THE IMPACT OF MORAL DISTRESS ON THE PROVISION OF NURSING CARE AMONGST CRITICAL CARE NURSES IN THE eTHEKWINI DISTRICT

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DECLARATION

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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ABSTRACT

Introduction

Moral distress is a widely recorded phenomenon in the nursing profession. It can be described as a form of distress that occurs when one knows the ethically correct thing to do, but is prevented from acting on that perceived obligation. Moral distress impacts patients, nurses and the organization. If the nurse is unable to advocate for her or his patient and avoidance behaviour occurs, increased patient suffering result. Moral distress results in high staff turnover, decreased quality patient care and low patient satisfaction. Unrelieved moral distress jeopardizes nurse's sense of self-worth and threatens their integrity.

Aim of the study

The aim of the study was to determine the impact of moral distress on the provision of nursing care amongst critical care nurses.

Methodology

A quantitative descriptive design was used to determine the intensity and frequency of moral distress amongst critical care nurses, to assess the impact of moral distress on the provision of nursing care to the patient as well as to evaluate the effectiveness of organisational strategies implemented to reduce moral distress. Critical care nurses from both private and public hospitals were selected to participate in the study. Data was collected by means of a survey using the moral distress scale which was revised to meet the objectives of the study. A non-probability purposive sampling technique was utilised to gather data from a sample size of 100 critical care nurses currently working in the critical care environment.

Results

The study indicates that the frequency and intensity of moral distress is related to specific clinical situations in the critical care environment. The study also specifies that moral distress continues to have a negative effect on the provision of nursing care. Critical care nurses feel that some strategies are effective whereas others are not at all effective.

Impact of the research study

This study reveals that there is a significant negative effect of moral distress on the provision of nursing care. Nurses experience challenges in the clinical environment that result in them experiencing moral distress. Nurses more attuned to the ethical dimensions of care may be more at risk for moral distress since these nurses see the moral dimensions of nursing being neglected. Nurses may find themselves distancing themselves from patient care, resulting in a perceived lack of care and concern for the patient.

DEDICATION

All glory and honour goes to the God of the impossible, my Lord Jesus Christ, my teacher and creator, for making this journey a victorious one.

I dedicate this dissertation to all those nurses who are in clinical practice, still at the patient's bedside in the critical care environment. You have chosen to pursue this voyage despite the challenges facing the critical care nurse in the clinical environment, and for that, I salute you.

To all those patients who have suffered at the hands of professionals due to unresolved moral distress, I pray that this study will help reduce this phenomenon and make life better for you, the recipient of healthcare.

To Pastor Roshini Joseph my spiritual mum, thank you for inspiring me to contribute positively to the nursing profession. Our short conversation on why nurses don't care had motivated me to pursue this topic.

To my husband Leo, and children, Rene and Daniel, thank you for all those times that you understood when I could not prepare supper or say good night. Love you stacks.

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GLOSSARY OF TERMS

Critical care nursing can be defined as the specialized care of patients whose conditions are life-threatening and who require comprehensive care and constant monitoring, usually in intensive care units (Hudak, Morton, Fontaine, and Gallo, 2008: 3).

Critical care nurse is one who has successfully completed specialist post-qualification education in critical care (or intensive care) nursing, which builds upon initial generalist nursing education. In meeting the complex needs of critically ill patients, such nurses have a well-developed knowledge base, along with specialist skills in both the technological and the caring dimensions of critical care nursing. They are equipped with the expertise to make sound and rapid clinical judgements within the critical care environment and to recognize and deal with the ethical issues inherent in such an environment (WHO 2003). In the context of this study, a critical care nurse has been identified as any category of nurse working in the critical care environment.

Moral distress is a psychological disequilibrium, negative feeling state, and the suffering that nurses experience when they do not act on moral decisions due to institutional constraints Corley (2002: 33). It is the suffering that occurs when one is unable to do what one believes to be the right thing, based on one's personal values and philosophy.

Moral sensitivity is 'the ability to recognize a moral conflict, show a contextual and intuitive understanding of the patient's vulnerable situation, and have insight into the ethical consequences of decision on behalf of the person (Corley 2002: 636).

Moral competency is the ability to make moral sense of situations, use good moral judgement and intention, and engage in morally appropriate behaviour (Corley 2002: 636).

Moral certainty is a feeling of absolute moral conviction that leads nurses to risk self, personally and professionally, to act on the 'rightness' of that conviction (Corley 2002: 636).

LIST OF ACRONYMS

Acronym	Full term
AACN	American Association of Critical Care Nurses
DOH	Department of Health
ICU	Intensive Care Unit
CCU	Critical Care Unit
KZN	KwaZulu-Natal
SANC	South African Nursing Council

CHAPTER 1: OVERVIEW OF THE STUDY

"Caring determines the quality of the connectedness between subject and object."

(Pera and van Tonder 2005: 17)

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Caring is not only an ethical principle – ethics in itself is caring. Caring is defined as directness; it is the quality of the subject object relationship. Caring determines the quality of all relationships that we have. Caring spells regard and appreciation. The concept of caring has been defined as an innate human attribute (Pera 2005: 11). There is some agreement that nursing provides a valued service to society, namely, caring, comforting, supporting, promoting dignity, preventing harm, advocating, and maximising autonomy. As such, nursing is an interpersonal, moral activity (Volker 2003: 207). As early as the era of Florence Nightingale, the act of modern nursing was associated with compassion and commitment to patient care. Present day challenges such as poor working conditions are impacting on the capacity of nurses to provide the type of nursing care they feel ethically obligated to give (Browning 2013: 145). It has been suggested that it is the goodwill of nurses that is holding the health system together (Buchanan *et al.* 2004: 35). There is an expectation that care will be provided despite the evidence that many nurses are leaving the profession (Buchanan *et al.* 2002: 2796).

Nursing has always been regarded as a humanistic profession (Sumner 2010: 1). It is not a commodity, even if provided in an increasingly business-driven healthcare delivery system. The commitment and care of nurses to nursing is a moral obligation that arises from a sense of altruism and an internal driving force of a need to help others. There are general guiding principles within which all societies live and the same is true for the nursing profession. The author further states that there are particular norms or standards by which nurses live their professional lives which are: a sense of duty and obligation toward the patient, to do no harm, and to provide optimum care. The ethical

theories that are applied to nursing practice work well in relation to the patient but less so for the nurse. Moral distress is the “psychological disequilibrium” that occurs when, for whatever reason, the nurse is not able to provide the care that is perceived to be “right” or “best” for the patient (Corley 2002: 636).

Moral distress has been a highly researched topic in the healthcare setting in the past three decades. Moral distress as a concept is not limited to nursing. It can be experienced in all professions and in all work settings. The earliest work found in the literature addressing moral distress was by (Jameton 1984: 246) who defined it as a psychological disequilibrium resulting from knowing the ethical action to take but not taking it due to an inhibiting medical power structure or institutional policy. Similarly, (Wilkinson 1987: 16) described moral distress as a sensory event – a negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision.

Nathaniel (2002: 5) proposes the following definition of moral distress: “Moral distress is the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing”. Range and Rotherham (2010: 225) state that moral distress is the painful feelings and/or psychological disequilibrium that results from recognizing an ethically appropriate action, yet not taking it because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations.

Moral distress in nursing knows no boundaries. It affects everyone who cares for the patient and is concerned about patient’s wellbeing (Yoes 2012: 14). A large number of studies addressing moral distress in nursing indicate that this challenging issue continues to distress the profession (Corley *et al.* 2005: 381). Nurses report greater frequency and intensity levels of moral distress than other clinicians (Rice *et al.* 2008: 360). Over 80% of nurses have reported medium to high levels of moral distress (Corley 2002: 636).

Society cannot take for granted that there will always be a never-ending supply of nurses. With the current nursing shortage, nurse professionals have a responsibility to decrease or eradicate moral distress. The following challenges continue to be barriers to achieving quality patient care and contribute to increase in moral distress: increase in patients' co-morbid conditions, an extending life span, limited institutional resources, changes in reimbursement, and the shortage of clinical professionals. Demographic data including age and education level have not been found to impact moral distress levels. However, studies have shown a correlation between the ethical climate of an organization and the level of moral distress experienced by staff (Corley *et al*. 2002: 636). Pauly *et al.* (2009) conducted a study which evaluated perceptions of moral distress among professional nurses compared to ethical climate. Findings showed a correlation between ethical climate and moral distress; the less ethical support within an organization, the greater the levels of moral distress (Pauly *et al.* 2009). This relationship is important for leaders and strategic planning.

The American Association of Critical Care Nurses (AACN) state that moral distress occurs when one knows the ethically appropriate action to take, but is unable to act upon it (American Association of Critical Care Nurses [AACN] 2008) (Brennan, Prince-Paul and Wiencek 2011: 379) The AACN further states that moral distress involves acting in a manner contrary to one's personal and professional values, which undermines one's integrity and authenticity. The AACN identifies sources of moral distress as being personal, interpersonal, and/or environmental. The organization states that moral distress causes suffering, may lead to burnout, and may result in resignation if left unresolved. Moral distress can lead to a positive change, creating an environment where critical care nurses can make their optimal contribution to the patients and families they serve, provided there is a commitment to address the phenomenon. The AACN, therefore, strongly advises health care organizations to implement programs to promote healthy work environments and reduce moral distress (Brennan, Prince-Paul and Wiencek 2011: 379). Furthermore moral distress has been found to affect the health of nurses and their provision of care, job satisfaction, and retention. Nurses who experience

moral distress have reported physical symptoms such as headache, neck pain, and stomach problems. Psychological and emotional symptoms include anger, guilt, depression, frustration, and feelings of reduced self-worth. They may also withdraw from family and friends (Schluter *et al.* 2008: 304).

1.2 PROBLEM STATEMENT

In the past 20 years, moral distress has been recognized as more prevalent in nurses working in critical care settings, and there is greater awareness of the influence of environment on its prevalence. Nurses practicing in CCUs are at higher risk of moral distress due to the nature of patient conditions and related ethical issues arising in these settings, for example, end-of-life decision-making, autonomy, allocation of scarce resources, and quality versus quantity of life. Thus, the majority of studies on moral distress have been conducted with nurses working in intensive care units (Hudak et al. 2008: 3).

Frequently nurses find themselves amidst life and death decisions and have watched patients and their families struggle with decisions regarding whether quality or quantity of life is more important. Nurses have witnessed health care providers making so called decisions pertaining to patient care, but are unable or unwilling to step forward and be that patient's advocate in the way that they ought to be. The National Core Standards for Health Establishments in South Africa includes patient safety, clinical governance and care as the key determinants of quality patient care delivery (Department of Health 2011).

Nurses are being viewed by the public as poor agents of care. A nurse is not human, let alone a nurse, if she does not display the caring ethic in her practice. Discussions pertaining to the healthcare arena eventually end up with the nurse and the lack of care she displays. So challenging is the mandate for the need for the element of care that healthcare institutions are implementing "care programmes" to help instil the vital characteristic of care during healthcare delivery. One may ask the question why? Why is it that the

nurse displays an apparent lack of care and concern for her or his patient, as this is not customary? What could contribute to this incidence?

A two day international symposium held on moral distress in 2010 highlighted concerns about moral distress in everyday nursing practice, and the limitations of the current state of knowledge development in relation to moral distress (Pauly *et al*. 2011: 561). Key experts in the field were invited to act as provocateurs in each of the following areas for action: education, practice, policy and research. Over 75 people attended including international participants and representatives from a broad range of disciplines. The presenters argued that conceptual and theoretical clarity are keys to development of an agenda on moral distress to guide policy, practice, education and research. This is particularly relevant when developing interventions, teaching practitioners, and guiding measurement and intervention research.

Failure to alleviate moral distress can impact patient care, lead to job stress and staff turnover, and cause some nurses to leave the profession (Corley 2002: 636). Moral distress occurs in both critical care and non-critical care nurses. Nurses engage in avoidance behaviour when faced with impediments to perceived moral practice (De Villers and DeVon 2013: 589). Avoidance behaviour is a conscious or unconscious defence mechanism by which a person tries to escape from unpleasant situations or feelings, such as anxiety and pain. This may be displayed by an inability to maintain eye contact, interact meaningfully or show empathy for the recipient of healthcare. This implies that there is a link between moral distress and the nurse's lack of care. This lack of caring ethic in nursing practice leads to defamation of the nursing profession as nurses fail to render care that promote therapeutic outcomes in their patients. Patients may be left feeling morally and ethically wronged by the nurse practitioner who fails to display these principles in her or his nursing practice.

Some of the ill-effects of moral distress amongst nursing professionals, as described by the AACN (2008) article entitled the 4A's to rise above moral distress are apathy, indifference, avoidance, erosion of relationships and disconnection with people, work, and community. All of these have a direct impact on the nurse-patient relationship and the nurse as a moral, ethical, caring agent. The article states that addressing moral distress requires making changes. The four cornerstones of rising above moral distress are asking whether one feels moral distress, affirming ones distress and commitment to take care of oneself, identifying or assessing sources of one's personal or professional distress and prepare personally and professionally to take action to resolve this distress (AACN 2008).

Moral distress is a major problem in the nursing profession, affecting nurses in all health care systems. It is common when there are insufficient numbers of staff, inadequately trained staff, and organizational policies and procedures that make it difficult, or even impossible, for nurses to meet the needs of patients and their families. This conflict results in moral distress for nurses, yet limited attention has been paid to this phenomenon, which is now an important element in any health care setting (Corley 2002). According to the AACN public statement (2008: 1), the sources of moral distress are identified as being personal, interpersonal, and/or environmental. Moral distress causes suffering, may lead to burnout, and may result in resignation if left unresolved. Groups of people who work together in situations that cause distress may experience poor communication, lack of trust, high turnover rates, defensiveness, and lack of collaboration across disciplines. Moral distress can lead to a positive change, creating an environment where critical care nurses can make their optimal contribution to the patients and families they serve, provided there is commitment to address the phenomenon. Health care organizations are urged to implement programmes to promote healthy work environments and reduce moral distress (AACN 2008: 1). The nurses' ability to rise above moral distress can be greatly influenced by AACN's 4 A's (AACN 2008:1).

Fundamental to the practice of nursing is the expectation that the nurse will always keep the patient from harm, will provide care that is safe and effective, and will be respectful of the dignity, worth, and autonomy of the patient (Dixon *et al.* 2010: 48). This can be supported by the ethical principles that are foundational to nursing science, such as beneficence, non-maleficence, autonomy, veracity, justice and many others.

One of the characteristics of a profession is that it has its own culture, with expected behaviour of those who are members. Nursing has a code of ethics that provides the cultural framework within which nurse's practice. However, this very foundation essentially creates situations where moral distress will occur, because there will always be situations where the nurse cannot do what is considered to be in the best interest of the patient. Therefore, it is inevitable for moral distress to occur. According to Gallagher (2011: 1) more needs to be learnt about the impact of moral distress on the provision of care as well as the impact of education on moral distress.

1.3 PURPOSE OF THE STUDY

The purpose of this study was to determine the effects of moral distress on the provision of care to patients. The intensity and frequency of moral distress experienced in the critical care nurse was determined and the effects of this were compared to the nurse's ability to render care to her or his patient. Existing strategies were identified and evaluated by the nurse for effectiveness in reducing moral distress.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Determine the intensity and frequency of moral distress amongst critical care nurses in the eThekwini District.
- Determine the impact of moral distress on the provision of nursing care to the patient in the eThekwini District.

- Determine the effectiveness of strategies implemented to reduce the incidence and frequency of moral distress in the eThekwini District.

1.5 RESEARCH QUESTIONS

- What is the intensity and frequency of moral distress amongst critical care nurses in the eThekwini District?
- What is the impact of moral distress on the provision of nursing care to the patient in the eThekwini District?
- How effective are strategies implemented to reduce the incidence and frequency of moral distress in the eThekwini District?

1.6 SIGNIFICANCE OF THE STUDY

Nurses experience adversity through organisational constraints, reduction in staff ratios, escalating workloads, and where patient acuity is increasing (Jackson *et al.* 2011: 655). This has an effect on the quality of patient care (Edward and Hercelinskyj 2007: 270). Some nurses will have no choice but to work in these environments and either suffer adverse effects, or adapt through inhibiting their capacity to provide morally sensitive patient care (Peter and Liaschenko 2004: 218). Alternatively, they may leave the workplace environment all together (Ulrich *et al.* 2007: 1711). Moral distress is not only a situational phenomenon, but holds the potential for long-term residual effects when moral distress is sustained.

Nurses confronted by situations that result in the experience of moral distress may become increasingly unable or unwilling to continue to practice in a profession that already faces a shortage of practitioners. Aiken *et al.* (2008: 3330) have pointed out that the current shortage is not necessarily a shortage of qualified nurses, but a shortage of nurses who are willing to work in the present conditions such as insufficient staffing, inappropriate skill mix, and inadequate support. These issues have been associated with the experience of moral distress. This erosion of the nurse workforce has significant

implications for the health and well-being of patient populations, as well as the nurse caregivers and their families. Nurses are the single largest group of health care providers and the void they leave in exiting the profession negatively impacts the quality and quantity of patient care. The failure to effectively cope with moral distress can lead to apathy, avoidance of patients and situations that evoke moral distress and burnout and impacts the quality and quantity of patient care delivered. Increased patient morbidity and, in some instances, mortality may result. Studies show that nurses most unable to cope with moral distress and likely to leave the profession may be the best patient advocates and have the highest levels of moral sensitivity (Tiedje 2000: 36). Millette (1994: 660) advises the importance of identifying those health care providers who are at risk for moral distress. In examining orientations toward moral reasoning, she found that nurses who used a 'caring' approach with an emphasis on relationships and personal connections rather than 'principles' and 'rules' to make moral decisions were more likely to exit the profession. These findings hold significant implications for managers, supervisors, and colleagues in identifying those nurses at risk for moral distress and retaining them through effective management of this challenge.

From the above, it is clear that the negative effects of moral distress are multidimensional. The significance of the study is to determine the relationship between moral distress and the quality of patient care delivered. It is also to determine the effectiveness of existing preventative strategies aimed at reducing this challenging issue.

1.7 THEORETICAL FRAMEWORK

The theoretical framework used for this study is derived from the work of Corley (2002: 636). Her study states that moral distress impacts on patients, nurses and organisations (Table 3.1 1). The moral distress theory outlines what happens when a nurse is unable or feels unable to advocate for a patient, and thus experiences moral distress. The theory addresses the internal and external environment of the nurse and its influence on the nurse's experience of moral distress. This is further discussed in chapter 3.

1.8 OUTLINE OF THE DISSERTATION

Chapter 1: Overview of the study

This chapter lays the foundation for the research study. It introduces the study and outlines the focus, research problem, purpose and objectives of the study. This chapter also presents the significance of the study, as well as the theoretical underpinning of the occurrence of moral distress.

Chapter 2 Literature review

This chapter provides a theoretical framework for the study, drawing upon literature which indicates the key factors influencing the development of moral distress in the context of the healthcare industry. This chapter further places the research study in a historical, economic, educational and humane context.

Chapter 3

This chapter will introduce the research methodology, describe the research design, setting, theoretical framework and sampling process that are to be used in the study. It will address reliability and validity of research tools used in the study and will conclude with discussion of ethical considerations to be adhered to.

Chapter 4

In this chapter, the findings of the study will be discussed; specifically the incidence and frequency of moral distress will be related to the impact on patient care. Effectiveness of existing strategies will also be evaluated. Findings of the research will address the research questions and provide a comprehensive description thereof.

Chapter 5

In this chapter, study limitations, implications for nurses, patients and the profession will be discussed. The result will also be related to the theoretical underpinning of the study. Recommendations arising from the study will be presented; areas for further research will be high-lighted. It will conclude with a reflection from the researcher on the experience of conducting the study.

1.9 CONCLUSION

Moral distress has proven to be a widely recorded phenomenon in nursing practice with grave consequences for the nurse, patient and the healthcare organization. Therefore, identifying the causes of moral distress in a specific healthcare setting and addressing these issues is imperative in maintaining the healthy image of the nurse and in promoting a therapeutic, caring, ethical nurse patient relationship and positive outcome in patients. Identifying strategies to enable a constructive response to moral distress remains the cornerstone to nurse success in an environment where the nurse remains morally and legally accountable for the care they render.

CHAPTER 2: LITERATURE REVIEW

"I can take care of and help the other to the best of my ability or else ignore or even destroy what has been delivered into my hands"
(Knud Logstrup 1997 cited in (Austin 2005: 317).

2.1 INTRODUCTION

A literature review was conducted to perform an evaluation of relevant documents on the topic. Information relating directly to the topic of moral distress in the critical care environment was synthesized. Areas of further research were identified. The researcher's interest in this topic stems from her role as a nurse with first-hand experience of the stresses facing the critical care nurse at the bedside as well through her experience as a nurse educator and listening to challenges student nurses face in fulfilling their caring role. Students' experiences of moral distress are often attributed to them questioning why things are not being done as they were taught. This distress may be compounded by inexperience and lack of knowledge. It is critically important to empower students with effective ways to process their concerns to ensure their successful admission into their professional roles. Conversations in the public arena relating to the nurses lack of care led to the researcher attempting to determine the reasons for this apparent lack of care displayed by the nurse professional.

2.2 DEFINITION OF CRITICAL CARE NURSING

Critical care nursing can be defined as the specialized care of patients whose conditions are life-threatening and who require comprehensive care and constant monitoring, usually in intensive care units (Hudak *et al*. 2008: 3). This is also known as intensive care. (Abbasi *et al.* 2013: 70) incorporate an element of compassion into their definition, stating that critical care nursing is concerned with human responses to life threatening problems, such as trauma, major surgery or complications of illness.

2.3 CRITICAL CARE NURSING TODAY

As the health care delivery system continues to evolve, so too does nursing and critical care. Since the opening of the first critical care unit (CCU) in the 1960s, significant technological advances have occurred, accompanied by a knowledge explosion in critical care nursing. It is in this critical care environment that integration of sophisticated technology, psychosocial challenges, and ethical conflicts associated with critical illness, as well as the needs and concerns of patients, concerned family members and other significant people in the patient's life occur. As health care becomes increasingly technological, the concurrent need for humanisation has become even more essential. Compatible with the need for humanised health care, is the need to provide ethically and morally grounded interventions (Hudak *et al*. 2008: 3).

Critical care nurses are under constant pressure to maintain clinical competence, to demonstrate how their care positively affects patient outcomes, and to participate actively in clinical decision making and practice improvements. Furthermore, cost effectiveness and efficiency with time and resources are mandated. They are compelled to use evidence based practice to ensure the best clinical outcomes for their patients. In addition to this, the critical care nurse needs a strong knowledge base and critical thinking skills to improve clinical outcomes and patient care (Hudak *et al*. 2008: 3). Critical care nurses need not only be technologically proficient, but competent in the psychosocial, developmental, spiritual, and caring domains to interact successfully with the patient, family and significant others. The critical care environment of tomorrow no doubt, will be even more technologically challenging.

2.4 NURSING AS A CARING SCIENCE

Despite innovations and advances in technology, and other therapeutic interventions, the mortality rate remains higher in the CCU than any other domain in the health care environment. Other sources of stress in the CCU

may be related to acuity of patients, unplanned hospitalisations, availability of resources, expected outcomes and patient-family separation (Hudak *et al*. 2008: 3). As a result of the above, a caring, competent nurse is even more essential in this environment to meet the humane needs of the critically ill patient. The high technology driven critical care environment is fast paced and directed towards monitoring and treating life threatening changes in patient conditions. Concern has been voiced about the lesser emphasis on the caring component of nursing in this fast paced, highly technologic health care environment. Nowhere is this more evident than in areas where critical care nursing is practiced (Urden, Stacy and Lough 2010: 5). Keeping the care in nursing is one of nursing's greatest challenges (Miller, Forbes and Boyle 2001: 230). The caring aspect between nurses and patients is fundamental to the nurse patient relationship and to the health care experience. It should be preserved at all costs.

2.5 MORAL INTEGRITY IN NURSING PRACTICE

Fundamental to the practice of nursing is the expectation that the nurse will always keep the patient from harm, will provide care that is safe and effective, and will be respectful of the dignity, worth, and autonomy of the patient (Hudak *et al*. 2008: 3). This can be supported by the ethical principles that are foundational to nursing science, such as beneficence, non-maleficence, autonomy, veracity, justice and many others. One of the characteristics of a profession is that it has its own culture, with expected behaviour of those who are members. Nursing has a code of ethics that provides the cultural framework within which nurse's practice. However, this very foundation essentially creates situations where moral distress will occur, because there will always be situations where the nurse cannot do what is considered to be in the best interest of the patient. Therefore, it is inevitable for moral distress to occur.

(Sumner 2010: 77) states that the usual ethical theories utilized in nursing practice, such as utilitarianism, a consequences-based approach, deontology, a duty-based approach, and virtues theory and values theories, are all uni-

directional, rational, and objective and do not address the fundamental vulnerability of the nurse. Neo-Stoic Eudaemonism is seen as being critical to ensure that humanistic care is offered to the patient. This is the driving force of nursing. Sumner further defined Neo-Stoic Eudaemonism as “that system of ethics which defines and enforces moral obligation by its relation to happiness or personal wellbeing”. Including Neo-Stoic Eudaemonism as one of the theories in healthcare enables nurses to resume their status as moral practitioners, who can flourish as true patient advocates and nursing advocates (Sumner 2010: 77).

2.6 DEFINITION OF MORAL DISTRESS

Moral distress is a widely recorded phenomenon in nursing practice. It can be described as a form of distress that occurs when one knows the ethically correct thing to do, but is prevented from acting on that perceived obligation It is the suffering that occurs when one is unable to do what one believes to be the right thing, based on one’s personal values and philosophy (Hamric 2010: 6).

According to (Elpern and Balk 2008: 7), moral distress involves the perception that core personal values or ethical obligations are violated. Nurses are expected to perform ethically in all circumstances; however, many situations create barriers that are unavoidable.

(Fenton 1988: 8) identifies moral distress as a disturbing emotional response occurring when one’s personal beliefs about right and wrong are violated. Corley (2002 33) drew from Jameton’s work in defining the concept of moral distress as psychological disequilibrium, a negative feeling state, and the suffering that nurses experience when they do not act on moral decisions due to institutional constraints.

Moral distress results in interior aversion or a dislike that results from a perceived harm to a known good (moral end). Interior aversion is a withdrawal from the perceived source of the harm and originates with a pre-cognitive

perception recognized as visceral discernment. Visceral discernment may preclude conscious recognition of initial awareness of moral distress, but may still initiate behaviours and symptoms of the phenomenon (Hanna 2004: 77). The author further states that moral distress can result in a disconnection from self and others. Corley (2002: 636) stresses that moral distress is a psychological disequilibrium that occurs when, for whatever reason, the nurse is not able to provide the care that is perceived to be 'right or best' for the patient (Corley 2002: 636). Moral distress has been described as the state experienced when moral choices and actions are thwarted by constraints (Austin *et al.* 2005: 1). Moral distress is the suffering that occurs when an individual is unable to do what that individual believes to be the right thing, based on personal values and world view (Baxter 2012: 28).

Jameton defines moral distress as a psychological disequilibrium resulting from knowing the ethical action to take but not taking it due to an inhibiting medical power structure or institutional policy. He explained that nurses feel moral distress when they know the right thing to do but are unable to make that decision due to institutional constraints (Jameton 1984 cited in Corley 2002: 637). Similarly Wilkinson (1987: 16) described moral distress as a sensory event: a negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision. Corley drew from Jameton's work in defining the concept of moral distress as psychological disequilibrium, negative feeling state, and the suffering that nurses experience when they do not act on moral decisions due to institutional constraints. Corley proposed a moral distress theory in 2002 that is based on Jameton's moral distress concept. She defined nursing as a moral profession that is grounded in ethical standards. These are reflected in nurse practice acts and standards of care. The theory expands from an explanation of moral distress to how it impacts the nurse, the patient, and the organization (Corley 2002: 637).

2.7 WHO EXPERIENCES MORAL DISTRESS?

Yoes (2011: 14) states that moral distress in nursing knows no boundaries. It affects everyone who cares for the patient and is concerned about patients' wellbeing. Demographic data including age and education level have not been found to impact moral distress levels. Wiegand and Funk (2012: 480) state that the majority of situations that cause critical care nurses to experience moral distress are related to end of life. A study conducted in 2012 (Varcoe *et al.* 2012) identified a range of situations as morally distressing, including witnessing unnecessary suffering, being forced to provide care that compromised values, and negative judgements about patients. This study further compels one to investigate the concept of moral distress and to establish institutional support structures to manage this occurrence.

2.8 THE SIGNIFICANCE OF MORAL DISTRESS IN NURSING

Society cannot take for granted that there will always be a never-ending supply of nurses. With the current nursing shortage, nurse professionals have a responsibility to decrease or eradicate moral distress. The following challenges continue to be barriers to achieving quality patient care and contributing to increase in moral distress: increase in patients' co-morbid conditions, an extending life span, limited institutional resources, changes in reimbursement, and the shortage of clinical professionals. Nurses experience adversity through organisational constraints, reduction in staff ratios, escalating workloads, and increase in patient acuity. This has an effect on the quality of patient care. Some nurses will have no choice but to live in these environments and either suffer adverse effects, or adapt through inhibiting their capacity to provide morally sensitive patient care (Peter and Liaschenko 2004: 218). Alternatively, they may leave the workplace environment all together (Ulrich and J Gotelli 2007: 2053).

Nurses need to be willing and able to recognize moral distress so as to identify it as an exception and not the norm (Jameton 2013: 297). She further states that if not, one may begin to demonstrate symptoms of anxiety,

depression, or guilt if not addressed effectively. Other symptoms mentioned are headache or stomach problems, lack of enthusiasm to go to work or shutting down emotionally when caring for patients or interacting with co-workers. Nurses confronted by situations that result in the experience of moral distress may become increasingly unable or unwilling to continue to practice in a profession that already faces a shortage of practitioners. The current shortage is not necessarily a shortage of qualified nurses, but a shortage of nurses who are willing to work in the present conditions such as insufficient staffing, inappropriate skill mix, and inadequate support. These issues have been associated with the experience of moral distress (Aiken *et al.* 2008).

This erosion of the nurse workforce has significant implications for the health and well-being of patient populations, as well as the nurse caregivers and their families. Nurses are the single largest group of health care providers and the void they leave in exiting the profession negatively impacts the quality and quantity of patient care. Moral distress is a major problem in the nursing profession, affecting nurses in all health care systems. It is common when there are insufficient numbers of staff, inadequately trained staff, and organizational policies and procedures that make it difficult, or even impossible, for nurses to meet the needs of patients and their families. This conflict results in moral distress for nurses, yet limited attention has been paid to this phenomenon, which is now an important element in any health care setting (Corley 2002: 636).

The effects of moral distress include loss of self-worth, interference with personal relationships, psychological (depression), behavioural (nightmares, crying), and physical symptoms such as heart palpitations, diarrhoea, and headache. Feelings of powerlessness, hopelessness, and lack of support have been reported as well as anger, nausea, frustration, grief, misery, and ineffectiveness. Moral distress is not only a situational phenomenon, but also holds the potential for long-term residual effects when moral distress is sustained. There are grievous consequences to sustained moral distress. Persons may carry with them long-term memories of events in which they compromised themselves when faced with moral distress; these times are

painful because they betray prized beliefs and values (Corley 2002: 636). The passage of time may blunt the acute distress, the profound uncertainty and fear, the guilt, and the remorse, but it has been suggested that people who have lived through serious moral compromise carry the remnants of the experience for many years, if not a lifetime.

A study conducted in 2012 by (Varcoe *et al.* 2012), identified a range of situations as morally distressing, including witnessing unnecessary suffering, being forced to provide care that compromised values, and negative judgements about patients. This study further compels one to investigate the concept of moral distress and to establish institutional support structures to manage this occurrence. Nurses who report having left, or who are considering leaving a position because of moral distress consistently report higher scores on the moral distress scale (Elpern, Covert and Kleinpell 2005; Cavaliere *et al*. 2010; Piers *et al*. 2011). These studies provide evidence that moral distress is a problem for professional nursing practice.

2.9 THE CHALLENGE FOR NURSING EDUCATION

The nursing profession has traditionally held to a high standard of moral behaviour and ethical practice. Nurses in clinical practice frequently report the distress they experience when, for example, a standard that they believe in is compromised in some fashion. Other times this distress occurs when the nurse does not believe that the treatment being provided to the patient is in the best interest of the patient, or does not mesh with the nurse's sense of right and wrong. Moral distress among nurse educators may arise from different situations than those related to patient care. However, the outcomes of this moral distress are the same, namely, an organizational climate that does not support healthy collegial behaviours. Academic dishonesty, grade inflation and or bullying may lead to moral distress that may influence faculty job satisfaction and student learning and are a danger to the academic environment and ultimately the nursing profession (Ganske 2010: 1). These situations can create moral distress in academia. Nursing is consistently listed as the most trusted profession; yet the public's trust in nursing could quickly

erode if the profession does not attend to maintaining ethical standards in academia today. If healthcare professionals fail in doing so, a culture of tolerance for the events leading to moral distress will grow.

This is not to say that a punitive atmosphere should be advocated. Instead a culture of integrity, one that fosters trust, collaboration, and a desire for the highest ethical behaviour, should infuse the fabric of both the academic and clinical environments in nursing so as to offer the highest quality of care and decrease the incidence of moral distress within the profession (Ganske 2010: 1). Healthcare professionals in both the above mentioned settings should take individual responsibility in maintain an ethical environment that will foster the development of morally competent healthcare professionals.

2.10 STRATEGIES TO ALLEVIATE MORAL DISTRESS AMONGST CRITICAL CARE NURSES

Vanderheide, Moss and Lee (2013:101) state that the workplace is morally uninhabitable and that nurses express aspects of moral habitability through the concepts of moral climate, moral agency, moral sensitivity and moral distress. They further explain that moral distress in the clinical environment can inhibit nurse's capacity to provide morally sensitive patient care if not dealt with adequately. They stress the importance of enhancing and sustaining the work environment to alleviate moral distress and make the work environment more habitable for nurses. Weaver, Morse and Mitcham (2008: 610) describe ethical sensitivity as a type of 'practical wisdom' that can be used and developed by the professional to promote quality patient care and moral ethical sensitivity. Their concept analysis resulted in a synthesised definition for the nursing profession: Ethical sensitivity is the capacity to decide with intelligence and compassion, given uncertainty in a care situation, drawing as needed on a critical understanding of codes for ethical conduct, clinical experience, academic learning and self-knowledge, with an additional ability to anticipate the consequences and the courage to act. This definition reveals a number of aspects of the concept that could be developed by the professional such as academic knowledge and reflective critique of practice.

They state that the outcomes of developing ethical sensitivity include preservation of integrity, growth, well-being and 'practical wisdom', for the professional and patient care that is focussed on their needs. Moral distress occurs in both critical care and non-critical care nurses. Nurses engage in avoidance behaviour when faced with impediments to perceived moral practice (De Villers and DeVon 2013: 589). According to Gallagher (2011: 1), more needs to be learnt about the impact of moral distress on the provision of care and the impact of education on moral distress and further state that one must identify strategies to enable a constructive response to moral distress.

The national core standards of the Republic of South Africa includes in its priorities patients' rights and states that the attitudes and values of the nurse is the first determinant of quality patient care (Department of Health 2010: 3). This indicates that the nurse's attitudes and values play a key role in the delivery of quality patient care. The nurse's attitude and values can be greatly influenced by moral distress, as evidenced by the AACN's (2008) 4 A's analysis.

A recent study evaluated perceptions of moral distress among professional nurses compared to ethical climate. Findings showed a correlation between ethical climate and moral distress; the less ethical support within an organization, the greater the levels of moral distress (Pauly *et al.* 2009: 561). Corley *et al.* (2002: 636) agree that a correlation exists between the ethical climate of an organization and the level of moral distress experienced by staff. Therefore, attempting to create a favourable ethical work environment will alleviate moral distress and its consequences. This relationship is important for leaders and strategic planning.

Critical care nurses' experience of moral distress are intense and frequent and is a serious issue and research on interventions to address moral distress is needed (Elpern, Covert and Kleinpell 2005: 523). Browning (2013: 22) highlighted that nurses who were psychologically empowered experienced less moral distress.

Staff educational level and peer support have been found to influence moral distress. The literature review by Schluter *et al*. (2008: 315) identified a significant relationship between educational level/experience and moral distress, suggesting that nurses with more education and experience have higher levels of moral distress and that ethics education may improve coping strategies. Schluter *et al*. (2008: 315) noted that coping strategies are also bolstered by good peer support, in that the empathic and educated understanding provided by nursing peers who understand the surrounding circumstances was found to be most beneficial.

Wood (2014:3), in consultation with experts in the American Healthcare industry identified ten best practices for addressing moral distress, in her online newspaper article: Ramon Lavandero, one of the experts and senior director of the American Association of Critical-Care Nurses (AACN) stated that the challenge is not to eliminate moral distress as it is becoming part of our new normal and not going away, so our new goals need to be learning how to recognize and address it effectively. He further stated that healthcare leaders can start by helping healthcare providers learn how to recognize moral distress and point them to resources to help address it.

Further points of interest in the article by other experts in the field of healthcare were supporting a nursing code of ethics and incorporating it into performance reviews; offering ongoing education to increase awareness of moral distress amongst healthcare professionals; creating an environment that supports nurses in raising ethical questions to empower them to address concerns; bringing different disciplines together such as in clinical rounds to discuss patient goals; providing the expertise of ethics experts to confidentially assist in viewing a situation from other perspectives; having unit based ethical mentors to help deal with issues earlier rather than later; holding family conferences to increase their awareness of the patient's condition and potential change of goals of care, such as hospice care; offer employee counseling services to assist in dealing with distressing situations that can contribute to moral distress (Wood 2014).

2.11 SOURCES OF MORAL DISTRESS

The sources of moral distress are identified as being personal, interpersonal, and/or environmental. Moral distress causes suffering, may lead to burnout, and may result in resignation if left unresolved. Groups of people who work together in situations that cause distress may experience poor communication, lack of trust, high turnover rates, defensiveness, and lack of collaboration across disciplines. Moral distress can lead to a positive change, creating an environment where critical care nurses can make their optimal contribution to the patients and families they serve, provided there is commitment to address the phenomenon. Health care organizations are urged to implement programmes to promote healthy work environments and reduce moral distress (Beumer 2008: 263). Browning (2013: 22) highlighted that nurses who were psychologically empowered experienced less moral distress. Gallagher (2011: 1), states that more needs to be learnt about the impact of moral distress on the provision of care and the impact of education on moral distress and that strategies need to be identified to enable a constructive response to moral distress. The author further adds that keys are to (1) recognize situations where moral distress is occurring or might occur, and (2) develop strategies that the nurse can use to minimize its effects.

A study conducted in 2012 by (Varcoe *et al.* 2012), identified a range of situations as morally distressing, including witnessing unnecessary suffering, being forced to provide care that compromised values, and negative judgements about patients. This study further compels one to investigate the concept of moral distress and to establish institutional support structures to manage this occurrence. These studies provide evidence that moral distress is a problem for professional nursing practice.

Nurse's attitude and values can be greatly influenced by moral distress, as evidenced by the AACN's 4 A's analysis. Study findings of Elpern, Covert and Kleinpell (2005: 523) confirm that moral distress adversely affects job satisfaction, retention, psychological and physical well-being, patient advocacy, self-image and spirituality. They further state that critical care

nurses encounter high levels of moral distress and recommend that strategies to mitigate moral distress be developed.

2.12 RELATIONSHIP BETWEEN ETHICAL CLIMATE AND MORAL DISTRESS

Olsen (1995:85) studied the ethical climate as a concept, noting its similarities to the concepts of ‘moral climate,’ ‘corporate ethical climate,’ ‘ethical work climate,’ ‘ethical environment,’ ‘ethical or moral culture or corporate culture,’ and ‘ethical dimension of the organizational culture.’ She further stated that all of these terms were used to describe the same phenomenon, and that an organization’s history, formal structures, mission, philosophy and values influence perceptions of ethical climate. The ethical climate of an organization consists of perceptions of organizational practice and conditions that facilitate the discussion and resolution of difficult patient care issues. She concluded by describing the ethical climate as one type of organizational climate that can be managed and changed in order to improve the workplace environment.

Pauley *et al.* (2009: 561) mention that there is some evidence that the symptoms of moral distress surface more readily when the ethical climate of an organization is not supportive and/or respectful of nursing practice. They further state that there are many factors that affect the ethical climate, such as peers, patients, managers, hospitals, and physicians and express that an ethically sensitive environment is one of the most important factors in decision making; it enables nurses to make sound observations and recognize potential consequences when dealing with difficult ethical situations. Corley *et al*. (2005: 381) agree that an ethical workplace environment is one that supports open reflection and discussion of the work of nurses as they practice. Further, they emphasized that an ethical environment supports both ethical decisions related to patient care and respectful treatment of staff through proper implementation of policies, organizational philosophy, and/or conflict resolution procedures.

Study findings of Elpern, Covert and Kleinpell (2005: 8) confirm that moral distress adversely affects job satisfaction, retention, psychological and physical well-being, patient advocacy, self-image and spirituality. They further state that critical care nurses encounter high levels of moral distress and recommend that strategies to mitigate moral distress be developed. The International Council of Nurses' 2014 position statement stresses that the work environment and conditions of nurses and other health care personnel are important factors in promoting quality patient care. Browning (2013: 22) highlighted that nurses who were psychologically empowered experienced less moral distress. Elpern, Covert and Kleinpell (2005: 14) state that critical care nurses' experience of moral distress are intense and frequent and warrant research on interventions to address this issue.

Sumner (2010: 51) states that the usual ethical theories utilized in nursing practice are uni-directional, rational, and objective and have the best interests of the patients at their core but they do not address the fundamental vulnerability of all participants and each individual's need for flourishing and happiness. Neo-Stoic Eudaemonism is seen as critical to ensure that humanistic care is offered to the patient – such are is the driving force of nursing. Neo-Stoic Eudaemonism is defined as that system of ethics which defines and enforces moral obligation by its relation to happiness or personal wellbeing. Including Neo-Stoic Eudaemonism as one of the theories in healthcare enables nurses to resume their status as moral practitioners, who can flourish as true patient advocates and nursing advocates (Sumner 2010: 51).

2.13 CONCLUSION

This study is intended to determine the impact of moral distress on the provision of nursing care amongst critical care nurses.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter presents research methodology. A research methodology may be defined as the systematic, theoretical analysis of the methods applied to a field of study. It provides the justification for the technical decisions involved in planning a research project. In health sciences, it provides the plan for selecting participants, research sites and data collection procedures to answer the research questions (McMillan and Schumacher 2014: 166).

3.2 RESEARCH DESIGN

A research design is a blueprint for maximising control over factors that could interfere with a study's desired outcome. It gives the researcher greater control and thus improves the validity of the study (Grove, Burns and Gray 2013: 43). Descriptive studies are designed to gain more information about variables within a particular field of study. (Grove, Burns and Gray 2013: 256). A descriptive quantitative research design was employed in this study as it sought to describe the occurrence of moral distress amongst critical care nurses and their ability to provide nursing care as well as to determine the effectiveness of strategies implemented to reduce this phenomenon. The existing phenomenon of moral distress was described by using numbers to characterize frequency and intensity.

3.3 RESEARCH SETTING

This study was conducted in the critical care units of four hospitals, as described below.

3.3.1 Hospital A (public tertiary hospital)

Hospital A is a tertiary hospital that has 846 beds with various disciplines. It is situated in a suburb outside the greater Durban area. It was named after a globally respected South African who was awarded the Nobel Peace Prize in 1960 and thus earned the honour of having this hospital named after him (KwaZulu-Natal Department of Health, 2015).

3.3.2 Hospital B (public regional and district hospital)

Hospital B is a regional and district hospital with 472 beds. The hospital is located in a popular suburb in the eThekwini health district. This hospital has grown from being a community hospital to one of the four major hospitals in the Durban region. The hospital is a referral hospital for other hospitals and clinics and has approximately 36 000 admissions a year and 600 000 outpatients annually (KwaZulu-Natal Department of Health, 2015).

3.3.3 Hospital C (private regional and district)

Hospital C is a member of one of the largest private hospital groups in South Africa. It is a 357 bedded private healthcare hospital with 26 intensive or critical care beds, and 20 high care beds.

3.3.4 Hospital D (private tertiary hospital)

Hospital D is a member of one of the largest private hospital groups in South Africa. This is a 177 bedded private healthcare hospital with 12 critical care or intensive care beds.

3.4 THEORETICAL FRAMEWORK

The theoretical framework used for this study is derived from the work of Corley (2002: 636). The moral distress theory outlines what happens when a nurse is unable or feels unable to advocate for a patient, and thus experiences moral distress. The theory addresses the internal and external environment of the nurse and its influence on the nurse's experience of moral distress. Her study states that moral distress impacts on the patients, nurses and organisations (Table 3.1). It is based on two premises, namely:

a) Nursing is a moral profession: nursing is a caring and fundamentally a moral enterprise, and nursing is characterised by its long and noteworthy moral tradition (Pera and van Tonder 2011: 4).
b) Nurses are moral agents: the nursing profession develops its practitioners to become ethical agents who will advocate the wellbeing of patients and their families with compassion, commitment, confidence, competence and a deep sense of moral awareness (Pera and van Tonder 2011: 4).

When a nurse cannot enact moral agency, she/he becomes vulnerable to moral distress. Moral concepts relating to moral distress are identified and distinguished from moral distress. Corley proposes there are moral concepts that impact the development of moral competency which is necessary for moral action. This will depend on how the nurse has incorporated these concepts into her value system and can lead to a decision to act or to moral distress if the nurse chooses not to act. Moral competency is fostered by moral commitment, moral sensitivity and moral imagination. The more morally committed and morally competent a nurse is, the greater the moral comfort she will experience and the less moral distress (Corley 2002: 643).

One of the aims of this study is to determine the intensity and frequency of moral distress among critical care nurses. This will increase moral sensitivity which in turn fosters commitment to patients and ethical decision making. Nurses who have lost their ability to care may lack moral sensitivity and may not experience moral distress (Corley 2002: 645). This study therefore

addresses the impact of moral distress on nursing care, as those lacking moral sensitivity may not be morally distressed but may lose their ability to care for their patients.

Corley further states that moral distress impacts patients, nurses and the organization. If the nurse is unable to advocate for her patient and avoidance behaviour occurs, increased patient suffering result. Moral distress results in high staff turnover, decreased quality patient care and low patient satisfaction. Unrelieved moral distress jeopardizes nurse's sense of self-worth and threatens their integrity. Corley further recognises the impact of moral suffering manifesting as resignations, burnout, and exodus from the profession (Corley 2002: 647). Moral comfort, on the other hand, is achieved when a nurse masters her/his internal environment and has an external environment that supports moral courage. As institutional constraints are thought to influence development of moral distress, this study also evaluates the effectiveness of organisational strategies.

Internal environment

When a nurse cannot enact moral agency, she/he becomes vulnerable to moral distress. Corley proposes there are moral concepts that impact the development of moral competency which is necessary for moral action. These are listed as moral concepts on Corley's model for a theory of moral distress. The relevant concepts named in the model and their progression in the development of moral competency to the eventual vulnerability to moral distress are presented in this section and illustrated in Table 3.1 as referenced from Corley (2002: 636). The author makes a distinction among these concepts, and explains ways in which they relate to each other and culminate in moral distress. This is essential in understanding and addressing the phenomenon.

Table 3.1: Concepts and their relation to moral distress

Concept	Definition	Relation to moral distress
Moral integrity	Adherence to moral values affecting the sense of dignity and self-respect.	Moral distress is a consequence of the effort to preserve moral integrity when the persons act against their moral convictions.
Moral residue	That which each of us carries with us from those times.	When in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised.
Moral sensitivity	The ability to recognize a moral conflict, show a contextual and intuitive understanding of the patient's vulnerable situation, and have insight into the ethical consequences of decision.	Nurses who have a high level of moral sensitivity are more likely to be committed to patients and to develop moral competency, and thus experience less moral distress. Nurses who are psychologically wounded and have lost their caring ability no longer experience moral sensitivity, and therefore do not experience moral distress.
Moral commitment	Engagement with a moral issue in patient care, loyalty to the values involved, and a willingness to take risks.	Nurses who have a high level of moral commitment to patients are more likely to develop moral competency, to demonstrate moral behaviour, and to have low levels of moral distress.
Moral competency	The ability to make moral sense of situations, use good moral judgement and intention, and engage in morally appropriate behaviour.	Nurses who have moral commitment but lack moral competency are more likely to experience moral distress. Nurses' self-perception of moral competency may not be accurate, leading to morally inappropriate action.
Moral imagination	That aspect of the imagination which potentially becomes active in the moral agent's attempt to consider what moral decisions to make.	Nurses who have an acute moral imagination are more likely to have a high level of moral sensitivity and moral competence, and to experience less moral distress.
Moral sense	The structuring of moral meaning	Nurses who have a high level of moral commitment and moral competence have greater ability to make moral sense of a situation and experience less moral distress
Moral autonomy	The freedom, right and responsibility to make choices.	Nurses who have moral autonomy are more likely to experience moral distress unless they also have moral commitment and moral competence.
Moral certainty	A feeling of absolute moral conviction that leads nurses to risk self, personally and professionally, to act on the 'rightness' of that conviction.	Nurses who have a high level of moral commitment, moral competence, and moral autonomy are more likely to feel moral certainty and to experience less moral distress
Moral judgement	Integration of numerous ethical considerations that count for or against a particular course of	Nurses who possess a high level of moral commitment, moral imagination, moral competency and moral sense making are more likely

	action in order to determine what ought to be done in a specific situation.	to exercise appropriate moral judgement and experience less moral distress.
Moral intention	Weighing up the priority of moral values over personal values to do what is morally right.	Nurses who have a high level of moral commitment and competency are more likely to exercise moral intention to take action and experience less moral distress.
Moral conflict	A clash of moral values concerning what is the morally right action to take.	Nurses are more likely to experience moral conflict if they believe that: they are advocates for patients, they have the autonomy to take action, they have limited choices, their values are being violated and they have a professional relationship with patients who are experiencing pain and suffering.
Moral outrage	Feelings of anger and shock about a moral situation that has arisen.	Nurses who experience moral outrage and have the autonomy to act on it are less likely to feel moral distress.
Moral courage	The willingness to take a controversial stand or one that challenges the health care organization or those in it, even when a person's job may be jeopardized	Nurses who have moral courage and act on it are less likely to feel moral distress.
Moral heroism	The willingness to take a controversial stand or one that challenges the health care organization or those in it, even when a person's job may be jeopardized	If nurses have moral sensitivity and commitment, but lack moral courage or moral autonomy, they suffer moral distress.
Moral behaviour (moral agency) or ethical comportment	Taking actual steps as a result of moral courage.	Nurses who are committed to patients, advocate for patients, and possess moral imagination and sensitivity, function autonomously, and intend to do what is morally right, are more likely to experience moral certainty.

Corley(2002:636)

As can be seen from Table 3.1, moral concepts all lead to either moral distress or moral intent to act. The development of moral competency will depend on how the nurse has incorporated these concepts into her/his value system. Moral competency is fostered by moral commitment, moral sensitivity and moral imagination. The more morally committed and morally competent a nurse is, the greater the moral comfort she/he will experience and the less moral distress (Corley 2002: 643). If knowledge, behaviour and attitudes lead to moral intent to act, taking the moral action will require some level of moral courage that leads to moral comfort. If nurses do not take moral action when they know that a moral problem is involved, they experience moral distress, with a potential subsequent impact on patients, nurses and the hospital or health care organization (Corley 2002: 636).

External environment

Since moral distress has been posited to occur as a result of institutional constraints, propositions from an organizational perspective are presented in this section (Corley 2002: 648):

- Nurses who have high levels of ethics work satisfaction and believe that they are in a more constructive work culture will have lower levels of moral distress.
- Nurses who have good relationships with their peers, patients, managers, the hospital administration and physicians will have less moral distress.
- Nurses who have more influence in their work environment and thus are more likely to take action to resolve ethical dilemmas will have less moral distress.
- Nurses, who work in health care organizations that do not provide policies that guide practice, provide a supportive environment, guide ethically complex care and provide a mechanism for addressing complex conflicts with physicians will experience more moral distress.
- Nurses who work in health care organizations that encourage collaboration with physicians and the development of trust with them will experience less moral distress in ethically complex situations.

- Nurses will resort to lesser degrees of responsible subversion if the work environment supports nurse autonomy and nurses' participation in decisions.

Corley further states that moral distress impacts patients, nurses and the organization. If the nurse is unable to advocate for her patient and avoidance behaviour occurs, increased patient suffering result. Moral distress results in high staff turnover, decreased quality patient care and low patient satisfaction. Unrelieved moral distress jeopardizes nurse's sense of self-worth and threatens their integrity. Corley further recognises the impact of moral suffering manifesting as resignations, burnout, and exodus from the profession (Corley 2002: 647). The author lists the following as institutional implications of moral distress: high nurse turnover, decreased quality patient care and low patient satisfaction. As institutional constraints are thought to influence development of moral distress, this study evaluated the effectiveness of organisational strategies to prevent moral distress. Moral comfort, on the other hand, is achieved when a nurse masters her/his internal environment and has an external environment that supports moral courage. (See Figure 3.1)

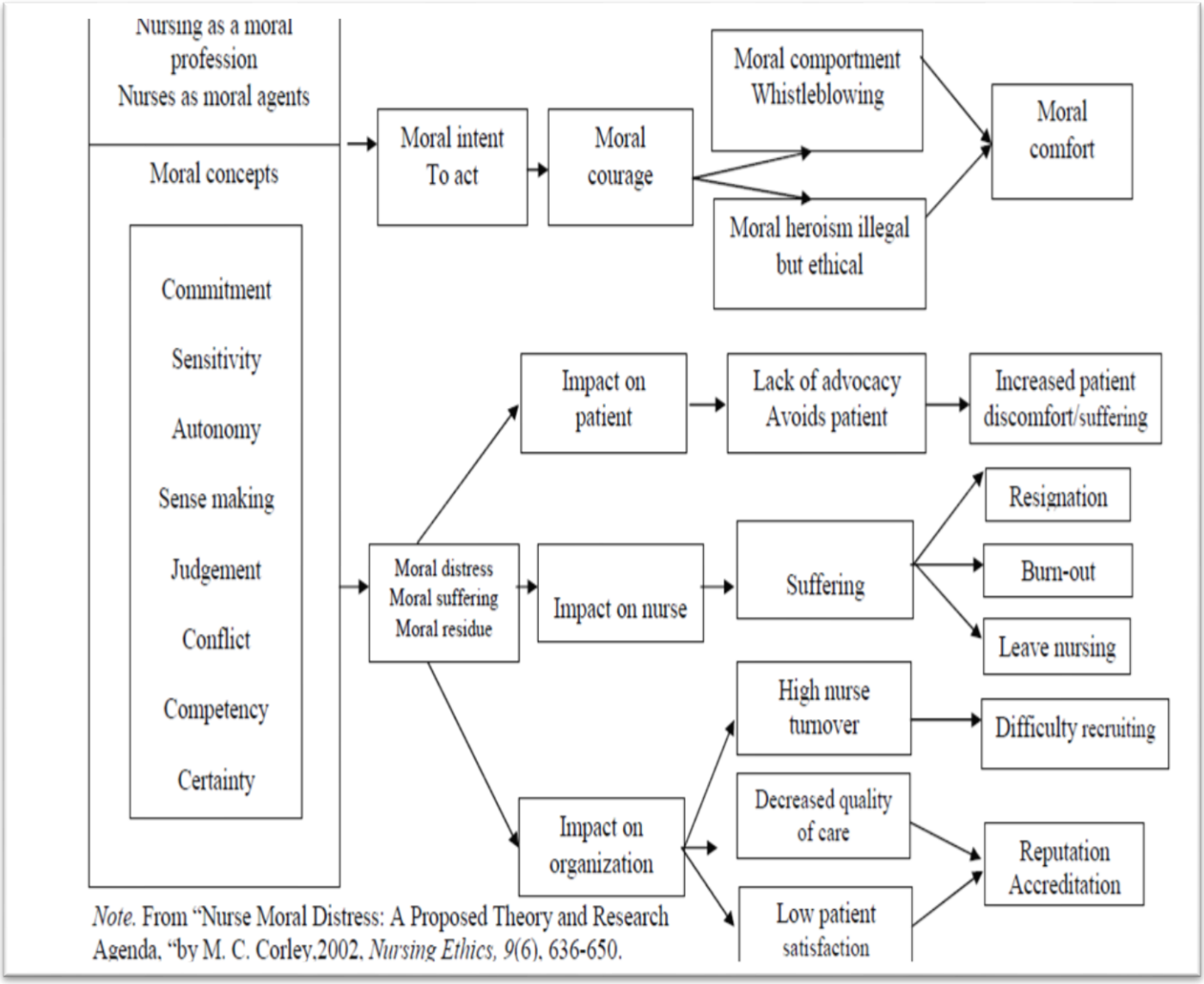

Figure 3.1: Model of a theory for moral distress

3.5 SAMPLING PROCESS

The aim of sampling in quantitative research is to allow researchers to reach statistical validity and to generalise their results. Sampling can be defined as the process of selecting cases to represent an entire population so that inferences about the population can be made. Two key considerations in assessing a sample in a quantitative study are its representativeness and size (Polit and Beck 2012: 275).

3.5.1 A representative sample

Representativeness means that the sample must be similar to the population in as many ways as possible (Brink, Van der Walt and Van Rensburg 2006: 125). To avoid the possibility of sampling bias, the researcher chose to include in the sample population critical care nurses of both the private and public healthcare sectors. This technique enabled an accurate representation of the target population and also provided adequate numbers of participants for the study.

3.5.2 Sample size

Selecting and obtaining the sample size and obtaining the required size are challenges that face every researcher. The researcher chose to use the assistance of a statistician in determining a sample size to ensure accurate representation of the target population. The final sample size in this study was 100. The total population was estimated to be 160.

3.5.3 Sampling approach

A non-probability purposive sampling approach was used for this study. This approach entails utilisation of participants that are representative of the study population (Brink, Van der Walt and Van Rensburg 2006: 133). For this reason all categories of staff working in a critical care environment; including both ICU trained and ICU experienced staff, enrolled nurses and ICU student nurses were utilised for this study.

3.5.3.1 Inclusion criteria

According to Polit and Beck (2012: 274), a population is the entire aggregation of cases in which a researcher is interested. Inclusion criteria can be defined as criteria that specify population characteristics (Polit and Beck 2012 :274). In this study, they were identified to be both ICU trained and non ICU trained professional nurses, enrolled nurses as well as ICU students working in the adult critical care units.

3.5.3.2 Exclusion criteria

Exclusion criteria are those characteristics that participants must not have. (Polit and Beck 2012: 274). In this study, all nurses working in general, paediatric and neonatal wards were excluded from the study. This was decided in order to focus on the critical care nurse in the adult critical care unit.

3.6 DATA COLLECTION PROCESS

Authorization was obtained from all relevant parties; thereafter meetings were scheduled with the hospital nursing manager of each hospital. At this meeting, key nursing personnel were given oral and written information on the research project. They were given a brief overview of the research topic, the purpose and aims as well as an outline of the procedure for data collection. The benefits of the study were communicated. They were given a guarantee of confidentiality during the analysis as well as anonymity in the publication of data. All nursing managers exhibited a keen interest in the topic and on finding out the results. They were informed of where the information was to be published.

Consent was then obtained at nursing management level; unit managers were approached and informed of the same. Once permission was obtained at unit level, shift leaders were approached and informed of all information pertaining to the study. The researcher then targeted every shift of staff members separately (both day and night). The researcher, after being introduced by the shift leader, addressed the staff in a group for approximately fifteen minutes in the duty station of the unit. This was done with all shifts (day and night) of each unit. The potential participants were each handed an information letter, research tool and a consent form to read, while the researcher explained the contents of the research using the information sheet as a guide. The title of the research study was stated. They were given a brief introduction to the study as well as the purpose and aims. They were informed of the freedom of choice with regards to participation, and were once again reassured of

confidentiality during the analysis as well as anonymity in the publication of data. They were given an outline of the procedure, that is, an explanation on how to complete the consent form and the questionnaire. They were requested to place the questionnaires separately from the consent forms, in separately labelled and sealed collection boxes, one for questionnaires and the other for consent forms. These boxes were located in the duty station. It was emphasised that the consent forms were to be placed in a separate box from the questionnaires, allowing no association between the two, to ensure confidentiality. Each section of the questionnaire was explained and any queries or questions were answered. They were also informed that the data collection boxes were to be collected the following day, allowing them adequate time to complete them. The collection boxes were removed from the unit on the following day and completed consent forms and questionnaires were removed by breaking open the seals on the boxes. The data was captured on a spread sheet that was formulated by the statistician.

3.7 PRE-TESTING OF DATA COLLECTION TOOL

In order to test the practical aspects of the research study, the researcher pre-tested the data collection tools. Pre-testing, sometimes referred to as a 'preliminary study' is a small scale study conducted prior to the main study on a limited number of participants from the population at hand (Brink, Van der Walt and Van Rensburg 2006: 166). According to Maree (2007: 150) ensuring validity through pre-testing is important. Pre-testing ensures content validity (Marshall and Rossman 2006: 201). Babbie and Mouton (2001: 186) explain that to pre-test a questionnaire for validity a researcher should use respondents for whom the study is relevant. The questionnaire for this study was pre-tested on a sample group of five nurses working in an intensive care unit. They were randomly selected from a private healthcare institution. These respondents were not included in the main study.

The purpose of this pre-test was to refine the research methodology which enabled the researcher to gather valid evidence for the study. It was also conducted to assess the feasibility of the study and to test the measuring

instrument as it was adapted for the purpose of this study. Assistance was sought from a statistician in revising a previously tested data collection instrument to yield the best possible evidence for the study. The statistician was consulted when constructing various aspects of the tool such as wording, layout, numbering of the questions and relevance to the study. The findings of a pilot study should address various issues, but one is central: feasibility. Feasibility can be defined as the extent to which the intervention can be implemented as conceptualised. The pilot study proved to be feasible. No major challenges were experienced. The recruitment of participants was easy and the questionnaire was appropriately answered. Four out of five questionnaires were completed.

3.8 DATA ANALYSIS

Assistance was sought from the statistician, once questionnaires from all targeted sample populations were collected. The data was reduced and analysed with the help of a statistician using the statistical software SPSS version 21.0. Descriptive statistics such as frequency and cross-tabulation tables and various types of graphs were used. Numerical analysis used included the use of the arithmetic mean and the standard deviations. Inferential statistics using Pearson's and or Spearman's correlations at a significance level of 0.05 were used to meaningfully analyse the collected data.

3.9 RESEARCH RELIABILITY AND VALIDITY

In health care and social science research, many of the variables of interest and outcomes that are important are abstract concepts known as theoretical constructs. Using tests or instruments that are valid and reliable to measure such constructs is a crucial component of research quality (Kimberlin and Winterstein 2008: 2276). The reliability of a quantitative measure is a major criterion for assessing its quality (Polit and Beck 2012: 331). Reliability is the consistency with which an instrument measures the target attribute (Polit and Beck 2012). Internal reliability in this study was evaluated by calculating the

coefficient alpha which is also called Cronbach's alpha coefficient (Polit and Beck 2012: 333). The normal range of values for this reliability index is from 0.00 to +1.00. Higher values reflect more internal consistency. Internal consistency may be defined as the extent to which items in the instrument are reliably measuring the critical attribute (Polit and Beck 2012: 333).

Moral distress has been known to be a complex and challenging problem for providers in all healthcare settings and across disciplines. The ability to test successful evidence-based interventions to alleviate moral distress is dependent upon a reliable and valid measure of the phenomenon. The Moral Distress Scale-Revised (MDS-R), the tool utilised to measure moral distress in this study, shows promise as such a measure as adequate reliability and evidence of construct validity were demonstrated in a previous research study (Hamric, Borchers and Epstein 2012). The tool was adapted to meet the aims of this research, through the guidance of a statistician.

External validity refers to the degree to which the results of a study can be generalised to other people and other settings. Questions to be answered about external validity are as follows:

- With what degree of confidence can the study findings be transferred from the sample to the entire population?
- Will these findings hold true in other times and places? (Brink, Van der Walt and Van Rensburg 2006: 101).

The researcher was careful not to exhibit any characteristics or behaviours which could have influenced respondent's responses during the group information giving sessions which were held with each shift of staff. The researcher kept a neutral facial expression and only conveyed the information as indicated in the information letter to familiarize the participants with the research study. The Hawthorne effect may be described as subjects responding in a certain manner because they are aware that they are observed. The researcher was cautious to avoid this effect by leaving the

questionnaires with the participants and only collecting them the following day.

Mortality can be defined as participants dropping out of a study (Brink, Van der Walt and Van Rensburg 2006: 101). This was minimised by allowing as much convenience as possible to enable participation in the study; only those staff that were on duty were selected for the study. The researcher targeted all shifts by making time available to address them all (both day and night). Selection bias is described as when differences exist in the way that participants are recruited for a study (Brink, Van der Walt and Van Rensburg 2006: 101). The same method of recruitment as discussed under data collection was utilised for all selected hospitals to alleviate selection bias.

The data collection instrument used in this study was the MDS-R. Four content experts on moral distress tested the content validity of the MDS-R. The entire data collection instrument was found to be reliable as it yielded a coefficient of 0.89 (Hamric, Borchers and Epstein 2012: 1). The outcome was that adequate reliability and evidence of construct validity were demonstrated (Hamric, Borchers and Epstein 2012: 1). The data collection tool was modified to address all the aims of this particular study.

3.10 ETHICAL CONSIDERATIONS

When humans are used as study participants, care needs to be exercised to ensure that their rights are protected (Polit and Beck 2012: 150). Humans should be treated as autonomous agents, capable of controlling their actions. Self-determination means that prospective participants can voluntarily decide whether to take part in a study, without risk of prejudicial treatment. It also means that people have the right to ask questions, to refuse to give information, and to withdraw from the treatment (Polit and Beck 2012: 154). The researcher ensured this by obtaining their permission to involve them in research and took all necessary measures to ensure their privacy. A letter of information was provided to participants before informed written consent was taken (Appendix 2). Informed consent means that participants have adequate

information about the research, comprehend that information and have the ability to consent to or decline participation voluntarily (Polit and Beck 2012: 157).

Participation in this study was voluntary and participants were informed that they were free to withdraw from the study at any given time. Research with humans involves intrusions into their personal, and in this case, their professional, lives (Polit and Beck 2012: 154). Strict confidentiality of information was maintained as boxes containing completed tools were sealed. Names were not included on the forms.

Before the commencement of the research study, ethical clearance was obtained from the DUT ethics committee (Appendix 1). Permission was sought and received from eThekwini Health District Manager (Appendices 2a and 2b), KZN Department of Health (Appendices 3a and 3b1b) and Nursing Managers of the hospital where data was collected (Appendices 4a, 4b and 4c).

One of the primary responsibilities that researchers have towards participants in a research study is that one must not harm them in any way. Non-maleficence imposes a duty on researchers to minimise harm and maximise benefits (Polit and Beck 2012: 150). The meaning of 'harm' should be interpreted in the broadest possible way, to include anything from physical discomfort to emotional stress, humiliation or embarrassment. In this study, participants may have been exposed to emotional stress when reflecting on their experience of moral distress. Therefore, counseling services were made available to staff who manifested psychological distress and asked for help.

3.11 CONCLUSION

This chapter outlined the research methodology that was used in this study. The theoretical framework and ethical considerations that guided the study were specified. The research setting, sampling process, data collection

process, pilot study, research reliability and validly were considered. The following chapter will present the results of the study.

CHAPTER 4: PRESENTATION OF RESULTS

"Compassion is the basis for morality." Arnold Schopenhauer
(Van Tonder 2011:10)

4.1 INTRODUCTION

This chapter will present the results of the study. The purpose of the study was to determine the effects of moral distress on the provision of care to patients. The intensity and frequency of moral distress experienced in the critical care nurse was determined by the use of the MDS-R and the effects of this were compared to the nurse's ability to render care to her patient. Existing strategies were identified from literature and evaluated by the nurses for effectiveness in reducing moral distress. The following objectives guided the research questions:

- The intensity and frequency of moral distress amongst critical care nurses.
- The impact of moral distress on the provision of nursing care to the patient.
- The effectiveness of strategies implemented to reduce the incidence and frequency moral distress.

The following statistical tests were used in the analysis of data:

- Descriptive statistics including means and standard deviations, where applicable. Frequencies are represented in tables or graphs.
- Chi-square goodness-of-fit-test: a univariate test, used on a categorical variable to test whether any of the response options are selected significantly more/less often that the others. Under the null hypothesis, it is assumed that all responses are equally selected.
- One-sample t-test: used to test whether the average value is significantly different from a value of 3 (the central score). This is applied to Likert scale questions.

- Kruskal Wallis Test: non parametric equivalent to ANOVA. A test for several independent samples that compares two or more groups of cases in one variable.
- Mann Whitney U Test: non parametric equivalent to the independent samples t-test.

4.2 DEMOGRAPHIC FINDINGS

4.2.1 Gender

Table 4.1: Gender of participants

		Frequency	Percent
Valid	Male	9	9.0
	Female	78	78.0
	Total	87	87.0
Missing	System	13	13.0
Total		100	100.0

The majority of the participants, 78% (n=78), were female and the minority were male, 9% (n=9).

4.2.2 Age

Table 4.2: Age of participants

		Frequency	Percent
Valid	20-29	10	10.0
	30-39	33	33.0
	40-49	34	34.0
	50-59	16	16.0
	60+	2	2.0
	Total	95	95.0
Missing	System	5	5.0
Total		100	100.0

Most of the participants, 34% (n=34), were between the ages of 40 to 49 years.

4.2.3 Race

Table 4.3: Race of participants

		Frequency	Percent
Valid	Black	34	34.0
	Coloured	5	5.0
	Indian	46	46.0
	White	7	7.0
	Total	92	92.0
Missing	System	8	8.0
Total		100	100.0

The racial distributions of the participants were as follows:

- Indian, 46% (n=46);
- Black, 34% (n=34);
- White, 7% (n=7); and
- Coloured, 5% (n=5).

4.2.4 Type of hospital

Table 4.4: Type of hospitals of participants

		Frequency	Percent
Valid	Private	55	55.0
	Public	42	42.0
	Total	97	97.0
Missing	System	3	3.0
Total		100	100.0

The number of participants from private hospitals were 55% (n=55), and 42% (n=42) of the participants were from public hospitals.

4.2.5 Staff category

Table 4.5: Staff category of participants

		Frequency	Percent
Valid	Professional nurse ICU experienced only	28	28.0
	Professional nurse ICU trained	40	40.0
	Staff nurse	18	18.0
	ICU student	10	10.0
	Total	96	96.0
Missing	System	4	4.0
Total		100	100.0

Professional nurses ICU trained comprised 40% (n=40) of the participants.

4.2.6 Number of years working in the critical care unit

Table 4.6: Number of years of participants working in the critical care unit

		Frequency	Percent
Valid	Less than 5 years	33	33.0
	5-10 years	33	33.0
	More than 10 years	31	31.0
	Total	97	97.0
Missing	System	3	3.0
Total		100	100.0

There were an equal number of participants working less than 5 years 33% (n=33) and between 5 and 10 years 33% (n=33). The remaining participants 31% (n=31) worked more than 10 years.

4.2.7 Type of discipline

Table 4.7: Type of discipline the participants worked in

		Frequency	Percent
Valid	SICU	16	16.0
	General ICU	54	54.0
	Cardiac ICU	20	20.0
	Other	6	6.0
	Total	96	96.0
Missing	System	4	4.0
Total		100	100.0

The number of participants from the general intensive care units were 54%, (n=54), ICU 20% (n=20), SICU 16% (n=16), and other ICU's 6% (n=6).

4.2.8 Current position

Table 4.8: Current position of the participants

		Frequency	Percent
Valid	Full time	83	83.0
	Part time	13	13.0
	Total	96	96.0
Missing	System	4	4.0
Total		100	100.0

The number of participants that were full time employed were 83% (n=83), and part-time employees 13% (n=13).

4.3 MORAL DISTRESS SCALE

4.3.1 Frequency of moral distress

Table 4.9: Clinical situations and frequency of moral distress from most to least frequent

ITEM	N	Average frequency
Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.	96	2.73
Work with nurses or other healthcare providers who are not as competent as the patient care requires.	95	2.43
Initiate extensive life-saving actions when I think they only prolong death.	97	2.29
Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.	97	2.25
Follow the physician's request not to discuss the patient's prognosis with the patient or family.	96	2.13
Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	96	2.09
Provide less than optimal care due to pressures from management to reduce costs.	99	1.83
Witness diminished patient care quality due to poor team communication.	94	1.81
Work with levels of nurse or other care provider staffing that I consider unsafe.	93	1.75
Follow the family's request not to discuss death with a dying patient who asks about dying.	94	1.64
Watch patient care suffer because of a lack of provider continuity.	93	1.53
Be required to care for patients I don't feel qualified to care for.	95	1.43
Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a law suit.	94	1.41
Witness healthcare providers giving "false hope" to a patient or family.	99	1.41
Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.	96	1.36
Ignore situations in which patients have not been given adequate information to insure informed consent.	94	1.28
Assist a physician who, in my opinion, is providing incompetent care.	95	1.20
Witness medical students perform painful procedures on patients solely to increase their skill.	96	1.15
Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.	94	1.14
Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	93	.98
Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.	95	.64

The clinical situation that led to moral distress most frequently was: “Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision,” at an average frequency of 2.73. The clinical situation that led to moral distress least frequently was: “Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death,” at an average frequency of 0.64.

4.3.2 Level of disturbance of moral distress

A larger amount of missing data was noted in this section of the tool. For this reason, an adjustment was made so that more data could be used. Instead of adding the variables across 21 items, the average variables across the number that a participants has given data for was calculated.

Table 4.10: Clinical situations and level of disturbance of moral distress from most to least frequent

ITEM	N	Average level of disturbance
Work with nurses or other healthcare providers who are not as competent as the patient care requires.	70	2.84
Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.	75	2.71
Witness diminished patient care quality due to poor team communication.	70	2.63
Work with levels of nurse or other care provider staffing that I consider unsafe.	69	2.61
Initiate extensive life-saving actions when I think they only prolong death.	72	2.50
Watch patient care suffer because of a lack of provider continuity.	69	2.38
Assist a physician who, in my opinion, is providing incompetent care.	72	2.38
Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.	70	2.37
Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	71	2.37
Follow the physician's request not to discuss the patient's prognosis with the patient or family.	71	2.32
Provide less than optimal care due to pressures from management to reduce costs.	76	2.32
Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a law suit	70	2.30
Ignore situations in which patients have not been given adequate information to insure informed consent.	64	2.30
Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.	72	2.24
Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.	68	2.24
Follow the family's request not to discuss death with a dying patient who asks about dying.	69	2.13
Witness healthcare providers giving "false hope" to a patient or family.	74	2.12
Witness medical students perform painful procedures on patients solely to increase their skill.	70	2.07
Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	69	1.90
Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.	68	1.84
Be required to care for patients I don't feel qualified to care for.	72	1.82

The clinical situation that led to the highest level of disturbance was: “Work with nurses or other healthcare providers who are not as competent as the patient care requires,” at an average level of disturbance of 2.84. The clinical situation that led to the least level of moral distress was: “Be required to care for patients I don’t feel qualified to care for,” at an average level of disturbance of 1.82.

4.4 MORAL DISTRESS AND THE DEMOGRAPHIC VARIABLES

A bivariate analysis was conducted to test whether average scores for frequency of moral distress and level of disturbance is significantly different in relation to demographic variables. The test used was the Kruskal Wallis. This test, a one-way analysis of variance by ranks (named after William Kruskal and W. Allen Wallis) is a non-parametric method for testing whether samples originate from the same distribution (McDonald 2014: 157).

4.4.1 Frequency of moral distress for demographic variables

4.4.1.1 Gender

No significant differences were noted between genders in the frequency and intensity of moral distress experienced.

4.4.1.2 Age

No significant differences were noted by age in the frequency and intensity of moral distress experienced.

4.4.1.3 Race

Table 4.11: Differences in frequency moral distress experienced between the races for specific clinical situations

		N	Mean	Std. Deviation
q2.1.freq Provide less than optimal care due to pressures from management to reduce costs.	Black	33	**1.21**	1.431
	Coloured	5	2.20	1.095
	Indian	46	**2.15**	1.429
	White	7	2.71	1.380
	Total	91	1.86	1.480
q2.4.freq Initiate extensive life-saving actions when I think they only prolong death.	Black	33	**1.61**	1.456
	Coloured	5	2.60	1.673
	Indian	45	**2.62**	1.451
	White	6	2.83	1.169
	Total	89	2.26	1.512
q2.21.fre Work with levels of nurse or other care provider staffing that I consider unsafe.	Black	30	**1.23**	1.501
	Coloured	5	1.00	1.000
	Indian	43	**2.09**	1.493
	White	7	2.57	1.618
	Total	85	1.76	1.540

The three clinical situations above indicated significant differences in both frequency and level of disturbance for moral distress between races. A closer look was taken to see where the differences lie. The test used for this was the Mann Whitney test. The Mann-Whitney U test is the alternative test to the independent sample t-test. It is a non-parametric test that is used to compare two population means that come from the same population, and is used to test whether two population means are equal or not. It is used for equal sample sizes, and is used to test the median of two populations (de Vos *et al.* 2011: 207).

4.4.1.4 Race

Table 4.12: Differences in frequency moral distress between Indian and Black critical care nurses for specific clinical situations

	Race	N	Mean Rank	Sum of Ranks
q2.1.freq Provide less than optimal care due to pressures from management to reduce costs.	Black	33	31.52	1040.00
	Indian	46	46.09	2120.00
	Total	79		
q2.4.freq Initiate extensive life-saving actions when I think they only prolong death.	Black	33	30.65	1011.50
	Indian	45	45.99	2069.50
	Total	78		
q2.21.fre Work with levels of nurse or other care provider staffing that I consider unsafe.	Black	30	29.95	898.50
	Indian	43	41.92	1802.50
	Total	73		

It was noted that Indian critical care nurses experience more moral distress than Black critical care nurses related to questions 2.1, 2.4 and 2.24. There is a significant difference in the frequency with which different races perceive “provide less than optimal care due to pressures from management to reduce costs” (χ^2 (3, N=91) = 11.110, p=.011) as a moral distress item. Specifically, Black participants perceive the distress less frequently (M=1.21) than Indian participants (M=2.15) (Z=-2.855, p=.004).

4.4.1.5 Hospital type

Table 4.13: Differences in frequency of moral distress by hospital type

Group Statistics					
	Type of hospital you work in	N	Mean	Std. Deviation	Std. Error Mean
q2.2.freq Witness healthcare providers giving "false hope" to a patient or family.	Private	55	1.84	1.371	.185
	Public	41	.80	.980	.153
q2.3.freq Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.	Private	53	2.58	1.460	.201
	Public	41	1.85	1.542	.241
q2.6.freq Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	Private	53	2.40	1.405	.193
	Public	40	1.75	1.565	.247
q2.13.freq Follow the physician's request not to discuss the patient's prognosis with the patient or family.	Private	52	2.60	1.445	.200
	Public	41	1.59	1.717	.268
q2.16.freq Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit.	Private	50	1.88	1.534	.217
	Public	41	.85	1.256	.196
q2.19.freq Ignore situations in which patients have not been given adequate information to insure informed consent.	Private	51	1.59	1.458	.204
	Public	40	.98	1.330	.210

Moral distress is noted more frequently amongst private hospital critical care nurses than public hospital critical care nurses specifically for the above clinical situations.

4.4.1.6 Category

Table 4.14: Differences in frequency of moral distress by staff category

	Staff Category	N	Mean	Std. Deviation
q2.1.freq	Professional nurse ICU experienced only	27	1.44	1.450
	Professional nurse ICU trained	40	2.35	1.477
	Staff nurse	18	1.50	1.150
	ICU student	10	1.50	1.716
	Total	95	1.84	1.483
q2.10.freq	Professional nurse ICU experienced only	26	2.35	1.623
	Professional nurse ICU trained	39	.64	1.063
	Staff nurse	16	1.44	1.672
	ICU student	10	1.80	1.687
	Total	91	1.40	1.577

Moral distress is noted more frequently amongst professional nurse (ICU experienced only) than professional nurse ICU trained. Moral distress is noted more frequently amongst professional nurse ICU trained experienced than staff nurses.

4.4.1.7 Experience

Table 4.15: Differences in frequency of moral distress according to years of experience

		N	Mean	Std. Deviation
q2.10.freq	Less than 5 years	30	2.30	1.579
	5 - 10 years	32	1.16	1.547
	More than 10 years	30	.83	1.289
	Total	92	1.42	1.591
q2.16.freq	Less than 5 years	31	1.32	1.469
	5 - 10 years	31	1.00	1.366
	More than 10 years	29	1.97	1.546
	Total	91	1.42	1.499

Moral distress is noted more frequently amongst those working between 5-10 years than those working more than 10 years.

4.4.1.8 Discipline

Table 4.16: Differences in frequency of moral distress according to discipline

		N	Mean	Std. Deviation
q2.1.freq	SICU	16	2.06	1.237
	General ICU	54	2.11	1.462
	Cardiac ICU	19	1.21	1.475
	Other	6	1.00	1.673
	Total	95	1.85	1.480
q2.2.freq	SICU	16	2.31	1.302
	General ICU	54	1.15	1.188
	Cardiac ICU	19	1.32	1.376
	Other	6	1.33	1.633
	Total	95	1.39	1.323
q2.3.freq	SICU	16	3.19	1.109
	General ICU	53	2.25	1.518
	Cardiac ICU	18	1.78	1.517
	Other	6	1.83	1.835
	Total	93	2.29	1.522

Moral distress is noted more frequently in Surgical ICU than Cardiac ICU and more frequently in General ICU than Cardiac ICU.

4.4.1.9 Position

Table 4.17: Differences in frequency of moral distress according to position

	N	Mean	Std. Deviation
Fill time	76	1.93	1.561
Part time	13	.92	1.115
Total	89	1.79	1.541

Moral distress is noted more frequently amongst full time staff than part time staff.

4.4.2 Level of disturbance of moral distress for the demographic variables

4.4.2.1 Gender

No significant differences were noted.

4.4.2.2 Age

No significant differences were noted in the level of disturbance of moral distress experienced by individuals of different ages.

4.4.2.3 Race

No significant differences were noted in the level of disturbance of moral distress experienced by individuals of different races.

4.4.2.4 Hospital type

Table 4.18: Differences in level of disturbance of moral distress according to hospital type

		N	Mean	Std. Deviation
q2.16.freq	Private	50	1.88	1.534
	Public	41	.85	1.256
	Total	91	1.42	1.499
q2.17.freq	Private	52	2.71	1.433
	Public	40	2.13	1.505
	Total	92	2.46	1.486

Levels of moral distress experienced by critical care nurses in private hospitals are greater than those in public hospitals.

4.4.2.5 Category

Table 4.19: Differences in level of disturbance of moral distress according to staff category

	N	Mean	Std. Deviation
Professional nurse ICU experienced only	18	1.78	1.437
Professional nurse ICU trained	31	2.39	1.564
Staff nurse	7	.71	1.496
ICU student	10	1.10	1.792
Total	66	1.85	1.638

Levels of moral distress experienced amongst professional nurses (ICU trained) is more than ICU students. The level of moral distress experienced amongst ICU students is more than that experienced by staff nurses.

4.4.2.6 By experience

Table 4.20: Differences in level of disturbance of moral distress by experience

	N	Mean	Std. Deviation
Less than 5 years	24	2.50	1.560
5-10 years	25	1.60	1.658
More than 10 years	22	1.41	1.436
Total	71	1.85	1.609

Levels of moral distress experienced are greater amongst nurses working less than 5 years than those working more than 10 years.

4.4.2.7 By discipline

Table 4.21: Differences in level of disturbance of moral distress by discipline

		N	Mean	Std. Deviation
q2.3.LoD	SICU	13	2.23	1.166
	General ICU	40	2.58	1.259
	Cardiac ICU	10	1.40	1.430
	Other	5	1.20	1.789
	Total	68	2.24	1.373
q2.15.LoD	SICU	13	2.38	1.660
	General ICU	36	2.22	1.551
	Cardiac ICU	14	1.14	1.460
	Other	5	.80	.837
	Total	68	1.93	1.586

Levels of moral distress experienced are greater in General ICU's than in Cardiac ICU's.

4.4.2.8 Position

No significant differences were noted.

4.5 LEAVING A CLINICAL POSITION AS A RESULT OF MORAL DISTRESS RELATING TO PATIENT CARE

Table 4.22: Leaving a clinical position as a result of moral distress relating to patient care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No, never left or considered leaving	65	65.0	67.0	67.0
	Yes, considered but did not leave	23	23.0	23.7	90.7
	Yes, I left a position	9	9.0	9.3	100.0
	Total	97	97.0	100.0	
Missing	System	3	3.0		
Total		100	100.0		

Significantly more nurses (65%) indicated that they have never considered leaving a position ($\chi 2$ (2, N=97) = 52.536, p<.0005).

4.6 CONSIDERING LEAVING A POSITION BECAUSE OF ONE'S MORAL DISTRESS WITH THE WAY PATIENT CARE IS HANDLED IN ONE'S INSTITUTION

Table 4.23: Considered leaving a clinical position as a result of moral distress relating to patient care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	15	15.0	15.6	15.6
	No	81	81.0	84.4	100.0
	Total	96	96.0	100.0	
Missing	System	4	4.0		
Total		100	100.0		

Significantly more nurses (81%) indicated that they have never considered leaving a position ($\chi 2$ (2, N=97) = 52.536, p<.0005).

4.7 EXPERIENCE OF MORAL DISTRESS AND ITS EFFECT ON PROVISION OF NURSING CARE TO PATIENTS

Table 4.24: Moral distress experience and effect on nursing care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Large negative effect'	36	36.0	39.1	39.1
	Small negative effect	24	24.0	26.1	65.2
	No effect	13	13.0	14.1	79.3
	Small positive effect'	7	7.0	7.6	87.0
	Large positive effect	12	12.0	13.0	100.0
	Total	92	92.0	100.0	
Missing	System	8	8.0		
Total		100	100.0		

The one sample t-test was applied to see whether the average effect score is significantly different from a neutral score of ‘3’.

The average effect score (2.29) is significantly different from a neutral score of ‘3’ ($t(91) = -4.858$, $p<.0005$). This implies that there is a significant negative effect of moral distress on nursing care.

4.8 EFFECTIVENESS OF STRATEGIES TO REDUCE MORAL DISTRESS

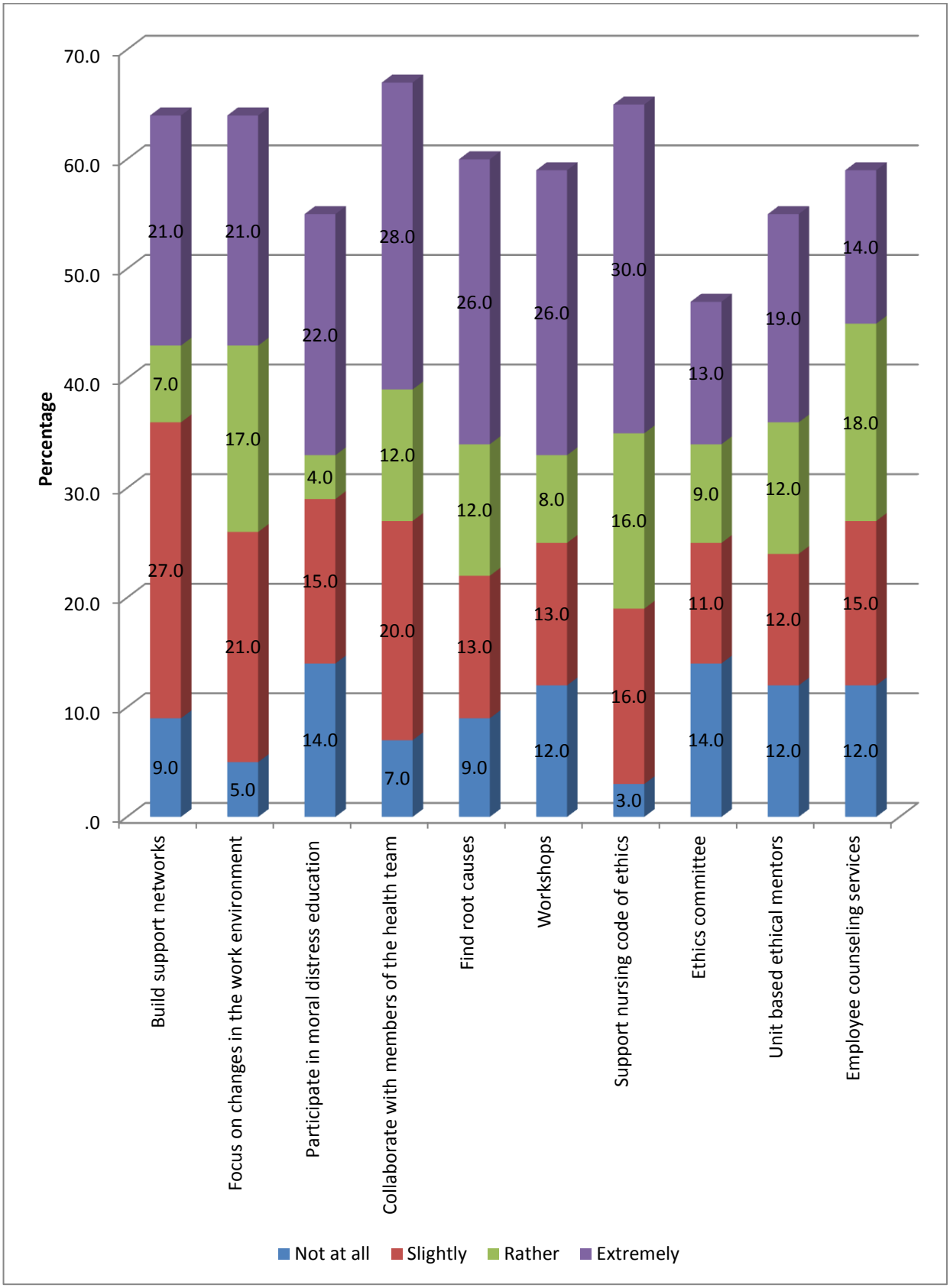

Figure 4.1: The effectiveness of strategies to reduce moral distress

4.8.1 Strategies identified as extremely effective in reducing moral distress

The following strategies were identified as being extremely effective in reducing moral distress:

- “Support nursing code of ethics” (30%).
- “Collaboration with members of the health team” (28%).
- “Finding the root cause” (26%).
- “Participating in moral distress education” (22%).
- “Building supportive networks” (21%).
- “Unit based ethical workshops” (19%).
- “Employee counselling services” (14%).
- “An ethics committee” (13%).

4.8.2 Strategies identified as not at all effective in reducing moral distress

The following strategies were identified as being extremely effective in reducing moral distress:

- Moral distress education and ethics committees (14%).
- Workshops, unit based ethical mentors and employee counselling services (12%).
- Building support networks and finding the root cause (9%).
- Collaborating with members of the healthcare team (7
- Focusing on changes in the workplace (5%).
- Supporting a nursing code of ethics (3%).

4.9 CONCLUSION

This chapter presented the study results. Chapter 5 discusses the results.

CHAPTER 5: DISCUSSION OF RESULTS

"But a caring nurse also identifies when her or his own needs must be satisfied to enable her or him to fulfil the caring role."
(Jooste 2013: 24)

5.1 INTRODUCTION

This chapter will discuss the results that were presented in the previous chapter. The discussion is based on the study objectives, namely to determine:

- The intensity and frequency of moral distress amongst critical care nurses.
- The impact of moral distress on the provision of nursing care to the patient.
- The effectiveness of strategies implemented to reduce the incidence and frequency of moral distress.

Conclusions will be drawn and limitations to the study, as well as recommendations, will be presented.

5.2 CLINICAL SITUATIONS AND FREQUENCY OF MORAL DISTRESS

In this study the clinical situation that led to moral distress most frequently was: "Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support", at an average frequency of 2.73. These findings are consistent with the study findings of Burston and Tuckett (2013: 317) whose study indicated that the provision of overly aggressive or futile treatment is a concept that emerges strongly as one causing moral distress. A study conducted by Wiegand and Funk (2012: 481) indicated that many clinical situations that resulted in moral distress were related to end of life care. The end-of-life situations that created moral distress were medical futility, organ donation,

over- or under-administration of analgesic medications and other end-of-life issues.

5.3 CLINICAL SITUATIONS AND LEVEL OF DISTURBANCE OF MORAL DISTRESS

The clinical situation that led to the highest level of disturbance was: “Work with nurses or other healthcare providers who are not as competent as the patient care requires”, at an average level of disturbance of 2.84. These findings are consistent with the study conducted by Burston and Tuckett (2013: 317), who state that while the use of a multidisciplinary approach to care can have significant benefits for care provision, a poorly functioning team may generate a range of detrimental effects such as discontinuity or omission of care, conflicting advice or education and subsequent poor use of valuable health resources. A study conducted by Bruce, Weinzimmer and Zimmerman (2015: 825) found similar results. They examined moral distress in the ICU and in particular explored how all categories of professionals in the ICU experience and responded to moral distress in the context of the team. They found that discordance between multidisciplinary team members was the most prominent source of moral distress. These areas of disparity were in the areas of non-beneficial treatment, lack of full disclosure, clinician-patient/family discordance and interfamily discordance. This often occurred between different professionals (nurses and physicians) or different disciplines (surgery verses ICU). The moral distress issues described in the study essentially points to issues of conflict between individuals and groups with different viewpoints. Furthermore, an interdisciplinary study conducted in Sweden confirmed conflicts of interest as one of the types of clinical situations that cause nurses and doctors moral distress (Hogan et al 2013: 211).

These results are in contrast to a study conducted by Ganz et al. (2013:23) who found that the most commonly reported morally distressing clinical situation in terms of frequency and intensity was inappropriate behaviour on the part of the patient or family member towards a member of the staff. In previous studies, researchers have established that the above concern

ranked highest (Wagner and Hendel 2000:54) or one among the top five dilemmas (Wagner and Ronen 1996: 294). This problem has also increased around the world with increased reporting of patient and family verbal and physical abuse to healthcare staff (Crilly *et al*. 2004; Camerino *et al*. 2008; Kisa 2008).

5.4 MORAL DISTRESS FREQUENCY AND LEVEL OF DISTURBANCE FOR THE DEMOGRAPHIC VARIABLES

5.4.1 Race

There were three questions that showed significant differences in both frequency and level of disturbance of moral distress between races. These were:

- “Provide less than optimal care due to pressures from management to reduce costs.”
- “Initiate extensive life-saving actions when I think they only prolong death.”
- “Work with levels of nurse or other care provider staffing that I consider unsafe.”

It was noted that Indian critical care nurses experience more moral distress than Black critical care nurses related to the above questions. These findings are in keeping with the contributory factors to moral distress mentioned in a study by Burston and Tuckett (2013: 315), who stated that the experience of moral distress is grounded within the individual, who they are and their perception of events. This includes individual character traits or personal qualities, a nurse’s world view (understood to encompass, for example, personal values, role perceptions and culture) and the personal experience a nurse has or has had. In addition, interpersonal relationships directly influence the nurses’ experience, or their ‘reality’, of moral distress.

There is a significant difference in the frequency with which different races perceive “provide less than optimal care due to pressures from management to reduce costs” (χ^2 (3, N=91) = 11.110, p=.011) as a moral distress item. Specifically, Black participants perceive the distress less frequently than Indian participants (M=2.15) (Z=-2.855, p=.004) and less frequently than White participants (M=2.71) (Z = -2.314, p=.021). Here again, these findings are in keeping with the factors mentioned in the study above, such as individual character traits or personal qualities, a nurse’s world view and culture may have an influence on the experience of moral distress. While the workplace culture then influences moral distress, so too does a person’s own cultural background (Burston and Tuckett 2013: 315).

5.4.2 Type of hospital

Moral distress frequency and level of disturbance is noted more amongst private hospital critical care nurses than public hospital critical care nurses specifically for the clinical situations mentioned below:

- “Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit.”
- “Work with nurses or other healthcare providers who are not as competent as the patient care requires.”
- “Ignore situations in which patients have not been given adequate information to insure informed consent.”

Currently, South Africa has a multicultural, transitional health care system. The two-tiered health care system has separate public and private sectors (Van Rensburg 2004: 4). The public sector, funded by general tax, is based on a district health system approach with its emphasis on primary health care. Sixty eight percent of the population depend entirely on the public health sector. Only 16% of citizens can afford private medical scheme cover and are able to access private health care exclusively. The private sector also enjoys a much more favourable health care provider to patient ratio (Rowe and Moodley 2013: 2). This system of health care delivery and financing – a private sector which is based on individual purchasing power, and a public

sector based on welfare provision – influences the type of healthcare users that these two different sectors service. The different socioeconomic, cultural and political healthcare environments may influence care providers and the type of care they deliver. Despite the healthcare environment, healthcare delivery should be ethically and morally motivated and not be dictated by whether individuals are private or public healthcare consumers.

5.4.3 Staff category

The results of this study indicated that professional nurses (ICU trained) experience moral distress more frequently than staff nurses and that levels of moral distress experienced amongst professional nurses (ICU trained) are more than ICU students. These findings are congruent with a study conducted by Ohnishi *et al* (2010: 726) whose findings revealed that levels of moral distress are related to an increase in the level of authority a nurse has. However, other studies reveal that moral distress is particularly prevalent in people who have limited authority over their actions, and in health care has therefore been mostly recognized among nurses and trainees (Burston and Tuckett 2013; Kalyanaraman *et al.* 2014; van Schaik 2015).

5.4.4 Number of years working in the critical care unit

This study has found that the frequency of moral distress is greater amongst those working between 5-10 years than those working more than 10 years and that levels of moral distress experienced are greater amongst nurses working less than 5 years than those working more than 10 years. A study conducted by Meaney (2002: 32) supported the above findings that nurses lacking experience in addressing ethically challenging situations may be at higher risk of experiencing moral distress.

A study conducted by Comrie (2012: 126) also supports these findings in stating that as nurses enter practice, they perceive or attend to moral issues differently than nurses who have many years of patient care experience. The author proposes that educational programs should consider ways to help

support the transition of students into the role of the nurse, emphasizing how to cope with moral issues that can result in moral distress. Various teaching strategies are mentioned to enhance moral sensitivity education. Patient simulations, with or without high fidelity simulators, provide an opportunity to discover types of moral issues that might arise during patient care experiences. Case studies, specifically designed to uncover examples of moral or ethical dilemmas, offer undergraduate students the opportunity to become familiar with issues that exist in current patient care settings. Narrated stories about the current health system and related issues provide students the opportunity to learn about larger ethical dilemmas tied to the distribution or accessibility of health care. Such educational activities might be more effective in cultivating the development of moral sensitivity (Comrie 2012: 126).

These findings are contrary to a study by Rice *et al.* (2008: 360), who state that the length of experience in nursing increased the exposure to episodes of moral distress. Wilkinson (1989: 519) suggests that “more experienced nurses probably encounter fewer instances of moral distress”. It is not clear if this is simply a reduced encounter rate, an evolved perception of what constitutes ‘real’ moral distress, an improved ability to pre-empt and resolve issues more rapidly or a dampening of the psyche from frequent exposure to morally difficult situations. Others, however, identified no correlation between nursing experience and moral distress (Burston and Tuckett 2013: 315). Corley *et al.* (2005: 388) describe a significant but low negative correlation between age and moral distress intensity; but also advocate that experience alone is of only limited help in dealing with it.

5.4.5 Type of discipline

This study has found that moral distress is noted more frequently amongst Surgical ICU nurse than Cardiac ICU nurses and more frequently amongst General ICU nurses than Cardiac ICU nurses. A study conducted by Bruce, Weinzimmer and Zimmerman (2015: 830) indicated that constructive behaviours, as a method of managing moral distress, was used more often by

Medical ICU staff and that Surgical ICU staff did not report constructive behaviours. These findings were attributed to unit culture and differences in professional backgrounds in the experience of moral distress. They identified a critical need to identify the ways in which moral distress manifests across different professions, disciplines, and critical care units.

5.4.6 Current position

Moral distress is noted more frequently amongst full time staff than part time staff. No literature pertaining to this demographic data was found. Therefore, more research needs to be conducted in this area.

5.5 RESIGNATION FROM OR CONSIDERING TO LEAVE A POSITION BECAUSE OF MORAL DISTRESS RELATED TO PATIENT CARE

This study has found that significantly more nurses indicated that they have never left a position as well as that they have never considered leaving a position as a result of moral distress. This is contrary to a previous study that indicated that nurses not only think about leaving their current position but also consider leaving the nursing profession altogether (Green and Jeffers 2006; Pendy 2007; Weissman 2009). In another study, nearly half the nurses interviewed left their units or nursing altogether because of moral distress Millette 1994: 666).

Piers *et al*. (2011: 2702) have found that moral distress is common among nurses and physicians in ICUs and is associated with an intent to leave the current clinical position, suggesting the degree of impact that moral distress has on staff (both physicians and nurses) well-being.

5.6 THE IMPACT OF MORAL DISTRESS ON THE PROVISION OF NURSING CARE TO THE PATIENT

The average effect score (2.29) is significantly different from a neutral score of '3' t(91) = -4.858, p<.0005). This study therefore reveals that there is a significant negative effect of moral distress on nursing care. The failure to address moral distress affects all nurses. They lose their capacity for caring, avoid patient contact, and fail to give good physical care; they experience physical and psychological problems and physically withdraw from the bedside, barely meeting the patient's basic physical needs (Rushton 2006: 161). Cohen and Erickson (2006:778) agree that when the morally correct course of action is impossible to pursue, nurses often choose not to discuss the problem or take no direct action at all. In the context of care and caring, it was found that a nurse would often avoid the patient, avoid a conflict situation and on occasions, this led to the nurse ending care delivery altogether (Kirk 2007: 25). Wiegand and Funk (2012: 482) further explain that the consequences of clinical situations that gave rise to moral distress are not only for patients and their families but also affect the care delivery to future patients. Participants described consequences for patients involved with the situation that caused the nurse to experience moral distress. Negative patient consequences included (a) suffering, (b) prolonged dying, (c) undignified dying, (d) quantity versus quality of life, (e) inappropriate care, (f) delayed treatment, (g) prolonged hospitalization, (h) disrespect, (i) the inability to be with family, and (j) false hope. All of the above negatively influences the provision of care to the healthcare consumer.

Vanderheide, Moss and Lee (2013: 110) supports the above by stating that the ethical climate, ethical sensitivity and moral distress influence adverse patient outcomes such as burnout, job dissatisfaction and poor patient care. They further state that nurses in their clinical work experience adversity and moral distress through interpersonal challenges and circumstantial difficulties that can inhibit nurses' capacity to provide morally sensitive patient care.

A study conducted by Piers *et al*. (2011: 2694) indicated that lower levels of general quality of nursing care, nursing skill and being less able to meet patient's needs were associated with higher frequencies of moral distress. However, this study also found that age and years of nursing experience were related to perceived quality of care. As nurses grow older they might tend to become complacent with the perception of the care they deliver. Clinicians in intensive care who perceive the care they provide as inappropriate, experience moral distress and are at risk for burnout. This situation may jeopardize patient quality of care and increase staff turnover. They found that perceptions of inappropriate care were frequently reported and were inversely associated with factors indicating good teamwork (Piers *et al*. 2011: 2694).

5.7 EFFECTIVENESS OF STRATEGIES IN REDUCING MORAL DISTRESS

5.7.1 Support of nursing code of ethics

A significant percentage (30%) of participants in this study indicated that "support of nursing code of ethics" is extremely effective in reducing moral distress. This is supported by a study conducted by Ulrich *et al*. (2007: 1788), who state that ethics education is suggested to instil practitioners with the confidence to accomplish moral action more effectively. They further state that ethics education has a significantly positive influence on moral confidence and moral action. Nurses may at times be disinclined to take risks; therefore ethics education may provide the courage to take additional risks as this may be "the greatest challenge in moving from moral distress to moral action" (Grady *et al*. 2008: 4). Another study conducted by Wintrup (2015: 22) concur that ethics education has a contribution to make in supporting and promoting ethical practice. The author further explains that ethics education that promotes moral agency, rather than problem solving approaches, would explore not only clinical problems, but also the difficult and contested fields in which they occur as well as the multicultural environment from which it emerges. This will support students to locate their practice in imperfect global contexts, and to

understand how individual and collective forms of power can influence healthcare quality.

Although the American Nurses Association (Corley 2002: 685) provides guidance for nurses' moral actions, Grady *et al*. (2008: 4) have found in their literature review that nurses have little knowledge regarding the content of these codes. Pavlish *et al.* (2011: 15) probed the influence of professional ethics codes in determining nurses' moral actions. They found that nurses facing difficult ethical situations were inclined to make intuitively based ethical decisions. Furthermore, in a large, multistate research study, nurses reported high levels of distress associated with ethical conflicts (Ulrich *et al*. 2007: 1708).

Pavlish *et al*. (2011: 13) conducted a study to explore nurses' descriptions of ethical incidents and perspectives on early indicators and risk factors for ethically difficult situations. Their ultimate goal was for nurses to recognize unfolding ethical conflicts early enough to promptly intervene, improve healthcare team communication, and mitigate any injurious effects. They concluded that nurses are keenly aware of pertinent risk factors and early indicators of unfolding ethical conflicts. Many nurses reported feeling powerless in the face of ethical conflict. They suggested that research that develops interventions to strengthen nurses' voices in ethically difficult situation is warranted. Supporting a nurse's code of ethics and ethics education therefore plays a vital role in empowering the nurse to make morally sound decisions.

5.7.2 Collaboration with members of the health team

A notable percentage (28%) of the participants indicated that "collaboration with members of the health team" is extremely effective in reducing moral distress. Previous studies (Oberle and Hughes 2001; Pendry 2007; Kalvemark *et al* 2004; Epstein 2010; Epstein and Hamric 2009) have indicated that fostering and participation in an inter-professional environment facilitates greater understanding of the perspectives of other health

practitioners and promotes understanding and reduces or prevents moral distress. Implementation of inter-professional forums is suggested as a worthwhile strategy to develop understanding of other disciplines' decision-making processes (Oberle and Hughes 2001: 707). The provision of a forum to discuss patient goals has also been revealed to be valuable in preventing morally and ethically distressing clinical issues (Montagnino and Ethier 2007:440). A study conducted by Wilson *et al*. (2013:1464) reported that the two most frequently selected resources nurses would use to cope with distressing circumstances were ethics committee and debriefing. Once recognition of a distressing situation occurs, participants indicated that a collective approach to addressing the situation should occur.

The American Association for Critical Care Nurses advocate that a collaborative, inter-professional, respectful environment is one that creates an environment for addressing morally distressing situations (AACN 2008). Ethics rounds, discussion groups and debriefing sessions may provide an opportunity to recognise and collaboratively contribute to discussions about experiences within the unit (Zuzelo 2007: 345). The AACN (2008) further recommends that charge nurses and/or counsellors be available in patient units for regular debriefing and discussions related to morally appropriate actions and further support the availability of an ethics committee 24 hours a day. The findings of the study by Rind *et al.* (2001: 829) found intra-team discordance to be a prevalent theme causing moral distress, and advocate a variety of management strategies such as venting, mentoring and building team cohesion to support collaboration with members of the multidisciplinary team to alleviate distress.

Sauerland *et al.* (2015: 33) claim that agreement on the patient's treatment path is not necessarily the only goal in resolving moral distress; they advocate the development of processes and supports that foster open and authentic discussion of ethical concerns from each person's perspective, including professionals, families, and patients. They further recommend that a culture of ethical questioning be endorsed by institutions, creating a mutual understanding among those involved, to make health care environments more

morally habitable. Building on sound professional relations such as respect, trust, and power sharing to ensure a common ground creates a conducive environment for moral practice. They further state that recognition of possible situations when moral distress may arise before it does is fundamental so that measures can be implemented to prevent, minimize, and ultimately resolve it. Lastly, they mention that effective communication along with bioethics education, personal reflection, taking time off to recharge, and seeking peer support are other useful strategies to improve the health care professional's ability to cope and to avoid detachment.

5.7.3 Finding the root cause and workshops

A notable percentage (26%) of the participants indicated that "finding the root cause" and workshops are extremely effective in reducing moral distress.

5.7.4 Participating in moral distress education

The study indicated that 22% of the participants specified that "participating in moral distress education" is extremely effective in reducing moral distress and 19% of the participants indicated that "unit based ethical workshops" are extremely effective in reducing moral distress. Wilkinson (1989: 517) supports this is by highlighting that ethics education raises awareness of potential moral issues and provides better understanding of relevant policies and laws influencing the management of this phenomenon. Rice *et al.* (2008: 362) agreed that moral distress education remains a key practice in reducing moral distress and suggest that collective techniques such as role plays, scenarios, ethics rounds and staff meetings be utilised to enhance moral distress education. Both Pendry (2007) and Tiedje (2000) added that storytelling or a narrative style teaching, which involves describing and discussing the experience of moral distress of an individual's or profession's ethical decision-making processes, is useful in moral distress education. This is further supported by VonDras *et al*. (2009: 330) who suggested that peer led discussions and guided reflections guide moral distress education. However, Sporrong *et al*. (2007: 830) have cautioned that care must be taken with

design and implementation of such programs as in one instance, despite the use of ethical education and forums, participants' moral distress did not change significantly.

5.7.5 Building supportive networks and focusing on changes in the work place

The study has indicated that 21% of the participants demonstrated that "building supportive networks" and focusing on changes in the work place are extremely effective in reducing moral distress. The AACN agree that a healthy work environment can lead to positive patient outcomes and nurse satisfaction and, on the contrary that unhealthy work environments lead to errors, ineffective care and moral distress (AACN 2008: 1). Corley *et al*. (2005: 388) recommend that role models or mentors be utilised to support particularly those experiencing high levels of moral distress intensity. A cultural shift towards a more open, approachable system that engenders trust and confidence could significantly improve the ability of staff to manage ethical conflicts, reducing the perceived degree of moral distress and its consequences. A supportive culture that respects and values the issues experienced by nurses, their ethical decision-making processes and their moral concerns must be fostered (Gammon, Christiansen and Wynn 2009; Nelson 2009; DeWolf, Bosek and Ring 2010; Glasberg, Eriksson and Norberg, 2008). Finally, a collective action in the form of practical guidance and discussion forums for sharing of concerns must extend to the patients and their family (Tiedje 2000: 38). Dudzinski and Shannon (2006:609) suggest a "negotiated reliance response" which may alleviate distress for practitioners. This involves discussions between all participants involved in care delivery, including the patient's family when appropriate; to facilitate a coordinated plan that incorporates the desires of all parties. Rice *et al.* (2008: 360) also supports the inclusion of the family unit, suggesting that all parties have a moral obligation to the care plan.

In a study related to students and education of moral resilience, Monteverde (2014: 360) highlights that preparing tomorrow's healthcare workforce for managing the growing complexity of care places high demands on students, educators, and faculties. In the light of distressing data about study-related stress and burnout, the author states that understanding how students manage stressors and develop resilience should be a prevalent topic of research. In addition to study-related stressors, moral stressors are also known to characterize the students' first clinical experiences. The author therefore states that healthcare ethics education has an important role to play in the promotion of students' mental and physical health by strengthening the knowledge base of moral resilience. Bruce, Weinzimmer and Zimmerman (2014: 823) agree that increasing education, cultivating mentoring networks, and conducting debriefing sessions are key strategies in reducing moral distress.

5.7.6 Employee counselling service

A small percentage (14%) of the participants indicated that "employee counselling services" are extremely effective in reducing moral distress and 13% of the participants indicated that "an ethics committee" is extremely effective in reducing moral distress. This is consistent with the recommendation of Wilkinson (1989: 515) that practitioners must actively seek assistance in dealing with the consequences of moral distress.

5.8 SUMMARY OF FINDING

5.8.1 Frequency and intensity of moral distress

In this study, the clinical situations that led to moral distress most frequently were related to continuing to participate in care for patients whose prognoses were poor (n=96). The clinical situation that led to the highest level of disturbance was working with nurses or other healthcare providers who are not as competent as required for the patient's care (n=70). It was noted that Indian critical care nurses experience more moral distress than Black critical care nurses related to the following specific clinical situations:

- “Provide less than optimal care due to pressures from management to reduce costs.”
- “Initiate extensive life-saving actions when I think they only prolong death.”
- “Work with levels of nurse or other care provider staffing I consider unsafe.”

Moral distress frequency and level of disturbance is noted more amongst private hospital critical care nurses than public hospital critical care nurses specifically for the clinical situations mentioned below:

- “Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit.”
- “Work with nurses or other healthcare providers who are not as competent as the patient care requires.”
- “Ignore situations in which patients have not been given adequate information to insure informed consent.”

5.8.2 Impact on care

This study reveals that there is a significant negative effect of moral distress on the provision of nursing care. Nurses experience challenges in the clinical environment that result in them experiencing moral distress. Nurses more attuned to the ethical dimensions of care may be more at risk for moral distress since these nurses see the moral dimensions of nursing being neglected. Nurses may find themselves distancing themselves from patient care, resulting in a perceived lack of care and concern for the patient.

5.8.3 Effectiveness of strategies to reduce moral distress

Strategies that have been identified as more effective than others in reducing or preventing moral distress in this study are as follows:

- Support of nursing codes of ethics.
- Collaboration with members of the health team.
- Finding the root cause, workshops.

- Participating in moral distress education.
- Unit based ethical workshops.
- Building supportive networks.
- Focusing on changes in the work place.
- Employee counselling services and an ethics committee.

It is central for nurses' wellbeing and endurance to acknowledge the existence of moral distress, understand its implications, and seek to resolve it to avoid isolation and loss of moral integrity.

5.9 CONCLUSION

The study indicates that the frequency and intensity of moral distress is related to specific clinical situations in the critical care environment. The study also specifies that moral distress continues to have a negative effect on the provision of nursing care. Critical care nurses feel that some strategies are effective whereas others are not at all effective.

5.10 LIMITATIONS OF THE STUDY

Some institutions were not familiar with their internal protocol of hosting researchers and a lot of time was wasted liaising between nursing and hospital management departments despite the researcher having all approvals in order. The small sample size (n=100) and lack of response on some questionnaires were specific limitations to the study.

5.11 RECOMMENDATIONS

Based on the study findings, the following recommendations are made with reference to nursing education, institutional management, practice and research.

5.11.1 Nursing education

Ethics education needs to include diverse perspectives in order to prepare nurses for moral resilience across disciplines, races and sectors of the health care delivery system. Moral distress and moral courage education in the curriculum is imperative to equip nurses to manage this phenomenon. Faculty to consider ways to help support the transition of ICU students into the role of the trained ICU nurse such as patient simulations with or without high fidelity simulators, narrations or case studies to provide an opportunity to determine moral issues that may arise in patient care settings.

5.1.1 Institutional management

Healthcare professionals need to be effective moral agents and need to foster an environment where moral courage is not just accepted but encouraged. Cultivating mentoring networks between disciplines and specialities may be helpful in increasing awareness of treatment plans and thereby reduce moral distress. Conducting debriefing sessions to encourage expression of emotions may enhance acceptance of certain treatment plans. Building team cohesion between disciplines (medical, surgical, cardiac) and amongst different healthcare professionals (multidisciplinary) emphasises common goals and shared values.

5.11.2 Practice

Unit Managers are advised to create a positive care culture where ethical care is standard practice. An ethical work environment is described as a unit where trust, respect and open communication are used to create a sense of equality and shared decision making amongst members. Individual interventions that staff could be encouraged to engage in are meditation, journaling, self-care, counselling and exercising. Unit based ethical rounds with ethics experts may enhance communication amongst healthcare professionals and alleviate unwarranted moral distress. A critical need has been identified to determine the ways in which moral distress manifests across different professions, disciplines, and critical care units.

5.11.3 Further research

Further research is required to determine the reasons for the difference in experience of moral distress amongst critical care nurses in different disciplines amongst full and part time nurses as well as amongst different races of critical care nurses. Further research is also warranted to effectively evaluate the various strategies in reducing moral distress.

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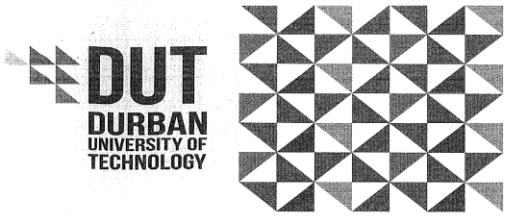
APPENDICES

APPENDIX 1: DUT ETHICS CLEARANCE



Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900
Fax: 031 373 2407
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

19 November 2014

IREC Reference Number: **REC 65/14**

Ms R Ragavadu
P O Box 56941
Chatsworth
4030

Dear Ms Ragavadu

The impact of moral distress on the provision of nursing care amongst critical care nurses in the EThekwini District

The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the piloting of your data collection tool.

Please note that you may now proceed with research on the proposed project.

Kindly ensure that participants used for the pilot study are not part of the main study.

Yours Sincerely,

[redacted]

Professor J K Adam
Chairperson: IREC

APPENDIX 2a: PERMISSION LETTER TO eTHEKWINI HEALTH DISTRICT MANAGER

P.O. Box 56941
CHATSWORTH
4030

The Acting District Manager
EThekwini Health District
Mayville
4001

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT STUDY

I am presently a Masters student at the Durban University of Technology at the Faculty of Health Sciences, Nursing Department. The proposed title of my research study is: '*The impact of moral distress on the provision of nursing care amongst nurses in the critical care units in the EThekwini District*'. I hereby request permission to conduct the study at the following hospitals: R K Khan Hospital, Inkosi Albert Luthuli Central Hospital.

Participants will be asked to answer questions which may cause discomfort, compromise them, diminish self-esteem or cause them to experience embarrassment or regret and for this reason your permission is requested for existing staff counselling services to be utilised for staff who display psychological distress. Alternatively, counselling services may be outsourced.

Questionnaires will be used to collect data from nurses that are currently working in critical care units. Data collection will take place during lunch breaks and will therefore not impact on service delivery. Participation is voluntary, and informed consent will be obtained from all participants. Confidentiality will be maintained at all times. Hospital names will not be mentioned.

I have attached my research proposal for your perusal. Your support and permission to conduct the study at your facility will be appreciated.

Yours sincerely

……

Ms R. Ragavadu (Student)
rita.ragavadu@lifehealthcare.co.za
Tel: 084 555 2606

……..

Prof M.N. Sibiya (Supervisor)
nokuthulas@dut.ac.za
Tel: 031-373 2606

……

Ms P Pillay (Co-supervisor)
padminip@dut.ac.za
Tel: 031-373 2606

APPENDIX 2b: APPROVAL LETTER FROM ETHEKWINI HEALTH DISTRICT MANAGER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Postal Address: Private Bag X54318 Durban 4000
ss: 83 Jan Smuts Highway, Mayville, Durban 4001
Tel.031 2405308: Fax. 031 2405500
Email. penny.dladla@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Ms Ntombifuthi Mthethwa
Tel: 031 240 5342
Date: 26 January 2015

Attention: Rita Ragavadu
E-mail : rita.ragavadu@lifehealthcare.co.za

REQUEST TO CONDUCT RESEARCH:

The impact of moral distress on the provision of nursing care amongst provision of nursing care critical care nurses in eThekwini district.

Support is hereby granted to conduct base line assessment on the above topic.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regard to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Ms. N.B. Mthethwa
[redacted]

For The District Manager
EThekwini Health District
Telephone: 031 2405342
Fax: 031 2405501
Email: ntombifuthi.mthethwa@kznhealth.gov.za

APPENDIX 3a: PERMISSION LETTER TO KZN DEPARTMENT OF HEALTH

P.O. Box 56941
CHATSWORTH
4030

The Health Research and Knowledge Management Component
KwaZulu-Natal Department of Health
Private Bag X9051
Pietermaritzburg
3201

Dear Sir/Madam

RE: REQUEST FOR PERMISSION TO CONDUCT STUDY

I am presently a Masters student at the Durban University of Technology at the Faculty of Health Sciences, Nursing Department. The proposed title of my research study is: The impact of moral distress on the provision of nursing care amongst critical care nurses in the EThekwini District. I hereby request permission to conduct the study at the following hospitals: R K Khan Hospital, Inkosi Albert Luthuli Hospital.

Participants will be asked to answer questions which may cause discomfort, compromise them, diminish self-esteem or cause them to experience embarrassment or regret and for this reason your permission is requested for existing staff counselling services to be utilised for staff who display psychological distress. Alternatively, counselling services may be outsourced.

Questionnaires will be used to collect data from nurses that are currently working in critical care units. Participation is voluntary, and informed consent will be obtained from all participants. Confidentiality and anonymity will be maintained at all times. Hospital names will not be mentioned.

I have attached my research proposal for your perusal. Your support and permission to conduct the study at your facility will be appreciated.

Yours sincerely

……

Ms R. Ragavadu (Student)
rita.ragavadu@lifehealthcare.co.za
Tel: 084 555 2606

……..

Prof M.N. Sibiya (Supervisor)
nokuthulas@dut.ac.za
Tel: 031-373 2606

……

Ms P. Pillay (Co-supervisor)
padminip@dut.ac.za
Tel: 031-373 2606

APPENDIX 3b: APPROVAL LETTER FROM KZN DEPARTMENT OF HEALTH

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM28/15
NHRD Ref: KZ_2015RP29_249
Enquiries : Ms G Khumalo
Telephone : 033 – 395 3189

Dear Ms R Ragavadu

Subject: Approval of a Research Proposal

1. The research proposal titled **'The impact of moral distress on the provision of nursing care amongst critical care nurses in the eThekwini District'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Inkosi Albert Luthuli Central Hospital & RK Khan Hospital.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

[redacted]

Dr E Lutge
Chairperson, Health Research Committee
Date: 18/02/15

APPENDIX 4a: PERMISSION LETTER TO THE HOSPITAL MANAGER

P.O. Box 56941
CHATSWORTH
4030

The Nursing Manager
XXXX Hospital
Durban
4000

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT STUDY

I am presently a Masters student at the Durban University of Technology at the Faculty of Health Sciences, Nursing Department. The proposed title of my research study is: '*The impact of moral distress on the provision of nursing care amongst critical care nurses in the EThekwini District*'. I hereby request permission to conduct the study in your hospital.

Questionnaires will be used to collect data from nurses that are currently working in critical care units. Participation is voluntary, and informed consent will be obtained from all participants. Confidentiality and anonymity will be maintained at all times.

Participants will be asked to answer questions which may cause discomfort, compromise them, diminish self-esteem or cause them to experience embarrassment or regret and for this reason your permission is requested for existing staff counselling services to be utilised for staff who display psychological distress. Alternatively, counselling services may be outsourced. Hospital names will not be mentioned.

I have attached my research proposal for your perusal. Your support and permission to conduct the study at your facility will be appreciated.

Yours sincerely

……

Ms R. Ragavadu (Student)
rita.ragavadu@lifehealthcare.co.za
Tel: 084 555 2606

……..

Prof M.N. Sibiya (Supervisor)
nokuthulas@dut.ac.za
Tel: 031-373 2606

……

Ms P. Pillay (Co-supervisor)
padminip@dut.ac.za
Tel: 031-373 2606

APPENDIX 4b: APPROVAL LETTER FROM THE HOSPITAL MANAGER (LIFE GROUP)

Life Healthcare Head Office
Oxford Manor, 21 Chaplin Road, Illovo 2196
Private Bag X13, Northlands 2116, South Africa
Telephone: +27 11 219 9000
Telefax: +27 11 219 9001
www.lifehealthcare.co.za

24 November 2014

ATTENTION: RITA RAGAVADU

APPROVAL FOR RESEARCH STUDY

TITLE: THE IMPACT OF MORAL DISTRESS ON THE PROVISION OF NURSING CARE AMONGST CRITICAL CARE NURSES IN THE eTHEKWENI DISTRICT

Our previous correspondence refers.

The Research Committee of Life Healthcare has granted approval for your study to be conducted within the company's facilities.

We look forward to the results of your study.

Yours sincerely

[redacted]

Anne Roodt
Education Specialist

Life College of Learning

Life Healthcare Group (Proprietary) Limited
Reg. no. 2003/024367/07 Registered address Oxford Manor, 21 Chaplin Road, Illovo 2196, Private Bag X13, Northlands 2116
Directors: A Meyer (Chief Executive Officer), CLW Bekker, D Scheuble, PP van der Westhuizen

APPENDIX 4c: APPROVAL LETTER FROM THE HOSPITAL MANAGER (RK KHAN HOSPITAL)

HEALTH
KwaZulu-Natal

R.K. Khan Hospital
Private Bag X004,
CHATSWORTH, 4030
Tel.: 031 4596001, Fax.: 031 4011247
Email.:reena.ramcharan@.kznhealth.gov.za
www.kznhealth.co.za

ENQUIRIES: DR P.S. SUBBAN

22 April 2015

Ms Rita Ragavadu
Durban University of Technology
Faculty of Health Sciences
Rita.ragavadu@lifehealthcare.co.za

Dear Ms. Ragavadu

Your letter requesting permission to conduct a study refers.

PERMISSION TO CONDUCT RESEARCH STUDY: "THE IMPACT OF MORAL DISTRESS ON THE PROVISION OF NURSING CARE AMONGST CRITICAL CARE NURSES IN THE ETHEKWINI DISTRICT."

Permission is granted to conduct your research at this institution provided:-

- Confidentiality is maintained at all times,
- Your research does not interfere with the smooth running of the hospital
- Proper consent is obtained from nurses participating in your study
- Research is conducted during normal working hours
- The hospital receives a copy of your research on completion.
- Kindly liaise with Mrs. A. Govender – Assistant Nurse Manager: M&E.
  Tel.: 031 459 6036.
  Email: Asothee.govender@kznhealth.gov.za

Yours faithfully

[redacted]

HOSPITAL CEO

APPENDIX 5a: LETTER OF INFORMATION FOR THE PARTICIPANTS

Thank you for agreeing to participate in this study.

Title of the Research Study: The impact of moral distress on the provision of nursing care amongst critical care nurses in the EThekwini District.

Principal Investigator/s/researcher: Ms R. Ragavadu, B Cur.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiya, D Tech: Nursing; Ms. P. Pillay, Masters in Nursing.

Brief Introduction and Purpose of the Study: Moral distress is a widely recorded phenomenon in nursing practice. It can be described as a form of distress that occurs when one knows the ethically correct thing to do, but is prevented from acting on that perceived obligation. The negative effects of this phenomenon have been known to impact on the nurse, patient and the healthcare organization. Nurse's experience this daily in their working lives. The study aims to:

- Determine the intensity and frequency of moral distress amongst critical care nurses.
- Assess the impact of moral distress on the provision of nursing care to the patient.
- Evaluate the effectiveness of organizational strategies implemented to reduce moral distress

Outline of the Procedures: You are kindly requested to complete a questionnaire. It will take approximately 15 minutes. Please complete all questions, where possible. Once you have completed to fill in the questionnaire, please drop it in the box that is provided to you.

Risks or Discomforts to the Participant: You will be asked to answer questions which may cause discomfort, compromise you, diminish self-esteem or cause you to experience embarrassment or regret and for this reason, should you feel you need to utilise the staff counselling services, please inform the researcher on the contact number provided. If you choose to access you own counselling services, also please inform the researcher on the contact number provided

Benefits: The findings of this study may be used to promote the nurse's, patients and organisational outcomes by increased awareness of the phenomenon, improving its management and therefore promoting quality patient care and effective of strategies to alleviate this occurrence.

Reason/s why the Participant May Be Withdrawn from the Study: Your participation is voluntary; you are under no obligation to participate. You may withdraw from the study at any time without penalty or prejudice.

Remuneration: None

Costs of the Study: None

Confidentiality: All data collected will be strictly private and confidential and will only be used for the purpose of the study. No information will be linked to your identity.

Research-related Injury: There will be no risk of research related injury.

Persons to Contact in the Event of Any Problems or Queries: Please contact the researcher, Ms R. Ragavadu, M Tech student, Tel: 084 555 2606; Prof M.N. Sibiya, supervisor, Tel: 031-373 2606; Ms P. Pillay, co-supervisor, Tel: 031-373 2293 or the Institutional Research Ethics administrator on 031-373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za

APPENDIX 5b: CONSENT FOR THE PARTICIPANTS

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Rita Ragavadu, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____ _____ _____ _____

Full Name of Participant Date Time Signature / Right Thumbprint

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____ _____ _____

Full Name of Researcher Date Signature

_____ _____ _____

Full Name of Witness (If applicable) Date Signature

_____ _____ _____

Full Name of Legal Guardian (If applicable) Date Signature

APPENDIX 6: PERMISSION TO USE THE MDS QUESTIONNAIRE

Dear Ms. Ragavadu,

Thank you for your interest in the Moral Distress Scale – Revised (MDS-R). There are six versions of this scale: nurse, physician and other healthcare professional versions for adult settings (including ICUs and other inpatient units), and parallel versions for healthcare providers in pediatric settings. The MDS-R shows evidence of reliability and validity, and a publication describing the instrument and its testing has been published in the *American Journal of Bioethics: Primary Research:*

Hamric, A.B., Borchers, C.T., & Epstein, E.G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Primary Research, 3*(2), pp. 1-9.

You should read this article before deciding whether the MDS-R will be appropriate for your project. I have attached a copy of the article and one subsequent correction in case you have not read it.

I am happy to grant permission to use any of the MDS-R scales, but require agreement to the following condition: Individuals wishing to use the MDS-R must agree to share their data with Drs. Hamric and Corley in an SPSS file in order to further the psychometric testing of the instrument.

If you agree to adhere to this condition for use, I am happy to give you permission to use the scales. I have attached the adult nurse version -- let me know if you are interested in other versions. If you decide to change items for particular specialty purposes or for different settings or outside the USA, Dr. Corley and I request that you keep us informed of the changes you make and the results you obtain.

Certainly you can ask other questions in a survey, but they would not be part of the MDS-R. You need to consult with your faculty advisor about these other questions.

Best wishes for success with your research!

Ann Hamric

****

Ann B. Hamric, PhD, RN, FAAN
Associate Dean of Academic Programs
Professor, School of Nursing

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****

On Mon, May 12, 2014 at 1:12 PM, Ragavadu,Rita <Rita.Ragavadu@lifehealthcare.co.za> wrote:

Hello Dr. Hamric

I am a novice masters research student at the Durban University of Technology, and would like your permission to use the moral distress tool (revised) in my study. If permission is granted, may ask where I could access this tool.

My research topic is “The impact of moral distress on the provision of care amongst critical care nurses.”

I would also like to determine two other aspects, namely:

1. How do you feel about the nursing care you provide to your patients.

2. How do you feel about the effectiveness of current strategies in reducing moral distress

Would you be able to advise me on whether I could include these questions as a separate questionnaire? I would like to make it structured and would therefore provide options to choose from.

Awaiting your response with much anticipation,

Kind regards

Rita Ragavadu
Nurse Educator
Life College KZN

Nazareth House, 82 Mazisi Kunene Road(South Ridge Road)
Berea, 4001
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APPENDIX 7 EDITING CERTIFICATE

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Re: **Rita Ragavadu**

Master's dissertation: **THE IMPACT OF MORAL DISTRESS ON THE PROVISION OF NURSING CARE AMONGST CRITICAL CARE NURSES IN THE ETHEKWINI DISTRICT**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at UCT was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). In my capacity as a part-time lecturer in the Department of Homoeopathy I have supervised numerous Master's degree dissertations.

Dr Richard Steele

29 November 2015

electronic

APPENDIX 8: QUESTIONNAIRE

1. DEMOGRAPHIC DATA

Please provide the following information by placing a cross in the appropriate block.

1.1	**Gender**	Male		Female							
1.2	**Age**	20-29		30-39		40-49		50-59		60+	
1.3	**Race**	Black		Coloured		Indian		White			
1.4	**Type of hospital you work in**	Private		Public							
1.5	**Staff Category**	Professional nurse ICU experienced only		Professional nurse ICU trained		Staff Nurse		ICU Student			
1.6	**Number of years working in the critical care unit**	Less than 5 years		5 to 10 years		Greater than 10 years					
1.7	**Type of discipline you work in**	MICU		SICU		General ICU		Cardiac ICU		Other: Please specify: _____	
1.8	**Current position**	Full Time		Part Time							

2. MORAL DISTRESS SCALE (REVISED) NURSE QUESTIONNAIRE (ADULT) © 2010, ANN BAILE HAMRIC , ADAPTED FOR THIS STUDY

- **Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints. The following situations occur in clinical practice.**
- **If you have experienced these situations they may or may not have been morally distressing to you. Please indicate, by placing a cross (X)**
  - **How frequently you experience each item described and how disturbing the experience is for you.**
  - **If you have never experienced a particular situation, select "0" (never) for frequency.**
  - **Even if you have not experienced a situation, please indicate how disturbed you would be if it occurred in your practice.**
- **Note that you will respond to each item by checking the appropriate column for two dimensions: *FREQUENCY* AND *LEVEL OF DISTURBANCE***

	FREQUENCY					LEVEL OF DISTURBANCE				
	Never				Very frequently	Never				Very frequently
2.1. Provide less than optimal care due to pressures from management to reduce costs.										
2.2. Witness healthcare providers giving "false hope" to a patient or family.										
2.3. Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.										
2.4. Initiate extensive life-saving actions when I think they only prolong death.										
2.5. Follow the family's request not to discuss death with a dying patient who asks about dying.										

2.6. Carry out the physician's orders for what I consider to be unnecessary tests and treatments.										
2.7. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.										
2.8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.										
2.9. Assist a physician who, in my opinion, is providing incompetent care.										
2.10. Be required to care for patients I don't feel qualified to care for.										
2.11. Witness medical students perform painful procedures on patients solely to increase their skill.										

	FREQUENCY					LEVEL OF DISTURBANCE				
	Never				Very frequently	Never				Very frequently
2.12. Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.										
2.13. Follow the physician's request not to discuss the patient's prognosis with the patient or family.										
2.14. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.										
2.15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.										
2.16. Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit.										

2.17. Work with nurses or other healthcare providers who are not as competent as the patient care requires.										
2.18. Witness diminished patient care quality due to poor team communication.										
2.19. Ignore situations in which patients have not been given adequate information to insure informed consent.										
2.20. Watch patient care suffer because of a lack of provider continuity.										
2.21. Work with levels of nurse or other care provider staffing that I consider unsafe.										
If there are other situations in which you have felt moral distress, please write them and score them here:										

SELECT ONE OPTION BY PLACING A CROSS(X) IN THE APPROPRIATE COLUMN.

3. Have you left a clinical position because of your moral distress with the way patient care was handled at your institution?

3.1.	No, I've never left or considered leaving a position	
3.2.	Yes, I considered quitting but did not leave	
3.3.	Yes, I left a position	

4. Are you considering leaving your position because of your moral distress with the way patient care is handled at your institution?

4.1.	Yes	
4.2.	No	

5. QUESTION ON IMPACT ON CARE

How does experiencing of moral distress affect your provision of nursing care to patients?

5.1	Large negative effect on provision of nursing care	
5.2.	Small negative effect on provision of nursing care	
5.3	No effect on provision of nursing care	
5.4	Small positive effect on provision of nursing care	
5.5	Large positive effect on provision of nursing care	

6. EFFECTIVENESS OF STRATEGIES TO REDUCE MORAL DISTRESS

Can you identify any strategies from the list below (by placing a cross **(X)** in the column on the left, that have helped you reduce moral distress, and then rate the effectiveness of the strategy you indicated in the column on the right.

		Strategies to reduce moral distress		Not at all	Slightly	Rather	Extremely
	X	**Strategy**	**Example of Implementation**				
6.1		Build support networks	Find colleagues who support you or who support acting to address moral distress. Speak with one authoritative voice.				
6.2		Focus on changes in the work environment	Involve yourself in changing issues in the work environment that affect moral distress				
6.3		Participate in moral distress education	Attend forums and discussions about moral distress. Learn all you can about it.				
6.4		Collaborate with members of the health team	Collaborate with members of the health team to discuss causes and prevention of moral distress.				
6.5		Find root causes	Focus on the common causes of moral distress in your unit.				
6.6		Workshops	Attend workshops that train nursing staff to recognize moral distress, identify barriers to change, and				

			create a plan for action.				
6.7		Support nursing code of ethics	Practice the Batho Pele principles.				
6.8		Ethics committee	Liaise with the ethics committee for guidance on moral decisions.				
6.9		Unit based ethical mentors	Get the assistance of unit based ethical mentors to deal with day to day ethical and moral issues.				
6.10		Employee counselling services	Utilize employee counselling services to help deal with distressing issues.				

If there are any other strategies that have helped you to reduce moral distress, please list them and rate their effectiveness.

	X	Strategies to reduce moral distress	Not at all	Slightly	Rather	Extremely
6.11						
6.12						