide adequate care to their residents due to unsafe staffing ratios. This resulted in feelings of guilt for the care provider. Therapeutic nurse-client relationships are seen as an integral part of quality patient care and when nurses are unable to nurture that relationship due to institutional constraints such as limited staff, they are placed at a greater risk of developing moral distress (Nordam, Torjuul & Sorlie). Contributing to this issue, Decker et al., (2001) found that it was shown that nursing staff employed in the LTC sector have significantly higher turnover rates when compared to their acute care equivalents (Decker et al., 2001).
**Policy or Administrative Barriers**

The power imbalance within the hierarchical structure and the lack of collaboration between nurses and physicians is a common stressor among nurses. Austin, Bergum and Goldberg (2003), conducted semi-structured interviews with six regulated and unregulated care providers and their experiences of moral distress. Mental health nurses in this study reported that they experienced moral distress when they lacked resources to give adequate care and their concerns were not heard by the administration. As a result they feel alone and “abandoned” in carrying out their responsibilities (Austin et al.,). For example, when a nurses suggestion about a medication is not acted on by the physician, the nurses’ sense of “self-efficacy is gradually eroded” (Pijl-Zieber et al., 2008 p. 43). Jakobsen and Sorlie (2010) found in a qualitative study, interviewing 23 care providers who worked in nursing homes, that when care providers perceived themselves as not heard and nothing about the situation they had addressed had been changed, they felt angry, powerless and suffered from bad conscience.

Disequilibrium between financial recourses, limited staffing or policy or administrative procedures can often be viewed as a constraint and give rise to moral distress for the care provider.

**Manifestations of Moral Distress**

General signs and symptoms that moral distress can elicit in individuals are: psychological feelings of anger, frustration, depression, embarrassment, loss of confidence, sadness, grief, feelings of worthlessness, depression and guilt (Bamford, 1995; Jameton, 1993; Rodney & Starzomsky, 1993, Wilkinson, 1987/1988). Physical symptoms can manifest for individuals in ways of crying, changes in sleeping patterns, heart palpitations, headaches and changes in bodily functions (Fry et al., 2002).

Therefore, if ethical issues are left unresolved, moral distress can manifest and result in negative physiological, emotional and social outcomes for all involved parties (Raines, 2000).
Consequences of Moral Distress

Nurses Health and Well-being and Patient Care Delivery

In 1987/1988, Wilkinson, conducted one hour interviews, with 24 bedside nurses regarding the phenomenon of moral distress. She found that in an attempt to restore their sense of wholeness from psychological disequilibrium, nurses may choose maladaptive behaviours to cope with their feelings of distress. Wilkinson (1987/1988) reported that if nurses were successful in restoring their equilibrium, they felt a sense of control and were able to give good patient care. However, if the nurse was unsuccessful, the nurse may feel powerless and this may damage their sense of wholeness and self esteem (Wilkinson). Wilkinson reported that when nurses’ were unable to successfully cope with moral distress, it affects the way they deliver both immediate and long term patient care (Wilkinson). For example, in the immediate moment a nurse may attempt to restore his/her sense of wholeness by distancing one’s self from patients, in order to cope with overwhelming feelings of frustration or guilt (Raines, 2000). Long term, a nurse’s sense of wholeness and eroded self esteem will affect both the nurse’s health and well-being and ultimately her ability to care for other patients (Wilkinson, 1987/1988).

Nursing Retention

Wilkinson also reported that moral distress can often affect a nurses’ sense of control and job satisfaction. She suggested that nurses who were unable to cope with moral distress may be more self aware and sensitive to moral issues. However, this enhanced sense of moral responsibility may ultimately be a deciding factor in whether the nurse leaves bedside care or the profession altogether (Wilkinson, 1987/1988).

Long Term Care Environment

As alluded to earlier, there continues to be a paucity of comprehensive literature discussing the prevalence of moral distress specifically in LTC. The absence of such data does not preclude the possibility that moral distress is an important and omnipresent issue for direct
care providers employed in LTC facilities. It has been documented that LTC has higher turnover rates for nurses as well as other increasing demands for resources to meet the needs of Canada’s older population; it is likely that nurses and other direct care providers in LTC are going to be increasingly affected by moral distress in their workplace (Pijl-Zieber et al., 2008). In an attempt to address this gap in research Green and Jeffers (2006) conducted a pilot study of six nurses, and their experience of moral distress specifically in LTC settings. Green and Jeffers’s study found that nurses’ experiences of moral distress were related to disagreements between the resident’s family members regarding treatment decisions pertaining to end of life and quality of life care. They also reported that nurses perceived that there was the lack of resources to meet the needs of residents living in LTC. They also reported that moral distress had both positive and negative effects on nurses.

LTC settings differ from acute care settings in that the proportion of regulated care providers is smaller than that of unregulated care providers. It is important to note that in LTC unregulated care providers are providing a majority of the ‘hands-on’ care for residents (Goodridge et al., 1996). Terri et al., (2006) conducted interviews with ten residents and reviewed essays from both residents’ relatives and nurses’ experiences of moral distress in LTC. They found that most elderly persons who currently live in LTC have functional limitations, suffer from dementia and have diminished capability to make decisions. Morgan et al., (2005) found by surveying 355 nursing care aides in Canadian nursing homes, that one of the most disturbing behaviours exhibited by residents who have dementia is “aggressive” behaviour (Morgan et al.,). Slettebo (2004) found in a qualitative comparative study of 14 RNs that when residents exhibited “aggressive” behavior, care providers would sometimes be required to restrain residents for safety purposes. When appropriate these restraints would be minimized as much as possible (Slettebo & Bunch 2004). Slettebo and Bunch (2004) found that all care providers that were interviewed gave examples when they had to restrain a resident. This is important to note as Wilkinson (1987/1988) reported that psychological distress can be one of the consequences for
staff who need to utilize restraints on residents, in order to provide direct nursing care. Jakobsen and Sorlie (2010) found in phenomenological-hermeneutic interviews of 23 care providers working in nursing homes that care providers described that using restraints was especially difficult when trying to preserve the dignity of patients who were diagnosed with dementia. In LTC a large proportion of direct care providers are unregulated and as a consequence, unregulated nursing personnel are placed at an increased risk of exposure to assaults from residents who suffer from dementia when compared to regulated nursing staff. Therefore, when exploring the prevalence of moral distress in LTC, it is necessary to address the experiences of both regulated and unregulated nursing personnel.

While there has been limited research studying moral distress for unregulated care providers, there has been some discussion that ethical issues affect this group in LTC settings. Researchers Livingstone and Livingstone (1984) found in a sample of 173 nurses that younger, lower ranking and less experienced nurses, who spent more time with patients, commonly reported more psychological distress. With this finding, one might infer that unregulated nursing care personnel are lower ranking within the hierarchical chain, and may also commonly experience psychological symptoms in morally distressing situations. In a discussion article, Stone and Yamada (1998) argue that frontline employees such as PSWs, often face great responsibility with minimal training, limited support and less job security. As the health care system continues to evolve, unregulated nursing personnel continue to be required to perform more frequent and complex tasks for residents living in LTC institutions (Stone & Yamada).
Chapter 3

Methodology

This chapter contains a description of the purpose of the study and the research questions; the design; sampling; inclusion criteria; agency feasibility; a brief description of each LTC site; the recruitment process as well as sources of data and data management. This chapter will also outline how the data were analyzed and how trustworthiness of the data was addressed. In addition, ethical considerations will be highlighted.

Purpose and Research Questions

The purpose of this research was to describe the experience of moral distress among regulated and unregulated nursing personnel employed in Long Term Care facilities. Specific research questions include the following:

- Do regulated nursing personnel experience moral distress?
- Do unregulated nursing personnel experience moral distress?
- What is the nature of moral distress experienced by regulated and unregulated nursing personnel in LTC facilities?
- How do nursing personnel describe and perceive the experience of moral distress?
- What are the organizational factors that they perceive as contributing to or reducing moral distress in their workplace?

Design of the Study

A qualitative, descriptive, study design was used in an attempt to “see the world as the participants see it” (Glass, 1989 p. 285). Descriptive research is often used to build on exploratory research when there is little research done in the area of interest (Fitzpatrick & Wallace, 2006). Sandelowski (2000) calls this approach “…basic or fundamental qualitative
description” (p. 335) and says that it is different from other kinds of qualitative research in that it is less interpretative, with the researcher engaged in less abstraction (Sandelowski).

**Planned Number of Recruited Participants & Sampling**

**Planned Number of Recruited Participants**

Long Term Care facilities in Ontario employ regulated (Registered Nurses and Registered Practical Nurses) and unregulated (Personal Support Workers or formerly called, Health Care Assistants) personnel to carry out nursing responsibilities. Two to three participants from each group at each of two sites were considered to be sufficient in identifying themes appropriate to the experience of moral distress among caregivers in LTC. The researcher chose to recruit more participants who were employed as RPNs and PSWs since both facilities employed a larger body of these caregivers compared to RNs. The proposed number of participants was a minimum consideration and the intent was to continue recruiting until no new themes emerged in the interviews.

**Purposive Sampling**

In order to acquire a deeper understanding of the phenomenon of moral distress, a purposive sampling technique was used. This type of sampling is often used in qualitative studies. Participants were selected for the purpose of describing a situation where they had experienced moral distress in their place of employment (Streubert, Speziale & Carpenter, 2007). Recruitment was therefore focused and participants were purposefully sampled on their ability to enhance the richness of the data, from each of the two LTC sites in Southeastern Ontario, Canada. Each of the two LTC sites was thought to be representative of a typical population of caregivers who may be particularly knowledgeable about this issue of moral distress (Polit & Beck, 2007).
**Participant Inclusion Criteria**

- Participants must be currently employed as a Registered Nurse or a Registered Practical Nurse (RN, RPN) or unregulated direct care provider (Health Care Assistant (HCA), or PSW) in one of the LTC settings.
- Participants must have been employed at the facility for a minimum period of twelve months in the setting.
- Participants must have nursing care responsibilities for the residents.

Each interview began with a collection of demographic data (Appendix B). The researcher utilized an interview guide which consisted of approximately eleven open-ended questions for each interview (Appendix C). Open-ended questions were used for the interviews to allow the researcher to adapt and form the most appropriate questioning, depending on the dynamics of the interactions (Miles & Huberman, 1994). The researcher concluded interviews once saturation was achieved (Polit & Beck, 2007).

**Agency Feasibility**

The researcher and the thesis supervisor visited two LTC sites to discuss the willingness to conduct research at these facilities and ways to reach potential participants. At this time a summary of the research project was prepared for each site (Appendix D). The feasibility of obtaining the required number of participants was discussed with each agency. Both agencies determined that it would be reasonable to recruit two RNs, three RPNs and three PSWs, given the actual numbers of regulated and unregulated care providers employed at each facility.

**Nature of the Job and Employee Descriptions of Responsibilities**

In Ontario, there are two categories of nurses, a RN (which includes Nurse Practitioners) and a RPN. The knowledge base varies between RNs and RPNs as there are differences in basic nursing education. A RN education is a four year university degree whereas; a RPN education is a three year college diploma program. Both programs focus on clinical skills while the RN
program also incorporates conceptual and theoretical frameworks as well as develops nurses’ critical thinking skills.

*Registered Nurses.* RNs are persons who have graduated from a recognized formal nursing educational program and have qualified to practise nursing as Registered Nurses according to appropriate provincial legislation. RNs are employed in many healthcare sectors, one of which is LTC. Depending on the size of the LTC facility RN positions may include Director of Nursing, Director of Care, supervisors and clinical nurse (Berta et al., 2006).

*Registered Practical Nurses.* RPNs are licensed practical nurses authorized to function within the same scope of practice as RNs as determined by the College of Nurses in Ontario (CNO) (Berta et al.,).

*Personal Support Workers.* PSWs are unregulated health care providers. When PSWs are utilized, they are assigned to assist RNs or RPNs in delivering resident care, where appropriate and under supervision (Berta et al., 2006). In Ontario there are no educational standards for Health Care Aids/Personal Support Workers (Smith, 2004). Currently, there is no officially recognized "certification" or "registration examination" for PSWs (Ministry of Training, Colleges and Universities, 2008; OCSA, 2008). There is however, a 24 week training program followed by a national examination administered by the National Association of Career Colleges.

**Different roles for RNs and RPNs in Acute Care and Long Term Care**

As the educational requirements differ between RNs and RPNs, so does the level of competency. For example, the knowledge base, skill set and judgment varies between regulated groups of nurses. One of the differences between the two registered nursing bodies in acute care settings is based on the delegation of workload regarding patient care assignments. RNs are assigned complex and/or unstable patients with unpredictable outcomes and RPNs are assigned stable patients with predictable outcomes. A patient whose condition is unclear remains under the care of the RNs (RNAO, 2010). In LTC RNs also assume more complex and unpredictable
patient care assignment however, their primary roles are typically less focused on providing routine resident care, they focus more specifically on documentation and administrative duties.

In LTC RPNs are primarily responsible for providing a majority of the hands on resident care.

**Brief Overview of Long Term Care Facilities**

Long Term Care (LTC) is a concept used in Canada to describe a complex system of care for persons who are at significant risk of having progressive and/or chronic conditions, and who require services to meet their long-term functional needs. The main components of LTC service delivery systems in Canada are home care and community based services, and institutional care in LTC facilities (healthworkermigration.com).

In Ontario the Ministry of Health and Long-Term Care (MOHLTC) is responsible for administering the health care system and providing services to the Ontario public through many programs, one of which is LTC. LTC is a home where residents live which is designed for people who require the availability of 24-hour nursing care and supervision within a secure setting. In general, LTC homes offer higher levels of personal care and support for individuals who require assistance with activities of daily living, compared to those offered by either retirement homes or supportive housing. In addition to providing LTC services to the public, the Ministry of Health and Long Term Care (MOHLTC) set standards for care and inspect LTC homes annually. There are three pieces of provincial legislation governing LTC homes. These are: the *Homes for the Aged and Rest Homes Act*, the *Nursing Home Act*, and the *Charitable Institutions Act*. LTC homes are owned and operated by various organizations such as, private corporations, municipal councils or non-profit groups.

As mentioned earlier there were two LTC homes chosen to participant in this research study. The first of the two homes had approximately 243 LTC beds, for residents whose medical conditions are stable, but required the 24-hour nursing care. The second site which agreed to participant had approximately 170 LTC beds. Similarly, this home provided care to individuals whose needs could no longer be met in the community. Both facilities had some policies that
were relevant to ethical issues. For example, both facilities had policies relevant to consent and do not resuscitate orders.

**Recruitment of Participants**

Two RNs, three RPNs and three PSWs were recruited from each LTC site. This was done by accompanying one of the administration department heads around to each unit for a face to face introduction. At this time a summary of the research study and inclusion criteria were discussed. Participants were informed that their participation was strictly voluntary and that they were free to withdraw from the study at any time should they choose to. The primary investigator also provided contact information at this time. Following the face to face interactions the researcher attended town hall meetings, staff meetings, administrative meetings, created and delivered power point presentations describing the research project to employees and designed posters summarizing the research, which were publicly placed within each facility (Appendix E).

It was anticipated that the recruitment process would take approximately three months to complete. The entire process however extended three months beyond the projected date. Additional recruitment efforts were necessary at one site where participation was low. After initial recruitment attempts, three months had passed and only one participant from that site had volunteered. Therefore, at that time the researcher re-approached the administrative team for additional guidance and as a result revisited each unit on a second occasion. On the second occasion the researcher recruited participants with a new spokesperson who was not part of the administration team. At this time the new spokesperson assisted with word of mouth recruitment. Additional recruitment posters were given to alternate employees and the investigator’s contact information was provided. These additional strategies resulted in seven more participants who came forward to volunteer in the study. Of the seven new participants who were recruited from the additional strategies mentioned above, half of them indicated informally that they were originally hesitant about participating in the study and were concerned about being identified as participants to the administration team within the facility. They expressed some fear of
repercussions, such as termination, if their views were not held in confidence. As the spokesperson was observed to be respected among the other employees at the site, the researcher found this person’s assistance to be extremely valuable in finalizing the recruitment process. The spokesperson had additionally reassured the other participants that their information would not be identifiable through research participation and that their data would be kept in extreme confidence. Participants were objectively observed to be reassured by the spokesperson’s guarantee and were more approachable during recruitment. The additional time required to complete the recruitment process was thought to be attributed to participants’ perception of repercussion.

Sources of Data Collection

Data were collected from two sources. The first source was institutional documents relevant to ethics mandates and policy and procedure documents that address ethical issues related to provisions of care from each site (Appendix F). The second source was a semi-structured interview (Appendix C).

Documents

One of the sites provided a package of relevant institutional documents while the second site allowed the researcher access to general corporate and site-specific binders which contained ethics-related policies and procedures relevant to resident care. Once access was obtained, the researcher searched and obtained the potentially relevant documentation.

Interviews

A face to face interview that lasted, on average, 30-60 minutes was completed with each participant. Once participants had indicated their willingness to take part in the study, given that the respondents had met the inclusion criteria, an interview date and time was negotiated between the researcher and the participant. Location of the interviews were determined based on the
participant’s location of preference - home, work or an alternately agreed upon confidential place.

All participants preferred to conduct the interviews at their place of work.

**Practice Interviews**

Two practice interviews were done prior to conducting the initial interviews with the actual study participants. These practice interviews were conducted at an alternate LTC site. These interviews were not transcribed or analyzed in the research findings. These practice interviews were conducted and used as additional self-critiquing tools which were to enhance the primary researcher’s interviewing skills prior to actual data collection (Miles & Huberman, 1994).

**Data and Analysis**

This study used Miles and Huberman’s framework of thematic content analysis. Miles and Huberman (1994) described the major phases of data analysis to be data reduction, data display, conclusion drawing and verification. By simplifying and transforming the data that appeared in transcriptions, the researcher was able to manage the data in a meaningfully way. Each interview was audio taped and then transcribed verbatim and was used as a primary data source (Halcomb & Davidson, 2006). Initially the researcher listened to audio tapes of the participants’ descriptions of their experience of moral distress in their entirety and then transcribed them verbatim. Once the interviews were transcribed, an overall summary was written based on the participant’s responses to the demographic questions and the research questions from each interview.

Since computer programs assist with organizing and managing large amounts of data, the interviews were transcribed and entered into NVivo 8 for coding and analysis (Polit & Beck, 2007). The computer software package NVivo 8, was used as a data management tool. (QSR International Pty Ltd., 2006).
Trustworthiness

The rigour of qualitative research is assessed in terms of the trustworthiness of a study. Trustworthiness of a study is addressed in terms of four criteria described by Lincoln and Guba (1985). These criteria are: credibility, transferability, dependability and confirmability.

Credibility. Credibility is the degree of confidence in the ‘truth’ of the findings and is achieved by ensuring a detailed description of the phenomenon is provided (Lincoln & Guba, 1985). The credibility of the findings for this study were established by including the use of open ended interviewing techniques and semi-structured questions to guide the researcher during the interview. In addition, the credibility of this research was further determined through member checking with one to two participants from each of the direct care provider groups. The researcher summarized the study’s key findings and returned these findings in a sealed envelope to six of the participants. No participants reported any changes be made to the study’s key findings.

Transferability. Transferability implies how accurately the findings from this study may be generalized or transferred to similar studies with different populations, settings or circumstances (Lincoln & Guba, 1985). In order to ensure that others conducting similar studies may consider the appropriateness of transferring the findings from this study a thick description of research procedures, methods, setting and recruitment considerations were provided (Polit & Beck, 2007).

Dependability. Dependability is a way to determine the consistency of the data and that the findings from this study can be repeated (Lincoln & Guba). In order to ensure dependability of the findings the researcher used an audit trail so that others who wish to repeat this research may yield similar results. An audit trail was used to provide a clear and full account of information regarding the researcher’s decision making process throughout the research study.
**Confirmability.** Lincoln and Guba (1985) described confirmability as a measure of how well the findings were supported by the data collected. This was done in part, by providing detailed information regarding the study’s procedure, how data were analyzed and by providing an audit trail of how decisions were made (Patton, 1990). This study used verbatim quotations from the participant’s interviews throughout the findings chapter. Participants’ quotes were used in order to confirm that their words supported the study’s key findings. As mentioned earlier once the key findings emerged, member checks were obtained from a portion of the study’s participants to ensure that the findings accurately reflected the participant’s experience of moral distress.

**Ethics**

As this study involves human participants, approval was obtained from the Queen’s University Research Ethics Board before any interviewing commenced (Appendix G). In addition, ethical approval was sought from each of the participating LTC health facilities. Consent forms were signed and obtained from each participant and kept in a confidential and secure location along with audio tapes (Appendix H).
Chapter 4

Findings

This chapter consists of a description of participants’ characteristics and research findings related to each of the initial research questions.

**Participant Characteristics**

Sixteen participants in total were recruited from two Southeastern Ontario sites, eight from each site. There were three groups of employees chosen who had direct nursing care responsibilities for residents. There were two RNs, three RPNs and three PSWs who were recruited from each site. Fourteen of the sixteen participants were female. The RNs had been registered for a longer duration of time than RPNs--a median of 15.5 years compared to 13.5 years. (A median for PSWs was not calculated as they are not a registered profession).

As there was a small sample size it was not normally distributed. In the table that follows, the median is used as an alternative measure of central tendency to highlight the lowest and the highest number of years that each participant reported. These participants’ demographic characteristics can be visualized in Table 1.

Table 1 Participant Demographic Characteristics

<table>
<thead>
<tr>
<th>Registration</th>
<th>Yr. in Profession</th>
<th>Yr. in LTC</th>
<th>Yr. in Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (Range)</td>
<td>Median (Range)</td>
<td>Median (Range)</td>
</tr>
<tr>
<td>RN</td>
<td>16 (7-39)</td>
<td>14 (7-39)</td>
<td>6 (3-39)</td>
</tr>
<tr>
<td>RPN</td>
<td>14 (1-28)</td>
<td>17 (1-28)</td>
<td>12 (1-26)</td>
</tr>
<tr>
<td>PSW</td>
<td>N/A (N/A)</td>
<td>10 (7-29)</td>
<td>8 (5-17)</td>
</tr>
</tbody>
</table>
**Duration of Employment**

Participants were asked how long they had been employed in their current LTC facility; the RN group reported a median number of six years, RPNs reported a median of 14 years and the PSW group reported a median of eight years.

**Nature of Employment**

In LTC facilities, RNs, RPNs and PSWs function as members of a direct nursing healthcare team. The nature of the job and the job responsibilities that the RNs, RPNs and PSWs expressed were described within the context of their current LTC environment. RNs described the nature of their employment in terms of position responsibilities, without denoting any particular priority or importance to these responsibilities. They provided some direct care and management responsibilities often providing direction to and supervision of other colleagues, and liaison with medical doctors. The RPN group most commonly reported the nature of their role to be a “team leader”. The “team leader” functions were described as supervising unregulated staff members, administering medications such as insulin for diabetic residents and providing non-complex wound care dressings for residents. The PSW group described the nature of their employment in terms of assisting residents with activities of daily living (ADL’s). These activities included assisting residents with bathing, dressing, eating, feeding, toileting and other daily personal care requirements.

**Situations Giving Rise to Moral Distress**

At the beginning of the interview participants were asked if they could think of an example from work when they felt they knew what the right thing to do was, but were unable to implement it. All care providers were able to describe a situation in response to this request (Appendix I).

The sixteen participants reported 52 examples of situations which gave rise to moral distress. During the interviews, participants described their perceptions and experiences of moral
distress using a variety of examples. These examples were categorized into four situations. The four situations participants described as giving rise to moral distress were: a resident’s end of life care, situations regarding residents’ behaviours, other direct care provider’s behaviours and situations related to the participants’ work environment.

**End of Life Care Situations**

The first situation that was reported to give rise to moral distress involved issues around caring for palliative residents and providing end of life care. Distressing end of life care examples included residents who were perceived to be suffering unnecessarily, suffering for a prolonged period of time and when participants had concerns that residents might die alone.

**Unnecessary Suffering.** Unnecessary suffering was described by participants who had to provide non urgent hygiene care, such as shaving and mobilizing palliative residents who were perceived to be additionally suffering due to this care. For example, participants reported unnecessary suffering when they:

...saw that [the resident] was drowning in his own fluid and we were told to get him shaved, I mean he didn’t have but a few hours and you know, well you better get him shaved-well that can wait (PSW 1).

This situation was described by the participants as especially difficult “...because I [the participant] saw the struggle he [the resident] was going through, and I mean, I know I wouldn’t want somebody digging around at me if you’re already struggling” (PSW 1).

An additional example of unnecessary suffering was described by a PSW care provider who recalled a morally distressing situation where she and her colleague were required to mobilize a palliative resident.

We had one gentleman who we knew was, you know, at the end. Generally, we leave them in bed and we reposition them and we do the mouth care and you know, but we were told that morning to get him up in a Broda chair... So we ended up having to do it and we put him in the fireplace room and a couple of hours later, he had died in the chair (PSW 1).
This same participant described her distress to the researcher, by stating that “it is 2008, you know, people are allowed to die with dignity” (PSW 1).

_Prolonged Suffering._ This example included situations in which medical interventions were used that prolonged life. Situations that participants described as prolonging a resident’s suffering related to artificial hydration, tube feedings and resident care orders such as CPR orders. One RN participant said: “I feel like tube feeding isn’t always the answer. I see some [residents] come back with them and its heart wrenching you know, why did we put a feeding tube in this person? To prolong what, what quality of life?” (RN 1).

Another RN care provider described: a resident “…with severe Alzheimer’s and dementia who’s contracted up to the point where, if you had to do chest compressions on her-you would have to break her legs” (RN 2).

_Residents Dying Alone._ Dying alone was described when a resident’s family members who were unable to be present with the dying resident. In the absence of families’ attendance, participants were distressed when staffing levels were not sufficient to support a staff member being with a resident who was dying. Participants reported:

> When you know somebody is dying and when the family members don’t want to stay there don’t--they don’t want to be with that person as they’re dying and that’s another thing that’s very hard, ‘cause you don’t-you don’t want to see them die alone (RPN 3).

_Situations Regarding Residents’ Behaviours_

The second kind of situation which gave rise to moral distress for participants was that of residents’ behaviours. Residents’ behaviours that might give rise to moral distress included behaviour that was “aggressive” or “combative” or behaviour choices that were related to the residents’ lifestyle. In some cases, these behaviour choices were considered by participants as inappropriate or unacceptable.
“Aggressive” or “Combative” Residents. Although such behavior was common in LTC, participants found that providing nursing care for residents’ who were resistive, was morally distressing. A PSW participant described how she and three of her colleagues had to provide hygiene care for a “combative” resident:

…four of us held her down, there’s a couple of us that had scars from –from her scratching and I mean just you could hear the I mean it wasn’t even, it was fear in this women’s scream-like just to leave her alone (PSW 2).

Resident Lifestyle Choices. Participants described moral distress in relation to what they considered to be a resident’s inappropriate or unacceptable lifestyle choices. To illustrate this example further participants described:

When we know someone is an alcoholic, we know they go out, you know, the amount of alcohol they’d consume when they’d come out and them come back in, is unknown and here we’re still administrating, you know, medications to this individual that are harmful with alcohol abuse. That’s always been a real long standing you know, ethical issue (RPN 2).

Situations Regarding Other Care Providers’ Behaviours

The third kind of situation described by participants as giving rise to moral distress was the behaviours of other care providers. Other care providers included RNs, RPNs, PSWs and Medical Doctors (MDs). These behaviours included: deception of cognitively-impaired residents, delayed care by other providers and care ordered by supervisors that the participant considered to as inappropriate. The following are examples of other health care providers’ behaviours that commonly gave rise to moral distress.

Deception. A RPN described the challenges associated with medication administration in LTC. She stated that “…sometimes care providers may “have to sneak it [medications] in their food, or give it to them [the residents] in like chocolate pudding or something” (RPN 1).
**Delayed Resident Care.** A care provider shared an experience when she perceived that the resident had suffered due to delayed care. Participants described this as a distressing situation since:

…nobody would come and help this poor woman [the resident]…. It was over an hour later like I said and she [another HCP] did go down and suction the resident later on and… I mean an hour went by where this woman suffered (PSW 4).

**Inappropriate Care Ordered by Supervisors.** An example of inappropriate resident care was when participants who perceived themselves as lower on the hierarchical chain of command described being ordered by their supervisors to provide inappropriate resident care. As an unregulated care provider in LTC, a PSW described being ordered by the regulated nurses to provide what she perceived as inappropriate care placed her in an environment of “chronic distress” (PSW 3). She shared an example in which she was ordered to help her supervisor mobilize a resident who hit her head when falling out of bed one evening. The PSW reported that she felt very uncomfortable with this order and stated that her supervisor told her:

I am the RN and I am telling you. Help me get her up and put her to bed. As unregulated, she’s my supervisor I have to respect what she’s telling me, or I’m charged with insubordination. So we put her into bed, and we put the rail up (PSW 3).

The participant explained that she felt this was an inappropriate order as “…she [the resident] needed to have an assessment done before being moved…. Because she [regulated nurse] didn’t know if she [the resident] had done damage, ‘cause she hit so hard”. PSW’s also reported that:

It’s just hard when we’re unregulated and we have a regulated staff member that tells us that she is our supervisor. We’re to do what they say and we’re also told well you do then and you deal with it later. But morally it’s hard (PSW 3).

**Situations Related to Work Environment**

The fourth type of situation which gave rise to moral distress was a difficult work environment. Aspects of the work environment that seemed to contribute to moral distress
included: decreased staffing levels, a sense of job insecurity and perceived lack of leadership. The only participants did not report moral distress as arising from their work environment were two RNs.

**Decreased Staffing Levels.** Both regulated and unregulated nursing personnel perceived that they were unable to adequately care for residents due to decreased staffing levels within their work environment. Participants described:

…we’re always working short and it really, when you’re giving pills to 42 people it kind of seems that you’re just going and sticking the pills in their mouth and going home. You don’t get a chance to care for them really at all (RPN 5).

There is not enough staff to resolve it. That’s the bottom line, is that they’ve cut staff so bad that you can’t do anything with them [the residents], you can’t sit and talk with them, you can’t take them out, you can’t take them outside… They [the administration] need people that will do that and they don’t have it (PSW 5).

Participants described having to “…remain flexible when delivering nursing care to residents, compared to the type you want to deliver….I would prefer to be turning that person [the resident] every hour, but I [the participant] don’t have the man power” (RPN 4).

**Sense of Job Insecurity.** Both regulated and unregulated participants reported that they perceived the threat of job dismissal or loss of licensure, in their workplace, which sometimes made them hesitant to advocate for residents. Unregulated participants reported that from their “…point of view, and from seeing what goes on in the facility; we’re the ones that get eliminated quicker than the registered staff do….So if I don’t comfortable with something and I don’t feel right, I just pass it on to the regulated staff” (PSW 6). A RN described an example where he had to call the physician late one evening to report the change in a residents’ condition. The resident was now showing signs of respiratory distress and the nurse felt the need to obtain an order from the on call physician. The RN reported that, “she [the physician] was probably offended because I [the RN] called her twice at 0430 in the morning” (RN 4). Since, this was the second call this
nurse had placed to the doctor late that evening, the RN stated that he was “…fearful of the next morning as he [the participant] and this doctor didn’t have a great relationship….he [the participant] was concerned and fearful that she [the physician] was going to file a complaint (RN 4).

Perceived Lack of Leadership. Many participants described the inconsistent messages from the organizational leadership as giving rise to moral distress. This example is evidenced by participants who described that when attempting to seek support within the organization or when trying to voice concerns that “…a lot of time it [participants concerns] falls on deaf ears” (PSW 1). Care providers further illustrated this opinion with the statement that “…in terms of receiving actual support you don’t, you don’t find that it’s in practice” (PSW 5). Participants stated that the administration, “…preach it, [supportive environments] but they don’t practice it…. So in terms of a support there is not so much management staff” (PSW 5). Participants also described the “lack of fit between what administration say, compared to what they do….you know we get it from the top, we don’t always see it from the top” (PSW 6). A PSW described a time when the Director of Nursing “…came up to talk to all the staff and reiterated time and again that this is their home; they [the residents] have the right to say no and I said it’s not the staff that you have to tell, it’s your managers” (PSW 3). Similarly, the RN group also reflected on the general belief that the inconsistencies of the leadership team gave rise to moral distress within their work environment. RNs stated:

I think there’s a huge feeling of mistrust in this-in this building now, which is really so you don’t know who you’re… who you can talk to, or who you can’t talk to and then that’s really a shame and it’s a really difficult environment (RN 3).

In summary, participants reported four kinds of situations that gave rise to moral distress within LTC: end of life care, residents’ behaviours, another health care providers’ behaviour and the participants’ and their work environment.
The Experience of Moral Distress

Two research questions that guided this study were: “What is the nature of moral distress and how do nursing personnel describe the experience of moral distress in LTC?” Participants were asked if they could think of an example at work when they felt they knew what the right thing to do was, but were unable to do it. All participants were able to describe a situation in response to this question. Participants described an initial emotional response, an action response to the situation and the outcome of the situation in terms of resolution.

Initial Emotional Response

Initial emotions were described by participants in an emotional range of either a positive or as negative emotional responses. Positive emotions included joy (hope, enthusiasm, excitement) and love. Negative emotions included anger, fear and sadness. The most commonly reported emotions participants described in relation to the experience of moral distress, were negative in nature.

In further discussion with participants regarding the description of positive emotions, it was found that these emotions were not initial responses. They were often referred to by participants in subsequent situations which were similar in nature to the initial, morally distressing situation. Participants illustrated this when describing two similar morally distressing situations. The first time the participant encountered the situation, they described that they experienced an initial negative emotional response. When a second, similar situation presented itself, the participant was able to leverage their previous experience. This second situation prepared them, and rather than experiencing an initial negative emotion, they were able to respond to the situation in a manner that resulted in a positive emotion. Participants reported that they experienced joy and love in the second situation and perceived themselves as being better able to advocate for the residents. One participant described that “She is excited because when she sees tube feeds in here; she is a little more of an advocate now” (RN 2). Although
participants described positive emotions as an initial response from their second morally distressing situation, the researcher notes that these situations by definition cannot be accurately defined as moral distress.

The negative emotion of “anger” was a frequently experienced initial emotion reported. All participants described the experience of moral distress as including “frustration” as the initial “angry” emotion. A PSW shared an experience when she and her fellow colleagues had to provide hygiene care for a cognitively-impaired resident, who was restless and “combative” towards her and the other care providers. The participant reported the initial negative emotions that she experienced when providing the hygiene care, with the following example:

…when your right in the height you know, it’s one of those times where your emotions are just...but you have to stay focused on the task, but it was more even after-when we were finished, and we were, my co-worker and I were discussing it. There was a lot of anger, at the situation, but again it wasn’t resident focused it was focused towards management. That I mean, like, we should never have been put in that situation. You know and then it was, I mean you feel almost remorseful, because you had to do that to a resident (PSW 2).

In another example a RN described her emotions when caring for palliative residents who have recently had feeding tubes inserted. The RN reported:” …my understanding of feeding tubes was that it’s a temporary thing. It shouldn’t be a long term thing….to stretch out a life, where the quality of life is slip-sliding away” (RN 2). When providing this type of care for palliative residents, this RN described her emotions as…”I mean it certainly makes you uncomfortable, even makes you a little angry” (RN 2). Another example of a situation that angered participants was illustrated by a PSW when she did not agree with the family’s decision to decline a medication for a resident who was deemed incompetent. The participant reported that:

…I mean that is something where the individual only had a bladder infection and you know, we dipped and we were ready to get the antibiotic, but the family member declined…. I was furious (PSW 6).
Other negative emotions reported less commonly were fear (apprehension, dread, tenseness) and “sadness (guilt, isolation, remorse). Participants reported difficult situations which provoked sadness:

When trying to control the pain for a resident who was palliative, and didn’t have any family members…. We can’t do sub-Qs. We can do morphine liquid. But at that point she needed a S/C. And it’s trying to get your point across to my supervisors that she needs more pain control. And that’s hard, and that goes with a lot of people here….I wasn’t in control of helping the resident (RPN 6).

The RPN described feeling “tearful, actually “as she “thought she [the resident] was suffering” (RPN 6).

All situations which gave rise to moral distress elicited an emotional response for participants. As illustrated above, the most common emotions were anger, frustration and sadness.

**An Action Response to Moral Distress**

Once the morally distressing situation occurred, the most common action taken by participants was some form of communication. Most participants chose to react by verbally and non-verbally communicating with others.

**Verbal Communication.** In most cases verbal communication took place at work with colleagues in order to “…try to bounce ideas off like during report or even while you’re doing your paperwork…your team members will try and discuss it and come up with different plans” (PSW 2). Communication most commonly occurred by moving up the hierarchical chain of command. PSWs communicated their concerns to the RPNs, the RPNs to spoke to the RNs and the RNs reported to the administrative team or the MD. A RN described this communication strategy within the hierarchy “…where a staff will bring up an issue or it will get passed up the chain of command so to speak. Like the PSW will notice something, and they’ll present it to the RPN” (RN 4). To illustrate this example further a participant reported that:
I’m a PSW, the RPN’s here are unable to call the doctors, aren’t able to make that family call. Because it’s supposed to be the RN and if you go over that you get your fingers kind of knocked like you know, that wasn’t protocol (PSW 6).

The data supported that a majority of the cases did follow the traditional chain of command. However, there were few cases in which participants took action by communicating outside of the hierarchical chain. One unregulated participant, described instances where they learned how to tactfully communicate outside of their chain of command. She described speaking with the MD in order to:

…Find a way to talk things out and even ways of you know cornering a doctor... It’s not my job, but you know just saying I just really noticed, oh the family was asking you know that this individual’s in a lot of pain (PSW 6).

Some participants described that in addition to talking with their colleagues at work, they also received support when communicating outside the workplace. Supportive communication was found from a significant other, a family member or a friend. “I talked to my wife, who is also a nurse….So she certainly has an understanding and key insight into my problems” (RN 4). Participants also reported that they sought support through prayer. “I had to learn to pray a lot” (PSW 5).

Non-Verbal Communication. Written text was the secondary form of communication used. This included writing in the nursing progress notes and the resident’s care plan. Participants reported that despite the outcome of a distressing situation, you learn how to document everything. “…you are the registered staff member you know, signing your life away here. Documentation is a real good thing. Always write a progress note you know…. I must say the doctor is well aware” (RPN 2).

When participants perceived themselves up against barriers and had no ability to immediately resolve their moral distress, they would document the events leading up to and during the morally distressing situation. In some cases a document trail was initiated and
electronically mailed to their supervisors, their unions and other appropriate personnel. If the participant’s degree of moral disequilibrium was great and the situation was deemed necessary, participants would electronically mail outside of the hierarchical structure in order to achieve resolution.

An unregulated care provider reported that: “I found another channel and when that one didn’t work there was another channel and then I charted” (PSW 6). Another care provider described an example where she perceived that the resident received delayed suctioning care. The care provider who had delayed the residents suctioning, was the participant’s supervisor. The PSW described what she did following the incident:

I was upset; I wrote a very big e-mail to the DON [Director of Nursing] and to the MRC [what is this] on the floor at that time. I didn’t use names of a staff, but I used names of family members and a long story short, I also sent it to a couple of union reps (PSW 4).

Participants described feeling the need to support care providers who were perceived as above them in the hierarchical chain of command. “I had to support him. I mean, I’m an RPN and I have to do what the doctor says” (RPN 4). A care provider described an example where she felt she had to provide documentation outside the hierarchical chain of command. She described an example where she and her unregulated colleagues were ordered by their supervisor to provide resident care that they found distressing. The participant described feeling that she had no option but to perform the task. She illustrated this perception by stating that, “we’re to do what they say and were also told, well you do then and you deal with it later”. Following the task the PSW reported that she immediately documented the situation stating that:

Thankfully, I was smart enough to get the other two co-workers that I was with that night, their signatures as well. They read it, they signed it and they each got a copy…and the original went to the medical director (PSW 3).
Resolution of Moral Distress

Participants described 52 experiences of moral distress, including whether or not they resolved the distress (see Appendix J). Some participants were unsure if their moral distress was resolved. In other cases, participants initially said that their distress was resolved, but later during the interview they contradicted themselves. The following quote is an example of when participants contradicted themselves during the interview:

…Lots of these behaviours and stuff end up being solved by the front line staff…. But then sometimes what happens is, I might think about it on my way home, driving home or whatever, but you come in the next day and it’s all there, it just comes right back. So, I mean, that’s where if there’s unsolved issues I mean, it’s just, it builds. It doesn’t, it’s not going to end, and it’s not going to get any better. So then there’s tension, you know (PSW 2).

As a result, of those participants who were unequivocal about resolution of a situation, half reported their distress was resolved and half of them remained distressed. For example, a regulated care provider described how she found resolution by stating that, “I talked to everybody, the whole team, nursing staff and other nursing personal…. And then it was resolved” (RN 3). An unregulated care provider reported her unresolved distress by stating that the day she experienced the morally distressing situation, she left work and, “…went home and I [the PSW] couldn’t sleep…. I felt awful, I think three days, I bawled. It still bothers me…. It’s been with me and will probably be with me all my nursing career (PSW 3).

Organizational Factors Mitigating Moral Distress

Participants were asked to comment on organizational factors that prevented the occurrence of moral distress, supported personnel dealing with moral distress and helped to resolve moral distress. Participants also proposed future initiatives that LTC organizations may wish to consider when preventing or assisting direct care providers in dealing with morally distressing situations.
Preventing Moral Distress. The perception of effective strategies which prevented moral distress in LTC facilities included: educational courses, committee involvement, revising existing policy and procedural documents and having a strong management team. Participants also reported that participation in courses such as, a residents’ rights committee and how to manage “aggressive” residents as beneficial in preventing moral distress. Participants reported that:

I’ve taken courses offered through (site) the Director of Nursing has signed me up and I went to a palliative care course. Which I thought was just excellent…. I went to the heart and stroke at (City College) and I took all that palliative care and heart and stroke courses (PSW 1).

Similarly, regulated care providers described taking a helpful educational course which was offered by her LTC organization. This course taught care providers how to deal with, “front line work training that’s for Alzheimer’s disease” (RPN 1). Participants reported that experience gave them confidence in dealing with moral issues and helped them in future situations when dealing with moral distress. For example, a PSW reported that “if it [the situation] had happened now, I have enough that I would stand up and say I’m not doing that, you [the supervisor] want it done, you go ahead and do it yourself. I will not be a part of it” (PSW 3). This example is further illustrated by another participant who reported that:

I do have a stronger stance now, I will stand up and be counted for… if I feel that something isn’t right, I won’t’ just go ahead and do because I was told….I mean I’ve grown as an employee, in my field and I would not longer accept that (PSW 1).

In addition to educational courses and developing confidence, participants also indicated that developing and sustaining a strong management team in the LTC organization would help prevent moral distress. A RN described that; “strong management…who would stand up for us” would be an effective strategy (RN 4).

Supporting Staff with Moral Distress. Participants from each site highlighted the need to create and maintain a supportive organizational environment as paramount in dealing with
moral distress in LTC environments. Participants described their experience of support to include: teamwork, effective communication, managerial support and support from MDs, as central to the perception of organizational support. A care provider reported that:

…The team leaders, who are the RPN’s, the medications nurses, I mean, most of them are fantastic as well, but, I mean you know it’s not always the case. I mean you’re trying to solve things, quite often as a team, will try and come up with a solution (PSW 2).

When asked what helps to supports you in your place of work in dealing with moral distress, a participant stated that is was, “the other girls that I [the participant] was working with, just staff members (PSW 4). Another care provider recalled a situation that was morally distressing and reported that she felt supported in dealing with the situation from the Director of Care. She stated that, “they were excellent in dealing with the problem and the issue; they were really good at giving me support…. She [the Director of Care] came up and she talked to all the staff” (PSW 3). A RPN concisely indicated that in regards to support, “…teamwork is a big thing” (PRN 2).

The data showed that the perception of support was noticeably dissimilar between the participants from each LTC site. Despite recognizing the importance of the above supports, participants from site two reported that they did not perceive that they were routinely supported in these ways within their current LTC facility.

Resolving Moral Distress. When participants were asked what the organizational factors were which contributed to resolving moral distress common responses included: policies and procedures, pastoral support, social worker support services and employee assistant programs.

Participants indicated that their LTC organization had a policy and procedure in regards to witnessing a resident who suffers a cardiac arrest, with statements such as:

… It has to be witnessed here too…. if someone does have a code, it has to be witnessed somebody…. If you come along and their dead in their bed we don’t initiate CPR. ‘Cause you don’t
know how long they’ve been deceased. That is our policy, which is helpful (RN 2).

A RN reported that her organization facilitated “pastoral care…. to staff and residents” as helpful when resolving a morally distressing situation (RN 1). Participants indicated that their organizations had access to a, “a social worker, if you felt that you wanted to speak to a social worker” (RPN 2). Participants reported that although they had not utilized the services personally, their organization had “organized, employee assistance program [EAP] stuff” if needed (RN 2). Another regulated care provider echoed this option stating that, “there’s an EAP program you know, if you need it” (RPN 6).

**Proposed Initiatives for the Future.** In addition to factors existing in organizations that were currently helpful, participants also proposed initiatives that their organization could implement in future: improved interpersonal communication among interdisciplinary team members, on-going educational initiatives and new or revised policies and procedures. A participant reported that signing for resident consent was an issue being, “brought up a few times, there’s still there’s no policy and procedure…. I have asked on several occasions, you know because we don’t have a policy and procedure on it” (RPN 2). Although this RPN reported the need for such a policy, when reviewing the organizational documents as a second data source, a policy that addressed consent was available of which this care provider was unaware of.

The proposed initiative most commonly reported to prevent moral distress for the future was to increase nursing and other direct care provider staffing levels. Participant indicated that situations that gave rise to moral distress could be more manageable if, “you’re not out there by yourself…. It’s just frustrating ‘cause you can’t do it by yourself” (PSW 4). Other initiatives proposed which would support care providers experiencing moral distress include: improve teamwork, ensuring care providers have professional cohorts to debrief with, ensuring an approachable management team and conduct ongoing educational sessions. Participants
proposed that having professional cohorts to debrief with would assist in dealing with situations that gave rise to moral distress.

A RN reported:

    When my other professional cohorts were here, I could talk to them…. I would never talk of the concerns and the things that frustrate me, that I need to talk about. I can’t talk to the RPN’s right, I can’t talk to the HCA’s I wouldn’t do that, not as a manager (RN 3).

Similarly, another regulated care provider shared the desire to have professional cohorts to talk with. He stated that, “the RNs don’t tend to share with the RPN’s and PSW’s here because again there’s a little bit of a hierarchy” (RN 4).
Chapter 5
Discussion

This chapter contains a discussion of the study’s key findings in relation to the existing research regarding the phenomenon of moral distress. The discussion will be presented in four sections: regulated and unregulated care providers in LTC, kinds of situations giving rise to moral distress, the experience of moral distress and the organizational factors which mitigate moral distress.

Regulated and Unregulated Care Providers in Long Term Care

All participants, both regulated and unregulated nursing personnel, were able to describe an experience in which they knew the right thing to do, but did not do it. Although the moral aspect of the distress was not always clearly delineated by participants, they did describe situations in which they seemed to feel that they were compelled to act in ways they thought were unacceptable and for which they did not have the liberty to do otherwise. Despite studies that acknowledged that moral distress is an issue for all care providers in LTC, no studies were found that compared the responses of regulated and unregulated nursing personnel. For example, Pijl-Zieber et al., (2008) suggested that both nurses and other care groups are beginning to recognize the issue of moral distress and the affects it has on work life and patient care, however their study focuses specifically on moral distress as experienced by Registered Nurses.

Unregulated care providers perceived themselves as lower on the hierarchy chain and may have felt more restricted, and compelled to follow orders. There were two RNs who did not report experiencing moral distress in relation to their work environment. It is speculated that those higher in the hierarchy perceived themselves as better able to control their work environment, although further research would be required to investigate this proposition. This is consistent with Rittenmeyer et al., (2009) who found that ethical problems were related to care
providers’ position on the hierarchical structure, specifically when care providers perceived themselves as subordinates and unable to interfere in situations that they felt were unethical.

**Situations Giving Rise to Moral Distress**

Common examples reported by both regulated and unregulated participants as giving rise to moral distress from this study were issues pertaining to: end of life care, residents’ behaviours, other care providers’ behaviours and factors relating to the work environment.

**End of Life**

Participants reported that issues around providing end of life care were commonly distressing when residents were perceived to be suffering, providing medical intervention to prolong a resident’s life and when residents were to die alone. It is not surprising that this area of care elicits moral distress among care providers, as death and end of life care are deeply intertwined with one’s own values and belief system. Green and Jeffers (2006) found by interviewing six RNs in LTC, that disagreements pertaining to end of life care often gave rise to moral distress. Similar findings were reported by Elpern (2005) who used a descriptive questionnaire of 27 RNs in an ICU setting to study moral distress. She found that the experience of moral distress surrounded issues pertaining to continuing life support measures, when it was not perceived to be in the best interest of the patient and providing extensive life saving action to prolong death. These findings are congruent with Rittenmeyer & Huffman (2009) systematic review of qualitative studies which identified ethical issues pertaining to end of life care. They reported that when nurses experience moral distress it is often in association with medical interventions used to prolong life.

**Resident Behaviours**

This study found that participants indicated moral distress when having to provide personal care for residents who, due to cognitive impairments or disease processes, were resistant to care. They often described resident behavior as “aggressive” or “combative”. Participants felt
that residents had the right to refuse care, even if the resident could not appreciate the consequences of his/her decision. Jakobsen and Sorlie (2010) similarly found that care providers experienced conflict between imposing care on residents with dementia. These findings are also congruent with Teeri et al. (2006) who explored ethically problematic situations in LTC. They interviewed ten residents and collected essays from both nurses’ and residents’ family members. They discussed how the LTC institutionalization of residents in itself, can compromise a resident’s sense of autonomy, privacy and integrity.

Participants reported moral distress when they had to give care in the face of the distressing behaviour and weigh the right thing to do. Though, this finding was not addressed in the literature as frequently. There were some situations that seemed less obvious as morally distressing behaviour and more obviously as an uncomfortable feeling experienced by the care provider. For example, participants from this study described moral distress when residents chose to abuse alcohol, had dementia and were flirtatious and those who were homosexual. In these situations it was less clear that a choice was involved in the residents’ behaviour. Participants in this study felt it was the residents’ choice to consume the alcohol. The distress arose when participants were expected to administer medication to the resident who was presumed to be intoxicated. Participants described examples when they felt that administering a narcotic to the intoxicated resident would be detrimental and therefore, withheld the medication. Participants were found to be conflicted between respecting the residents’ autonomy to drink versus the right to receive the appropriate medical care, such as the narcotic. One study conducted by Adams (1995) reported that the combined use of alcohol and medications were common among residents living in retirement communities. However, this kind of behaviour was not found in the literature as giving rise to moral distress.

**Other Care Providers’ Behaviours**

Participants indicated that other care providers included: RNs, RPNs, PSWs and MDs. Examples participants reported as most distressing pertained to: deception of incompetent
residents, delayed resident care and inappropriate care orders received from supervisors. When comparing these findings to the literature, orders received from supervisors were discussed in terms of hierarchy. These findings were congruent with Teeri et al., (2006) who interviewed ten residents and collected 17 nurse essays regarding the phenomenon of moral distress. They found that care providers perceived residents’ in LTC, to not always be treated well by colleagues (Teeri et al.,). These findings were also congruent with Rittenmeyer and Huffman’s (2009) meta-synthesis.

It was found that, participants were distressed when they perceived residents to have had to wait to receive care. Regardless of the reasons why another care provider may have been delayed in providing the care, participants perceived themselves as unable to advocate for the resident. These findings were also consistent with Rittenmeyer and Huffman’s (2009) analysis. They also reported that nursing care providers experienced moral distress, when they perceived physicians as inattentive to patients (Rittenmeyer & Huffman, 2009).

The findings from this study highlight the example of inappropriate orders in terms of the hierarchical structure. All three groups of care providers from this study were found to experience moral distress in association with the hierarchical structure. As PSWs subjectively placed themselves at the bottom of the chain of command, they described the perception of feeling more powerless. In most cases PSWs additionally perceived themselves as the most suppressed and unable to enact change and positively influence their moral distress, when compared to the regulated group of care providers. The inclusion of both regulated and unregulated care providers in this study, established the obvious importance that hierarchy has when examining the phenomenon of moral distress within the work environment. Theses finding are congruent with the literature that states that unequal power hierarchies in institutions’ contribute to moral distress (Rittenmeyer & Huffman, 2009). They found that care providers who perceived themselves lower within the chain of command, routinely felt devalued and felt a general lack of recognition of their expertise, from supervisors’. Rittenmeyer and Huffman
(2009) further described that the position within the hierarchical structure affected the way care providers act upon moral distress.

**Work Environment**

Situations giving rise to moral distress which pertained to the participants’ work environment were reported to include: insufficient staffing levels, the perception of job insecurity and lack of leadership.

It was found that not having enough staff to care for residents was a frequently reported factor in contributing to situations which gave rise to moral distress. Participants acknowledged that despite knowing what type of care they wanted to provide, there simply was not enough staff to implement that type of care into practice. Similarly, Pijl-Zieber et al., (2008) found when reviewing the literature in LTC, that the nursing shortage was associated with giving rise to moral distress. Green and Jeffers’s (2006) found that care providers attributed not having enough staff with an increase in workload and time constraints. Thus, adding more barriers for the nurse to overcome, when delivering what is perceived as the right type of resident care (Rittenmeyer & Huffman, 2009).

Although care providers described job insecurity as distressing, the moral basis of this distress was not always clear. This study found that lack of leadership was an important factor within the participants’ work environment. Participants were distressed by the imbalance between espoused principles and the practice of them. Another aspect of the work environment found in this study was that moral distress was associated with the nature of the care providers’ job responsibilities. Pilj-Zieber et al., (2008) similarly reported that the experience of moral distress is person specific and highly related to the circumstance in which the care providers worked.
The Experience of Moral Distress

Moral distress was described by participants as an experience where they found themselves in a situation when they had to provide resident care that contradicted what they believed to be the right thing to do for the resident. The realization that this experience felt intrinsically wrong to the participant, initiated the moral distress reaction and process. This process was similar to Wilkinson’s (1987/1988) study findings. She interviewed 24 nurses and defined moral distress to occur when the care provider experienced a psychological disequilibrium, followed by a negative feeling when they were unable to perform a morally right behaviour. It was found that the most common emotions expressed were negative. Following the initial emotional reaction care providers took action or chose not to take action in order to resolve this painful feeling. The most common action participants reported were verbal and non-verbal communication. Following communication, some participants described their unresolved distress as having a lingering residual component that persisted when they recalled the incident. This lingering component was described by Webster and Baylis (2000) as “moral residue”. Similar to Hart (2009) study, it was found that moral residue presented after a prolonged amount of time in which the participants’ moral distress had not been resolved.

Initial Emotional Reaction

It was found that the most common emotions expressed were anger, frustration and sadness. These findings were consistent with Gutierrez (2005) study. She interviewed 12 critical care RNs in surgical ICU’s and found that once nurses experience this dissonance and cannot act on their sense of what is morally right, due to constraints, negative emotions occur (Gutierrez). Sundin-Huard (1999) found these same results when she interviewed ten critical care nurses. Apart from the prevalence of negative emotional reactions, there is minimal research to support that moral distress can also elicit positive outcomes for individuals. Some participants indicated that they had become more confident and aware of their values and beliefs, as a result of their
moral distress. Stating that, “I have grown where I know I’ll never do it again and I mean no matter what you’re told to do or whatever, you always have that right” (PSW 2). Likewise, Hart (2009) found in his study that Nurses identified similar positive outcomes that ranged from changing practices, to knowledge expansion and a positive change in their work environment. Given a future situation that was morally distressing, participants indicated that they felt they would be more proficient when advocating for what they believed was the right course of care, for their residents’. These findings are congruent with Green and Jeffers (2006) research study which examined moral distress in LTC. They stated that care providers may experience personal and professional growth and become more self aware from their morally distressing experience (Green and Jeffers, 2006).

**Reaction to Moral Distress**

Following the care provider’s initial physiological disequilibrium, this study found that participants chose either to take action or chose to remain inactive, in response to their moral distress. The most common action participants described was verbal and non-verbal communication. Either form of communication, was traditionally done up the hierarchical chain of command. When reviewing the literature, this finding was consistent with Green and Jeffers (2006) who found that care providers believed that talking with other care providers was the most effective way to deal with situations that were morally distressing.

In some cases participants also reported that they chose to do nothing when faced with moral distress. Those who felt resigned to defeat, chose to remain inactive as their perception was that nothing would change. These findings were congruent with Jameton’s (1993) differentiation between initial and reactive distress and Pijl-Zieber et al., (2008) findings that, sometimes care providers are not able or willing to take action in response to their initial distress.
**Resolution of Moral Distress**

In this study, participants indicated that half of the examples that gave rise to moral distress were resolved and half of them remained unresolved. Also, following the initial disequilibrium, emotional reaction, response and the outcome of the distress, some participants indicated that they also continued to experience persisting residual thoughts. When reviewing the literature it was found that both resolution and no resolution were plausible outcomes of a morally distressing situation however, there were no studies found that examined the extent to which participants felt that their distress was resolved.

Of the examples of unresolved moral distress, some participants were found to experience negative feelings that were long lasting. These findings were congruent with Webster and Baylis’s (2000) case study, which identified and defined the term “moral residue”. Moral residue occurred when nurses were unable to pursue the right course of action and his/her moral integrity was compromised (Webster & Baylis). Hart (2009) also found in a descriptive study of eight RNs employed in complex-continuing care, that participants experienced persistent moral distress.

**Mitigating Moral Distress**

When participants reported organizational factors which mitigate moral distress, findings included a range of preventative and supportive activities. These included: ongoing employee education, creating and sustaining supportive environments and enhancing policies and procedures. In conjunction with this study’s findings Rittenmeyer & Huffman (2009) found that care providers perceived that there was a lack of policy direction to support the provision of care, specifically for palliative patients. Green’s and Jeffers’s (2006) study recommendations included the recognition and continued exploration of moral distress in LTC in order to support nurses experiencing moral distress.
Chapter 6

Summary and Implications

In this chapter, I discuss contributions to the literature, implications for nursing education and clinical practice, Long Term Care administration and recommendations for future research.

Contributions to the Literature

This study contributes to the empirical literature on moral distress, in that it addresses the LTC setting which has received little attention, and includes unregulated caregivers, a group about which little is known. This is a significant contribution in that a majority of care providers employed in LTC are unregulated. This study clearly illustrated that unregulated care providers reported moral distress as well as regulated care providers. Moreover, as they are lower in the hierarchy, they are more apt to be ordered to provide care that they may perceive as inappropriate.

This study identifies categories of situations which gave rise to moral distress in LTC. Three of these categories were similar to ones identified in studies in other settings. The category that seemed different in this setting, related to residents’ behaviors, in that resident lifestyle choices have not been identified as a source of moral distress in previous research studies. Similarly, another finding not reported in previous studies was that half of the examples participants described as morally distressing remained unresolved.

Implications for Nursing Education and Clinical Practice Settings

This study has several implications for undergraduate programs in nursing with respect to moral distress. Undergraduate students should learn about the kinds of situations giving rise to moral distress, when providing end of life care, caring for residents with different lifestyles and dealing with residents who are “aggressive”. They need to be provided with realistic learning experiences such as, case studies, role playing, and simulation exercises that enable students how
to prevent and cope with situations they may encounter in clinical practice, particularly clinical practice in LTC.

Similarly, workplace educational sessions in LTC should address those areas known to give rise to moral distress. In services include, practical case studies and tabletop exercises, facilitated by experienced direct care providers. By practicing and through role playing activities, new and inexperienced care providers can expand on their ethical awareness and develop strategies for preventing and mitigating moral distress. In addition, time should be allotted following the exercise to debrief as a group. It would be advantageous to provide staff with educational tools during the exercises such as, recommended ethical and best practice guidelines, algorithms and relevant policies and procedures. By expanding nurses’ and other direct care providers’ personal experiences and strengthening their ethical awareness, care providers can begin to identify and continue to resolve the ethical challenges associated with both their educational and clinical practice.

**Implications for Long Term Care Administration**

This research has implications for administrators in LTC settings. Given that all care providers experience moral distress, attention needs to be given to unregulated as well as regulated care providers. These providers should be included in any discussions of ethics or ethical situations such as, educational inservices, ethics rounds or debriefing sessions following clinical situations with an ethical component. Such personnel should also be included in any team building and daily activities such as, change of shift reports, e-mail distribution lists to ensure that they are valued members of the healthcare team.

Given that this study showed four kinds of situations giving rise to moral distress policies and procedures should be reviewed that address specific ways that could prevent or could resolve moral distress related to each category. For example, are there policies and procedures needed to support or to report ethical concerns in end of life care situations? In addition, efforts should be
made to ensure that employees are aware of existing policies and procedures that exist that would mitigate moral distress.

As ethical issues arise in LTC and give rise to moral distress, LTC administrators should ensure that there are mechanisms in place to enable staff members to bring forward ethical concerns and to create a forum to resolve ethical distress. This may assist direct care providers to dialogue with other members of the multidisciplinary team.

**Recommendations for Future Research**

Further research in the area of moral distress should be done to address the following questions;

1. Is there a relationship between level of education and resolution of moral distress?
2. Participatory Action Research related to empowerment, to study the experiences of unregulated care providers with moral distress and the resolution of moral distress.
3. Exploration of the relationship between levels of moral distress around staff in LTC and institution ethical committees and institutional policies and procedures relevant to ethics.

**Concluding Summary**

In summary, both regulated and unregulated care providers employed in LTC settings experience moral distress. The situations that seemed to give rise to moral distress were categorized as: end of life care, resident behaviours, behaviours of other healthcare providers and aspects of the work environment. Participants described the experience of moral distress in terms of an initial emotional reaction which was negative, followed by an action or inaction. Action or inaction took the form of verbal communication with others in the facility or through documentation. The final phase of moral distress was described by participants as resolved or left unresolved. In half of these examples, half of the situations described remained unresolved. Participants were able to describe organizational factors that they thought assisted in preventing, reducing and resolving moral distress.
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Appendix A

Moral Distress Table of Search Results

<table>
<thead>
<tr>
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<tbody>
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<td>EMBASE</td>
<td>311</td>
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<tr>
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<td>CINAHL</td>
<td>384</td>
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<td>COCHRANE</td>
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Total # of Articles Found:

- MEDLINE: 396
- EMBASE: 311
- AMED: 08
- PsycINFO: 160
- CINAHL: 384
- COCHRANE: 11

Number of Articles = 1270-156
Duplicates = 1121
Total Articles = 30

Potential Relevant Articles

30
Appendix B

Demographic Questionnaire for Nursing Care Personnel

1) What type of nursing registration do you currently hold?
   - [ ] Registered Practical Nurse (RPN)
   - [ ] Registered Nurse (RN)
   - [ ] None

2) How long have you been registered?

3) How many years have you been in your current position?
   [ ] Years

4) What is the nature of your role? For example, what are your responsibilities for resident care?
   __________________________________________________
   __________________________________________________
   __________________________________________________

5) Has that always been your role?
   - [ ] Yes
   - [ ] No

   If no, when did it become your role? __________________________________________________

61
6) How long have you been employed in long term care?
   
   [ ] Years

7) How long have you been employed in the current long term care facility?

   [ ] Years
Appendix C

Semi-Structured Interview Guide

1) Can you think of an example from work when you felt you knew what the right thing to do was, but were unable to implement it?
2) Can you describe that situation?
3) How did that situation make you feel?
4) Can you describe what you did?
5) Who did you talk to?
6) Did the situation get resolved?
7) How did the situation get resolved?
8) When you first developed the distress, what did you do personally to resolve or decrease it?
9) Is there anything at work, which supports you in dealing with this kind of situation?
   (People, policies, support groups, meetings/briefings, professional groups)
10) Is there anything at your place of work, which helps to prevent this type of situation?
    Please, elaborate.
11) Is there anything at your place of work, which helps to resolve this type of situation?
    Please, elaborate.

Thank you
Appendix D

Summary of the Study

Moral Distress among Regulated and Unregulated Care Providers Employed in Long Term Care

The Topic

There has been relatively little research describing the existence and even the experience of moral distress amongst nursing personnel. Specifically there is a paucity of literature exploring the experience of moral distress in long term care settings. In Canada the topic of moral distress has been predominantly explored among nurses working in critical care settings. Researchers have found that ethically challenging decisions, if left unresolved, may result in moral distress for the care provider. It is known that long term care institutions house a multitude of ethically challenging dilemmas. Therefore, it is anticipated that the existence of moral distress among nursing care personnel in long term care facilities, is theoretically prevalent. The purpose of this study is to describe the experience of moral distress among regulated and unregulated nursing personnel employed in long term care facilities. The intent is to gain insight into how moral distress manifests in long term care and how nursing personnel manage ethically challenging situations.

The Method

A qualitative, descriptive exploratory design will be used to study the experience of moral and ethical distress among care providers employed in long term care facilities. Two long term care sites will be chosen. Institutional documents relevant to provisions of care and ethics will be reviewed. One hour semi-structured interviews with regulated and unregulated nursing personnel will be done. Follow up interviews will be conducted if required, in order to ensure
verification and accuracy of the data and meanings. The interviews will focus on the employees’
experience with ethical distress.

Documents, observational data and interview transcript will be entered into a program for
qualitative data analysis and data will be analyzed to look for common themes and meanings
within and between regulated and unregulated groups of nursing personnel.

The Researchers

Megan Manning, graduate student, School of Nursing at Queen’s University is the
principal investigator. Dr. Marianne Lamb, Graduate coordinator, School of Nursing at Queen’s
University will be responsible for supervising the student’s overall research.

Study Approvals

Approval will be obtained for this study from the Queen’s University Ethics Board before
interviewing commences. In addition, ethical approval will be sought from each of the
participating long term care health facilities, prior to any interviewing.
Confidentially of the data will be maintained and no names will be used in any presentation or
publication.

For any additional questions, contact:

Megan Manning
Queens University
6mm52@queensu.ca
(613) 767-3628
Appendix E

Recruitment Poster

TITLE OF PROJECT
Moral Distress among Regulated and Unregulated Care Providers Employed in LTC.

OVERVIEW OF THE STUDY
You are being invited to participate in a research study directed by Megan Manning, a graduate student in nursing at Queen’s University.

The purpose of this study is to learn about the experience of moral distress among nursing personnel who work in long term care settings and to learn how they deal with ethically challenging situations.

There has been little research describing the experience of moral distress amongst nursing personnel in long term care settings. In Canada, most research on moral distress has focused on registered nurses working in critical care settings. There continues to be limited research, despite the fact that it is known that both regulated and unregulated nursing staff in Long Term Care also encounter ethically challenging situations.

DETAILS OF THE STUDY

You will be considered for the study if you:

Are currently employed as a regulated licensed nurse (RN, RPN) or unregulated nursing personnel (HCA, PSW).

Have been employed by your current employer for at least one calendar year.

The researcher will conduct an interview with you at a time and location that is convenient to you. The interview will take approximately one hour and focus on your experience with ethically difficult situations. With your permission, the interview will be recorded using a tape recorder.
There are no known risks or side-effects from participating in this study. While you may not benefit directly from participating in this study, recommendations may result that lead to improvements in policy and practice for long term care settings.

**STUDY APPROVALS**

This study has been reviewed for ethical compliance by each of the participating long term care health facilities, and the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

**CONFIDENTIALLY**

Confidentially of the data will be maintained and no names will be used in any presentation or publication.

*Your participation in this study is voluntary and you may withdraw from the study at any time.*
Appendix F

Institutional Documents

- Committee documents relevant to ethics mandates
- Policy and procedure documents that address ethical issues
- Policy and procedure documents that address provisions of care

**Site 1 Relevant Organizational Documents listed as follows;**

**Corporate** *Taken from the policy and procedure manual:*

(A1) Mission

(A2) Vision

(A3) Values

(B-1) Illicit Drugs and Substances

(B-17) Euthanasia and Assisted Suicide

(B-18) Care of the Dying

(B-19) Complementary Physical and Psychological Therapies

(B-26) Extent of Treatment

(B-27) Resolution of Ethical Dilemmas

(B-36) Obtaining Informed Consent for Research

(B-47) Witnessing of Signatures

(B-49) Client Sexuality

(B-49) Death of an Inpatient

**Site Specific** *Taken from site policy and procedure manual:*

N/A (Therefore, included a table of contents).

**Nursing Specific** *Taken from the care delivery policy and procedure manual:*

(site-CD-D-1a) Death of resident procedure
Appendix G

Ethics Approval

QUEEN'S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING HOSPITALS RESEARCH ETHICS BOARD

January 11, 2008

This Ethics Application was subject to:
☐ Fall Board Review
☐ Meeting Date:
☒ Expedited Review

Ms. Megan L. Manning
School of Nursing
Queen's University

Dear Ms. Manning,

Study Title: Moral Distress Among Regulated and Unregulated Nursing Personnel Employed in Long Term Care
Co-Investigators: Dr. Marianne Lamb

I am writing to acknowledge receipt of your recent ethics submission. We have examined the protocol and consent form for your project (as stated above) and consider it to be ethically acceptable. This approval is valid for one year from the date of the Chair's signature below. This approval will be reported to the Research Ethics Board. Please attend carefully to the following list of ethics requirements you must fulfill over the course of your study:

➢ Reporting of Amendments: If there are any changes to your study (e.g., consent, protocol, study procedures, etc.), you must submit an amendment to the Research Ethics Board for approval (see http://www.queensu.ca/vpe/reb.htm).

➢ Reporting of Serious Adverse Events: Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information.

➢ Reporting of Complaints: Any complaints made by participants or persons acting on behalf of participants must be reported to the Research Ethics Board within 7 days of becoming aware of the complaint. Note: All documents supplied to participants must have the contact information for the Research Ethics Board.

➢ Annual Renewal: Prior to the expiration of your approval (which is one year from the date of the Chair's signature below), you will be reminded to submit your renewal form along with any new changes or amendments you wish to make to your study. If there have been no major changes to your protocol, your approval may be renewed for another year.

Yours sincerely,

[Signature]
Chair, Research Ethics Board

Study Code: NUS-218-08

➢ Investigators please note that if your trial is registered by the sponsor, you must take responsibility to ensure that the registration information is accurate and complete
Appendix H

Information and Consent Form

TITLE OF PROJECT

Moral Distress among Regulated and Unregulated Care Providers Employed in LTC.

OVERVIEW OF THE STUDY

You are being invited to participate in a research study directed by Megan L. Manning (Nursing graduate student at Queen’s University). Dr. Marianne Lamb, (Graduate coordinator, School of Nursing at Queen’s University) will be responsible for supervising the students overall research.

The intent of this study is to gain insight into how moral distress manifests in long term care and how nursing personnel manage ethically challenging decisions. Megan L. Manning will read through this consent form with you and describe this study in detail and answer any questions you may have. This study is being sponsored by CIHR and QJBC (If researcher is being paid directly by the sponsor, this should be indicated).

This study has been reviewed for ethical compliance by the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

BACKGROUND INFORMATION

There has been little research describing the existence and even the experience of moral distress amongst nursing personnel, specifically unregulated nursing personnel in long term care settings. In Canada the topic of moral distress has focused on nurses working in critical care settings. It is known that long term care institutions also have many ethically challenging dilemmas. Researchers have found that if ethically challenging decisions are left unresolved, this may result in moral distress for the care provider.
DETAILS OF THE STUDY

The purpose of this study is to describe the experience of moral distress among regulated and unregulated nursing personnel employed in long term care facilities.

1. You will be considered for the study if you are able to give informed consent.
2. Currently employed as a regulated licensed nurse (RN, RPN) or unregulated nursing personnel (HCA, PSW).
3. Have been employed for at least one calendar year.
4. You must be responsible for providing direct care to residents.
5. Are able to speak English.

DESCRIPTION OF STUDY VISITS

The researcher will conduct an initial one on one interview, with a regulated or an unregulated nursing participant. Interviews will take place at the participant’s location of preference (home, work or an alternately agreed upon confidential place). Follow up interviews will be conducted if required, in order to ensure accuracy. These interviews will be approximately one hour and focus on the employees experience with difficult situations (Ethical distress).

Risks/Side-Effects

There are no known risks or side-effects from participating in this study.

Benefits

While you may not benefit directly from participating in this study, results from this study may improve the understanding of moral distress among nursing personal. Through continued research, improvements in policy developments and practice may emerge.

Confidentiality

All information obtained during the course of this study is strictly confidential, and no names will be used in any presentation or publication. The research findings will be identified as common themes. Data will be stored in locked files and will be available only to Megan L. Manning (principal investigator) and Dr. Marianne Lamb (Students thesis supervisor).
Voluntary nature of study/Freedom to withdraw or participate

Your participation in this study is voluntary. You may withdraw from the study at anytime without repercussion.

Liability

Statements which waiver the subject's right to compensation in the event of injury are inappropriate for Canadian forms.

By signing this consent form, you do not waive your legal rights nor release the investigator(s) and sponsors from their legal and professional responsibilities.

Payment

There will be no compensation for participants involved in the study.

SUBJECT STATEMENT AND SIGNATURE SECTION

The study protocol and the consent form will be read to and discussed with each participant by the principal investigator, Megan L. Manning.

Should participants have questions or problems, please contact;

Megan L. Manning
School of Nursing
Faculty of Health Sciences
Queen's University
Cataraqui Building, 92 Barrie Street
Kingston, Ontario
K7L 3N6 megman123@hotmail.com

Dr. Marianne Lamb
School of Nursing
Faculty of Health Sciences
Queen's University
Cataraqui Building, 92 Barrie Street
I have read and understand the consent form for this study. I have had the purposes, procedures and technical language of this study explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions, problems or adverse events, I can contact

Principal Investigator    Megan L. Manning at telephone number 613 7673628 or

Department Head (Name and Title) at    telephone number

If I have questions regarding my rights as a research subject I can contact

Dr. Albert Clark, Chair, Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at    533-6081

By signing this consent form, I am indicating that I agree to participate in this study.

_______________________ ___________________
Signature of Participant    Date

STATEMENT OF INVESTIGATOR

I, or one of my colleagues, have carefully explained to the subject the nature of the above research study. I certify that, to the best of my knowledge, the subject understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

___________________________
Signature of Principal Investigator    Date
## Appendix I

### Occurrence of Moral Distress

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<th>Other Care Provider</th>
<th>Work Environments</th>
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</table>
Appendix J

Resolution to Situations Giving Rise to Moral Distress

Examples of Situations Giving Rise to Moral Distress
52

Experiences Omitted as Resolution was Unknown
52 - 8 = 44

Experiences Omitted as Responses were Unreliable
44 - 6 = 38

Examples of Situations Giving Rise to Moral Distress
38

Moral Distress Reported as Resolved
19

Moral Distress Reported as Unresolved
19