

LAKEHEAD UNIVERSITY

“What guides us here?”

Exploring community health nurses’ experiences of moral distress

by

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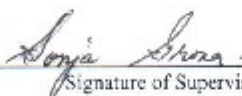
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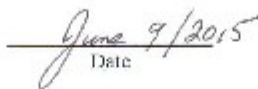
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Date

Abstract

The concept of moral distress was first developed in the mid 1980's by the American philosopher Dr. Andrew Jameton. Since then, moral distress has been studied in many health care practice settings and among various disciplines. However, moral distress among nurses in community health care settings has remained largely unexplored. Community health nurses (CHNs) work with clients, families, and communities with a variety of diverse care needs. Therefore, in this research I cast a wide net by asking a broad question, "What guides us here?" What guides nurses through the ethical landscape of community health nursing? The purpose of this research, then, is to explore CHNs experiences of everyday ethical issues and moral distress and identify educational opportunities for ongoing learning and support. To do this I used a narrative inquiry approach and interviewed 20 Canadian CHNs by phone. Based on my analysis of the data, categories of key ethical issues, themes, and educational needs were explored and identified. From the interview data, participants' stories were then re-storied by me into meta-narratives. Nine meta-narratives, inspired by multiple-participant interview responses, were created as an end product of this study. The meta-narratives represent stories that are true to life in the details regarding situations that the CHNs reported from their nursing practice. At the same time, however, the meta-narratives do not describe any one situation; rather they reflect aspects of several stories combined. Thus, the meta-narratives offer protection of confidentiality, provide an evidence-based, detailed account of these experiences, and are educational resources for CHNs. I also designed and had participants evaluate an educational intervention in the form of a self-directed e-learning module (e-module). Based on the research findings, I offer recommendations for action to promote ethical nursing practice and support CHNs, which include implications for education, theory, research, and nursing practice. This research provides foundational knowledge about the ethical landscape of community health nursing in Canada, the

everyday ethical issues faced, experiences of moral distress, and educational opportunities to support CHNs.

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Finally, I wish to express sincere gratitude for the blessings of my children, Brittany and Tyson Kavcar, and my step-daughters Erika and Andrea Bonofiglio.

Dedication

In loving memory of Anna Jaremy, Rosemary Jones, and Teresa Bonofiglio.

Truly, they did not know the impacts that their lives had on others.

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Chapter One: Introduction to the Study

Nursing is a moral endeavor that occurs in a variety of ethically challenging practice environments. As Neville (2004) highlights, “almost every decision a nurse makes has a moral dimension. This applies not just to life or death situations, but also to the mundane issues encountered on a daily basis” (p. 128). Nurses’ experiences of ethically and morally challenging situations are important areas for academic scrutiny. According to Eizenberg, Desivilya, and Hirschfeld (2009) many factors, such as concerns for cost-effective care, the need to contain rising costs, the increasing use of technology, and cultural diversity have all impacted the nature of contemporary nursing practice. In the Canadian health care system, economic constraints have resulted in the shifting of many services from acute care hospitals into community health care settings. According to the Community Health Nurses of Canada (2011), community health care settings are defined as being where people “live, work, learn, worship, and play” (p. 4). This includes, but is not limited to, health care received in one’s home environment. As a result, nurses in community health care settings are often called to respond to acute and highly variable patient care circumstances despite practice realities such as limited resources, collegial isolation, and often restrictive agency policies. For nurses practicing in rural and remote communities, these challenging circumstances are further exacerbated by issues of geographic isolation, waiting lists for services, and the unpredictable forces of mother nature that often hamper patients’ abilities to access health care services (i.e., winter weather conditions). It is not only the changing landscape of health care systems that has implications for ethical practice, but also changes to nursing practice itself.

The expansion of scopes for nursing practice and changes to nursing roles contributes to the complexity of contemporary ethical and moral dilemmas for nurses (Martin, Yarbrough, &

Alfred, 2003). For example, professional nurses who work in community health care settings have very diverse roles. According the standards of practice for Community Health Nurses (2011), the roles of a nurse in community settings may include the care of individuals, families, groups, communities, populations, and/or systems. Community health nurses (CHNs) focus on health promotion, protection, and preservation, with consideration for the social determinants of health within environmental, political, and cultural contexts. They support capacity building and community development by enhancing respect and dignity, and by engaging with healthy public policy. Through participation in knowledge translation and evidence-based decision making, they promote equity and social justice while practicing in collaboration and in consultation with teams. At times, CHNs works autonomously with a variety of health care service delivery approaches. This list of possible roles for CHNs helps to identify some of the complexities of scopes for nursing practice in community settings. Given the complex range of possible roles and contexts for CHNs, we need their unique accounts of their experiences of everyday ethical issues. This study has a specific focus on the ethical situations that CHNs most closely identified with moral distress experiences. At this time, there is a gap in the academic literature as to the ethical and moral challenges that may be present for CHNs.

Background

Moral distress can be defined as an experience where one has made a decision about what to do in an ethically challenging situation but cannot follow through with the desired action (Jameton, 1984). The topic of moral distress in nursing theory, practice, research, and education has received increasing recognition in the nursing literature since it was first introduced in the early 1980's (Pauly, Varcoe, Storch, & Newton, 2009). These multi-dimensional, moral distress experiences may affect the individual nurse (e.g., ability to practice, recruitment, retention)

(Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Pendry, 2007), the functioning of the team (Austin, 2007), patient care and patient outcomes (Gutierrez, 2005; Corley, 2002; Wilkinson, 1987/88), the health care agency (Aiken, Clarke, & Sloane, 2000), and ultimately, the health care system as a whole (Kalvemark, Hoglund, Hansson, Westerholm, & Arnetz, 2004; Clarke et al., 2001).

The lack of research on everyday ethical issues and moral distress experiences for nurses in community health settings substantiates the need for this study and reveals a significant gap in academic insight and knowledge. There have been many studies done about moral distress among health care professionals, particularly in acute care settings. For example, attention has been focused on: perinatal/neonatal nursing (Janvier, Nadeau, Deschenes, Couture, & Barrington, 2007; Tiedje, 2000; Jameton, 1993), intensive care/critical care nursing (Wiegand & Funk, 2012; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; McClendon & Buckner, 2007; Elpern, Covert, & Kleinpell, 2005; Gutierrez, 2005; Corley, 1995; Rodney, 1988), intensive care nursing and medicine (Hamric & Blackhall, 2007), oncology nursing (LeBaron, Beck, Black, & Palat, 2014; LeBaron, 2013), medical/surgical nursing (Corley, Minick, Elswick, & Jacobs, 2005), pharmacy and clinical practice (Sporrong, Hoglund, & Arnetz, 2006; Sporrong, Hoglund, Hansson, Westerholm, & Arnetz, 2005), mental health nursing (Lutzen, Blom, Ewalds-Kvist, & Winch, 2010; Austin, Bergum, & Goldberg, 2003), psychology (Austin, Rankel, Kagan, Bergum, & Lemermeyer, 2005), respiratory care (Karen, 2006; Schwenzer & Wang, 2006), pediatric intensive care nursing (Austin, Kelecevic, Goble, & Mekechuk, 2009), military nursing (Fry, Harvey, Hurley, & Foley, 2002), nurse practitioners (Laabs, 2005), perioperative nursing (Regehr, Kjerulf, Popova, & Baker, 2004), long-term care nursing

(Edwards, McClement, & Read, 2013; Pijl-Zieber et al., 2008), nursing and non-nursing students (Range Rotherham, 2010), and medical students (Wiggleton et al., 2010).

Although a large volume of scholarship has been produced on the topic, the focus of research on moral distress has largely been on the acute care sector. Collectively, the body of research noted in the preceding paragraph speaks to the diverse findings and interpretations among studies on moral distress for health care providers. There remains a need to gain a broader and deeper perspective of the concept of moral distress in general, and to further explore the implications for a wider range of practice and patient care outcomes. In addition, studies have not fully explored potential educational interventions that may support CHNs to cope with ethical decision making and experiences of moral distress. Therefore, I have identified gaps in academic understanding concerning the potentially unique experiences of everyday ethical issues and moral distress for nurses in community care settings. These gaps suggest that there is a need for increased research on moral distress in the community health care sector due to the paucity of academic attention and understanding of this area at this time. A detailed discussion of the academic literature on moral distress in nursing practice is provided in chapter two.

The Study

The purpose of this doctoral research study was to explore CHNs' experiences of everyday ethical issues and moral distress, and to identify some of the educational needs of CHNs regarding how to cope with and effectively respond to these issues in their nursing practice. The study's design required some changes and adaptations along the way, as is often the case with qualitative research, but the end product consisted of two phases. In phase one, I conducted semi-structured, individual telephone interviews with 20 Canadian CHNs and explored their experiences by listening to their stories. From the stories gathered in these

interviews, I developed nine meta-narratives and created an e-module. In phase two, I sought feedback on the e-module from study participants.

Using a narrative inquiry approach, which captured the experiences of 20 nurses in community health care settings, this study fills one of the many gaps in the academic understanding of everyday ethics and moral distress. The distress for CHNs, arising from the possible moral implications of not being able to do what needs to be done in their nursing practice, serves as the key focus for this study. “What guides us here?” is a question for CHNs, both individually and collectively, who grapple with complex ethical issues and experiences of moral distress in their practice. This question can best be answered by those who are up close, both personally and professionally, and who are keenly aware of the nature of these experiences. In asking the open-ended question, “What guides us here?” I gained a deeper understanding about everyday ethical issues and experiences of moral distress for CHNs.

In addition, I explored the use of an educational intervention and meta-narratives as resources for guiding CHNs through the ethical and moral landscapes of their nursing practice. The nine meta-narratives developed in this study were based on participants’ responses concerning fundamental ethical issues and moral distress experiences in community nursing. The e-module features three of the meta-narratives and provides information and links to additional resources on ethics and moral distress.

Research Questions

With a focus on exploring the specific categories of everyday ethical issues in community health care settings as well as the contextual meanings of experiences of moral distress, I created a multi-phase study with three research questions in mind.

1. What are the key ethical issues and themes identified by community health nurses when they are asked to discuss their experiences of everyday ethical issues and moral distress within the context of their nursing practice?
2. What are the self-identified needs for education and ongoing learning related to the topics of ethics and moral distress for community health nurses and how would they suggest that these needs be met?
3. In what way, if any, in the view of community health nurses, can contextually-rich educational meta-narratives support and enhance the delivery of an educational intervention (e-module) on moral distress for community health nurses?

Significance

The problem this study addresses is the knowledge gap related to the ethical and moral issues experienced by nurses in community health settings and what types of educational and ongoing learning opportunities might be most helpful. In addition to the research findings, a tangible outcome of this study was the development of nine meta-narratives and an e-module to facilitate knowledge exchange about everyday ethical issues and moral distress experiences in community health nursing settings. Preliminary feedback on the e-module was also received from some of the CHNs in this study.

For the purposes of this study, the term meta-narrative refers to a combination of details taken from the data of many stories concerning actual experiences of CHNs with everyday ethical issues and moral distress. From this data, a re-storied story was created which is true to life in the details although, in its entirety, not in fact a recounting of just a single scenario. The purpose of re-storying the data, in this study, was to provide a safe venue to discuss and disclose difficult ethical and moral issues. Re-storying data into meta-narratives offers protection for both

the teller of the story as well as those that the story is about. If a difficult story cannot be told due to concerns about breaching confidentiality or fears of unsuccessfully preserving anonymity, then it may never be told. Positive changes in community health nursing practice cannot be expected to occur in isolation and silence. Thus, nine meta-narratives were created from the interview data and were designed to resonate with nurses in community health care settings regarding their practice experiences with everyday ethical issues and moral distress. This research, including the educational intervention that was created, represents an original contribution to scholarship on nursing ethics, moral distress, and nursing education. In doing so, this research adds to a growing but still not fully developed understanding in this field.

The study findings will be disseminated at local, regional, provincial, national, and international venues via poster and oral presentations such as at academic conferences, as well as via academic articles that will be submitted for publication in academic journals. Based on these modes of dissemination, the results of this study will contribute to an increased professional awareness amongst allied health care academics, researchers, and front-line care providers about: i) everyday ethical issues and moral distress in community health care settings; and, ii) needs for ongoing educational and professional development opportunities for nurses and other health care practitioners. This study is one avenue for highlighting, through their own voices, some of the challenges that are abundant for nurses working in the often-overlooked sector of community health care. This research contributes to further development of a foundational knowledge in this area and highlights the need for additional research studies on the impact of everyday ethical issues and moral distress on professional nursing practice in community health care settings. Only through further research exploration of everyday ethical issues and experiences of moral distress in the context of community health nursing practice can

educators properly and fully support ongoing ethics education that is relevant and reflective of the actual challenges of everyday practice for CHNs in Canada.

Conceptual Framework

Although moral distress was identified as a concept more than 30 years ago, academic research in this area has flourished mostly in the last ten years. The concept of moral distress in nursing was first described by the American philosopher Jameton (1984). According to him, moral distress can be described as a potential reaction to a situation where one knows what to do but is unable to do so as a result of institutional constraints. Webster and Baylis (2000) expanded this definition to include situations where one fails to act ethically or fails to provide optimal patient care for any of a variety of reasons, not just due to institutional barriers. I argue that the phenomenon of moral distress may also occur in any situation where there is potential for violation of personal and professional norms, values, beliefs, and ethics. Even if a nurse is perceived to have acted appropriately, moral distress may occur as a result of recognizing the potential alternative outcomes if he/she had not acted as he/she did. As well, sometimes action on the part of the nurse may incur negative reactions from colleagues, management, and/or another agency even though the action may have been entirely ethical and appropriate. The potential for backlash (whether it actually occurs or not) should also be considered as a possible trigger for experiencing moral distress. This range of situations that may result in moral distress leads me to suggest that this phenomenon needs a broader definition. For the purposes of this research, I define moral distress as being a personal experience resulting in a negative reaction to a situation that compromises or constrains the ability to fulfill one's moral obligation to practice ethically, meet professional standards, or maintain personal values. Therefore in this study the

focus was to gain a better understanding of what potential elements resulted in morally distressing ethical situations.

My Assumptions

I conducted this study with three main assumptions that are quite basic given that every nurse faces ethical challenges in practice and at some point in his or her career is highly likely to face some level of moral distress as a result. The first assumption is that these experiences exist also in community health settings even though there is minimal documentation in the literature in the context of community health nursing. The second assumption is that CHNs want to share these experiences, and specifically, that I'm in a good position to receive their stories. The third assumption is that CHNs need responsive educational interventions to support them in their practice. Based on these basic assumptions, this study was designed to create a safe and confidential means for participants to share their stories about experiences and to contribute to identifying educational strategies to support nurses to effectively cope with and respond to these issues. Here follows further discussion of the three basic assumptions underlying the study.

First, I have assumed for the purposes of this study that everyday ethical issues and experiences of moral distress occur among nurses in community health care settings in Canada. This is a reasonable assumption, well grounded in the literature, as there is abundant support for the claim that nurses all over the world experience ethical issues and moral distress in their practice. In addition to North American studies, research has been conducted on moral distress across the globe, for example in: Australia (such as Kilcoyne & Dowling, 2008; Neil, 2010), Japan (such as Ohnishi et al., 2010), Brazil (such as Dalmolin, Lunardi, Barlem, & Silveira, 2012; Barlem et al., 2013), Norway (such as Forde & Aasland, 2008), Africa (such as Fournier, Kipp, Mill, & Walusimbi, 2007; Haggstrom, Mbusa, & Wadensten, 2008; Harrowing & Mill,

2010; Maluwa, Andre, Ndebele, & Chilemba, 2012), Italy (Karanikola et al., 2013), Sweden (Silen, Svantesson, Kjellstrom, Sidenvall, & Christensson, 2011), Ireland (Deady & McCarthy, 2010), and the Middle East (Khoiee et al., 2008; DeKeyser Ganz et al., 2012; Foroozan, Tahereh, & Farideh, 2012; Hamaideh, 2013). The assumption that everyday ethical issues and experiences of moral distress occur among nurses in community health care settings in Canada is further supported here in chapter two.

Second, I have assumed that CHNs would like to talk about these experiences and share triumphs and challenges from their professional practice, but may feel constrained due to fears about the risk of harming those for whom they are caring and/or themselves. This second assumption was based on my master's thesis work on moral distress where participants shared their experiences and needs for support (Jessiman, 2008). Also, in 2010 I attended an international symposium on moral distress that was held in Vancouver, British Columbia, Canada, where 73 participants from countries around the world gathered to discuss this important phenomenon (Pauly, Storch, & Varcoe, 2012; Pauly, Varcoe, & Storch, 2012). Such gatherings also substantiate the interest in the phenomenon of moral distress relating to health care practice and the desire among professionals in nursing and other health fields to discuss and learn more about this issue.

Additionally, I was in a good position to receive these stories due to my previous experience as a registered nurse. My nursing background was beneficial for me to establish rapport with the CHN study participants during interviews where potentially emotional topics would be discussed. Also, my nursing experiences allowed me to bring an understanding of the moral pressures and ethical challenges of nursing practice to this research. This assisted me also in finding rich meaning during the analysis of the interview data.

Third, I have assumed that there is a need to develop educational resources for CHNs to support them with everyday ethical issues and experiences of moral distress. This third assumption is also based on my master's work, where almost 80% of the 66 study participants requested further ethics education to support their community-based practice (Jessiman, 2008). Education as a valuable resource to support ethical nursing practice has also been suggested by a number of other researchers (such as Hamric, 2000; Peter, Lunardi, & Macfarlane, 2004; Kalvemark Sporrang, 2007). Thus, the development of an e-module and meta-narratives to support CHNs in their everyday practice is an important and original contribution of this current study.

Situating Myself in this Research

As a researcher and a PhD student conducting this study, I must acknowledge that I bring my own collection of social locations to this work. Social location can be described as the lens through which I see the world and this includes my personal and professional history, unique characteristics, and present circumstances. Why does my social location matter? It is important because it speaks to my ontology (view of reality) and epistemology (theory of knowledge) as it relates to this research. This is my reference point from which decisions have been made for this dissertation, action taken, experiences processed, and from which my creativity stems. It has shaped my role and my interest in this research. It guides my motivation and may constrain my research endeavours to some extent by shaping my interpretations. For these reasons I wish to be upfront and clear with readers about who I am and what is important to me by outlining how I am situated in respect to this research.

I am a white, middle-class female. I was born and raised in a community on the Northern shores of Lake Superior. It is on traditional land of the Anishnawbe people. I have been involved

with university in some capacity, as student, lecturer, researcher, for over twenty years. I have a genuine interest in generating new knowledge and understanding. My Western-oriented thought processes and culture may unavoidably impact my perspective to some extent.

My professional history includes being a registered nurse in acute care and correctional nursing, and a faculty member in undergraduate nursing education. I bring with me my own recollections of both inspiring and painfully difficult professional experiences, the experiences of nursing students that I have supervised and supported, as well as stories from nursing and allied health care professional colleagues, and continuing education opportunities. I want to tell readers about my own nursing stories, some positive and some negative, but I cannot do that here. The risks of telling stories about ethical issues and moral distress directly are too great. These risks can be personally and/or professionally damaging, for example, risking judgment, risking embarrassment, or risking the admission of participation in less-than-optimal care for clients or families. Similarly, these risks can also be damaging for nursing colleagues and other members of the health care team. Further, any agencies or organizations involved in these stories may have their reputation and public image at risk, not to mention legal risks. Perhaps of most importance, telling these types of stories directly may breach patient and family confidentiality and privacy. This, in itself, is an ethical issue as nurses have a duty of fidelity. Telling a story that places trust at risk is a high stakes choice that can compromise past, present, and future relationships.

The approach taken in this study is, in contrast, one that allows for the creation of stories that can be told. The meta-narratives developed from the data reflect the realities of everyday ethical issues and moral distress in community health nursing. These meta-narratives, based on combinations of participant responses relating to more than one story, have been constructed to

ensure confidentiality for the CHNs who shared highly sensitive material relating to their personal experiences of moral distress.

My interest in moral distress began during my master's thesis in a study of case managers' (nurses and social workers) experiences of everyday ethical issues and moral distress in Northwestern and Northeastern Ontario (Jessiman, 2008). For that study, I utilized a survey design to learn more about the frequency and intensity of moral distress experiences. While the survey results were important to the purpose of that study, I was intrigued by the lengthy stories written by the participants in the small section reserved for additional comments. Also from my master's thesis research, I heard a call for continuing education on this important topic. Thus my doctoral research provided an opportunity for me to explore the topics of nursing ethics and experiences of moral distress further and more deeply, interviewing nurses across the country, telling their stories through the use of meta-narratives, and developing an educational intervention (e-module).

My role in this research study was that of a facilitator and storyteller, or, rather, re-storyteller. My first priority in this research was to be respectful of the relationships created with the study participants. As the facilitator, I wanted to be considered by the participants to be trustworthy enough to share their stories with. My research objective was to gain further insight into community health nursing practice realities, rather than to merely confirm or deny what I was most familiar with. I endeavoured to provide a safe, non-judgmental space to share stories. In this space, I asked participants to tell me about situations where they felt challenged or unable to provide appropriate, ethical nursing care as defined by them and/or by their profession.

This research was a learning experience for me that required my flexibility and responsiveness to the need for change. For instance, original plans for this study included an

educational intervention in the form of a local workshop on moral distress. The plans for a workshop evolved to become a self-directed e-learning module (e-module) instead. This is one example of the flexibility that was required in order to be responsive to a changing research environment. I was, and still am, committed to finding new paths and exploring different ways of facilitating educational opportunities and educational research on the topic of moral distress in a variety of nurse practice settings.

Through this doctoral research, I offer a deeper understanding of some of the most difficult ethical questions arising from community health nursing practice in Canada in order to broaden knowledge and explore the everyday ethical issues and moral distress experiences that may arise from them. This research also highlights the need for opportunities for nurses and other members of the health care team to receive education to support them through ethically-challenging situations and experiences of moral distress. As Gordon (2009) keenly notes in his discussions on constructivism, our knowledge is constructed in relationships, interactions that are shaped by social, cultural, and personal values. Therefore, it must be together, collectively and collaboratively, that the question is asked, “What (ethical compass) guides us here?”

Organization of the Dissertation

What follows, then, is chapter two which reviews the literature to situate this study within the context of the academic landscape on moral distress, everyday ethical issues, and nursing practice. It is here that the reader will discover the relevance of morality and ethics as central to nursing practice. Chapter three details the research methodology and methods for this study. Chapter four presents the findings and chapter five presents a synthesis of the findings using nine meta-narratives. Chapter six discusses thematic interpretations of the findings and situates them

in the context of the scholarly literature. Finally, chapter seven concludes with recommendations for nursing practice, theory, education, and research.

Chapter Two: Literature Review

Chapter two situates this study within the academic literature on ethics, everyday ethical issues, moral distress, and nursing. My analysis of the literature is organized to provide foundational knowledge of the theoretical concepts of moral distress. This approach will familiarize the reader with key research and the ongoing dialogues about moral distress in the academic and health care communities, and build a framework for understanding the findings and interpretations of this study. The articles discussed cover the topics of ethics generally, nursing ethics, moral distress, educational interventions, and moral distress as conceptualized in the context of this study. This chapter has been organized, therefore, to provide an overview of the important variables associated with moral distress, as well as to identify some of the critical gaps in existing knowledge that this study helps to address.

Overview of Ethics

To begin my analysis of the literature on experiences of everyday ethical issues and moral distress, it is useful to explore the overall concept of ethics and consider its origins and various meanings. Here, I give a brief account of the evolution of ethics through the writings of world-renowned, Australian moral philosopher Peter Singer (2014). The very first written teachings about ethics came from the Middle East in Egypt at around 3,000 BCE and later in Babylonia from the Hebrew people. The study of ethics more formally as moral philosophy is documented in writings from India (1500-1200 BCE) and later in Buddhist and Chinese philosophy doctrines (6-4 BCE). However, the Western world most often attributes the birthplace of ethics and moral philosophy to ancient Greece and the thinking of the great philosophers during the Classical Period, namely Socrates, Plato, and Aristotle.

The Greek word for ethics (i.e., ethos) originally referred to the customs or the character of a person or group (Merriam-Webster, 2015). Thus, the development of Greek writings on ethics within a society was partly about encouraging adherence to social norms and customs. Reference to the character of a person or group speaks to the earliest works on moral philosophy and connections to broader spiritual reasons and guiding beliefs for adhering to certain practices and patterns of thought. What follows is a further discussion of moral philosophy in terms of the application of ethical principles into practice or more commonly referred to as applied ethics.

Applied Ethics

The area of ethics known as normative ethics attempts to be prescriptive and describe norms or rules for how one ought to act in a given ethical circumstance (Keatings & Smith, 2010). Through the development and application of theory, ethical principles that guide moral thoughts, attitudes, and behaviours can be explored. These normative ethical principles or rules can guide behavior prior to action and help to reflect on and evaluate past behaviours (Davis Fowler, & Aroskar, 2010). Over time, many theories about ethical decision making have become exercises in moral reasoning, focused on the establishment of principles and an almost-mathematical approach to putting moral logic into practice (Noddings, 2003). The area of ethics known as applied ethics attempts to put theory into practical application. Sometimes known as practical ethics, it involves the application of ethical theory to moral problems (Davis et al., 2010).

For example, bioethics is the study of ethics in health care practice and research, and it addresses contemporary moral dilemmas in medicine and science (Kass, 2001). Writings about principles to guide ethical human research endeavours and principles-based approaches to ethics began in the 1970's and articulated methods for achieving ethical practice (McCarthy, 2003).

While there are many bioethical theories, probably the most well known in Western philosophy is principlism. Principlism refers to four privileged ethical principles, most commonly associated with Beauchamp and Childress (2001), which include autonomy (i.e., respect for choice), beneficence (i.e., acting to benefit another), nonmaleficence (i.e., avoiding harm), and justice (i.e., fairness, equity). Beauchamp and Childress (2001) claim universality for these principles and describe them as being drawn from a common morality. This principles-based ethics model is a framework for ethical decision making that encourages negotiation and balancing between the four principles and each individual ethical situation (McCarthy, 2003). In fact, Jameton (2013) recommends the use of bioethics principles as one route to consider for resolving the ambiguity found in moral distress experiences.

Population and Public Health Ethics

In contrast to an individual approach to ethical decision making, one must also consider the tensions for ethical decisions that involve larger groups of individuals, such as communities. According to the Public Health Agency of Canada (2008), the core values for public health professionals are rooted in the social determinants of health and include:

- social justice and sustainable development;
- commitment to equity;
- empowerment and community participation;
- recognition of the importance of the health of individuals as well as communities;
- self-determination; and
- respect for diversity.

Broadly speaking then, public health care is focused on promoting health and on preventing illness and injury of populations and communities (sometimes from a global

perspective) with the goal of achieving the common public good (Kenny, Sherwin, & Baylis, 2010). The moral considerations involve a balancing of benefits over harms for a population versus for any one individual (Weijer, Skelton, & Brennan, 2013). This focus, therefore, leads to a different discourse from the above discussions on an individual's rights of autonomous choice and personal decision making. As such, the moral foundation for contemporary public health practice is social justice, with special attention paid to addressing inequalities and correcting injustices for the most vulnerable members of society (Kenny et al., 2010; Powers & Faden, 2006). Population and public health ethics has created some suggested core principles (e.g., reciprocity, distribution of risk, and equity and justice) and organizations such as the Canadian Institutes of Health Research-Institute of Population and Public Health (CIHR-IPPH), the Public Health Agency of Canada (PHAC) and the National Collaborating Centre for Healthy Public Policy (NCCCHPP) are working collaboratively to advance work on this important area of ethics (Viehbeck, Melnychuk, McDougall, Greenwood, & Edwards, 2011).

Caring and Relational Ethics

Western concepts of ethics and moral philosophy, as referred to earlier in this chapter, rely heavily on the application of abstract principles to ethical issues (Sherwin, 1992). Frank (2004) asserts that ethics “needs to shift its orientation from decisions to identities—that is, who I become as a result of making this decision” (p. 357). This is an important distinction for ethics in nursing, as nursing ethics is not just about the ethical choices that are made. Nursing ethics relates to the outcomes of the ethical decisions and to the impacts that ripple out from individual, interpersonal, institutional or agency, community, and societal levels. The potential ripple effect of nurses' ethical decision making can be far reaching and complex, particularly in settings such as the community where the variables are more diverse.

Therefore, ethical concepts such as caring and caring in relationships must be considered in this discussion. Since the 1980's an ethics of caring has been discussed in the nursing literature (Davis et al., 2010). There is an argument for caring as a primary ethical value, especially in professional nursing practice, in order to create a foundation of a wider moral framework for ethics to be established (Held, 2006; Herring, 2013). While discussing "caring relation as ethically basic" (Noddings, 2003, p.3), Noddings urged carers to focus on "how we meet the other morally...to preserve the uniqueness of human encounters. Since so much depends on the subjective experience of those involved in ethical encounters, conditions are rarely 'sufficiently similar' for me to declare that you must do what I do" (p.5). In this statement, she draws attention to the fact that caring practices are about more than just making a rational ethical decision and re-applying that decision to similar ethical issues. It is about the unique contexts of the caring relationships, how the decision was carried out, and the relational outcomes that flow from those actions, behaviours, and attitudes. This may be an uncomfortable place for moral philosophy to settle as it may be considered to be far too subjective.

Therefore it is the caring practices that create a moral dimension to the work and professional identity of nurses. "Thus a morally good nurse is actively concerned with fostering well-being through a caring relationship in the context of attentive, efficient, and effective nursing practice" (Oberle & Bouchal, 2009, p. 44). This concept of a good nurse refers to the motivation to achieve the patient's best interests and optimal professional outcomes (Oberle & Bouchal, 2009). Therefore, it is important that professional caring, with both positive and negative experiences (e.g., moral distress), be understood in a relational context shaped by the interconnections between the individuals involved and the multiple dynamics that it exists within.

A relational context for ethics and ethical decision making is found in relational ethics theory. This theory describes “that our ethical understandings are formed in, and emerge from, our relationships with others” (Oberle & Bouchal, 2009, 40). As well, being in relationship with another, results in a sharing of that person’s experiences (Maeve, 1998). Relational ethics requires consideration of multiple contexts within and between individuals, societies, as well as power inequities (Rodney, Burgess, Pauly & Phillips, 2013). It is within the relational space where morality is enacted and the effects can be felt at all levels of health care practice (Bergum, 2013).

Narrative Ethics

Another contemporary approach to ethics, one that can encompass the individual through to the community in a relational context, uses narratives (stories) to express the voices of those involved. “Narrative ethics requires that we listen to details about social context, personal history, and factors that have shaped the ‘who’ of the story” (Oberle & Bouchal, 2009, p. 17). Narratives allow others to engage vicariously in the rich details of another’s experience, through their own subjective stance, as the story evolves over time (Grace, 2009).

Narrative ethics is not without its criticisms. While learning through narrative may facilitate contextual understanding of ethical issues, it is often problematic for determining the right or best course of action from a principles-based perspective (Grace, 2009). However, many narrativists argue (such as MacIntyre, 1981; Brody, 1987; Montgomery Hunter, 1992; Frank, 1995; and Walker, 1998) that combining narrative with principles-based approaches can enhance ethical decision making by “focusing on the relational and communicative dimensions of moral situations” (McCarthy, 2003, p.67). While this approach may yield more questions than answers, the underlying tenets of narrative ethics speak to the value of opening dialogue, challenging

views and beliefs, and exploring tensions to discover shared meaning over any attempts to select a single course of morally-acceptable action (McCarthy, 2003).

Introduction to Nursing Ethics

Next I consider ethics more fully in the context of nursing practice. As described by Kunyk and Austin (2011), “nursing provides rewarding and enriching careers for its members but, at the same time, often proves to be demanding, stressful and isolating” (p.381). Thus, it is important to situate nursing into the ethical dialogue and introduce the topic of nursing ethics. Sellman (1996) defined ethics as “the application of moral philosophy in an attempt to deal with questions of right and wrong” (p. 44). This definition provides a deceptively simple approach that quickly becomes problematic when applied to the complexities of nursing practice. To take the understanding of ethics to a deeper level, ethics can be considered as “a way of being, a process of enactment” (Varcoe et al., 2004, p. 319). From a relational perspective, this process of enactment requires the nurse to critically reflect on the choices available, justifications for those options, and how one might respond (Hardingham, 2004). Therefore, nursing ethics can be described as what you do, how you do it, who you are, and who you become, during and after the experience, all of which encompasses a more complex process than simply applying moral philosophy.

Ethics in nursing requires an understanding of both the virtues of nursing and the obligations of nursing (Oberle & Bouchal, 2009). From the mid 1800’s onward, nursing was seen as a vocation (or calling) and early nurse leaders such as Florence Nightingale promoted moral education based on Aristotle’s views of virtue ethics and Christian moral principles (Sellman, 1997). Modern nursing ethics, as defined by Keatings and Smith (2010), involves the moral questions within nursing practice and establishes nurses as moral agents whose character

and relationships are the foundation. The term moral agent describes nurses as having “a responsibility to conduct themselves ethically in what they do and how they interact with persons receiving care (Canadian Nurses Association [CNA], 2008, p. 5). This burden of moral work comes from the professional judgments that nurses have to make that affect peoples’ lives, involving relationships and conflicts of values, duties, and priorities (Davis et al., 2010).

Nursing Codes of Ethics

Over time nursing codes of ethics have evolved, as nursing as a profession has evolved from having limited roles, such as the physicians’ handmaiden, to a more fulsome scope of professional nursing practice (Viens, 1989). Contemporary nursing codes of ethics are foundational to ethical nursing practice. Since World War I, nursing has been a regulated profession in Canada (Keatings & Smith, 2010). The first code of ethics for nurses was established by the International Council of Nurses (ICN) in 1953 (ICN, 2012; ICN, 2006). This code mapped out four fundamental nursing responsibilities: 1) promoting health; 2) preventing illness; 3) restoring health; and 4) alleviating suffering. The original ICN code was adopted by Canadian nurses in 1954 and used until 1980 when a Canadian code of nursing ethics was created (CNA, 2008). The current Code of Ethics for Registered Nurses (CNA, 2008) is a statement of values and commitments for nurses, and it is made up of two parts: 1) values and ethical responsibilities; and 2) ethical endeavours (e.g., social justice approaches, accountability to relationships, advocacy). The first part of the CNA code lists seven core values for nursing as a profession:

1. providing safe, compassionate, competent and ethical care;
2. promoting health and well-being;
3. promoting and respecting informed decision-making;

4. preserving dignity;
5. maintaining privacy and confidentiality;
6. promoting justice; and
7. being accountable (p.3)

Far from the focus of early nursing codes on virtue and etiquette, modern nursing codes of ethics are frameworks for integrating nursing ethics theory into practice, guiding moral reflection, and supporting ethical decision making (Keatings & Smith, 2008). These codes provide a systematic and consistent approach to analyzing and articulating ethical aspects of nursing practice (Davis et al., 2010).

Community Health Nursing and Ethics

Community health care settings, which are the focus of this research study, represent diverse environments for providing and receiving nursing care. Thus the ethical issues encountered there are of great interest. Community health care can take place anywhere beyond the walls of a traditional hospital environment. For nurses who work in community health care settings in Canada, the negative impact of provincial health care reform, the resulting lack of resources, and professional isolation all further compound the ethical challenges in their nursing practice (Jessiman, 2008).

The crux of the problem with everyday ethical issues and ethical decision making in community health care settings is not that nurses are unable to grasp the concepts necessary to plug into a standard ethical framework. Rather, it is that the available ethical frameworks do not have the capacity to support contextualized decision making due to the myriad of confounding and conflicting variables that are involved in these types of situations. Thus, nurses are faced

with morally distressing ethical issues in their practice that require attention, thoughtful consideration, and navigation.

Everyday Ethics

Often, ethical issues are defined as questions related to life and death, such as euthanasia, assisted suicide, abortion, organ transplantation, and stem-cell research. These types of ethical issues may be some of the first to come to mind, but they are not the ones faced by most nurses on a regular basis. Therefore it is important to consider the dialogue needed to also support ethical practice regarding the issues that are faced by every nurse on a more regular basis, the everyday ethical issues. According to the CNA (2008),

Nursing ethics encompasses the breadth of issues involved in health-care ethics, but its primary focus is the ethics of the everyday. How nurses attend to ethics in carrying out their daily interactions, including how they approach their practice and reflect on their ethical commitment to the people they serve, is the substance of everyday ethics. (p.5)

The potential significance of everyday ethical issues and experiences of moral distress cannot be simply reduced to being the natural consequence of caring too much, becoming over-involved, or an expectation of nursing practice. As Epstein and Delgado (2010) and Hardingham (2004) suggest, moral distress is inherently disruptive to an individual's sense of wholeness as a person. As such, moral distress can affect individuals not only professionally, but personally as well. Recognizing and understanding the potential moral significance of these experiences is important. However, as Austin (2007) astutely highlights "the *ordinariness* of everyday ethical issues can mean that their moral significance goes unrecognized" (p. 82, emphasis in original).

Moral Identity

Many authors have argued that it is the moral component of nursing practice that predisposes nurses to experience moral distress related to the ethical challenges that impact one's values and beliefs (Hamric, 2012; Lutzen & Kvist, 2012), sense of power (Epstein & Hamric, 2009), and integrity (Corley, 2002). However, if nursing practice has an inherently moral component, then would it not make sense that moral distress must be an unavoidable part of nursing practice? Research on the broader concept of moral stress explores the routine moral tensions and burdens in nursing practice and sees these as moral demands that are normative for the occupation (Lutzen & Kvist, 2012; Cribb, 2011; Lutzen, Conqvist, & Magnusson, 2003). Moral stress occurs on a spectrum that may have both positive and negative outcomes as nurses negotiate ethical conflicts in morally demanding situations. It does not, however, involve crises with moral identity and moral integrity.

Moral identity can be defined as the basing of one's identity and self-concept on consistently maintained positive moral values (Johnston, Sherman, & Grusec, 2013). Moral integrity can be defined as adherence to these values (Corley, 2002). Therefore, if one is able to consistently adhere to these values, the integrity of one's moral identity may be successfully maintained. If there is a perceived compromise of the moral values then erosion may occur (Epstein & Hamric, 2009). The situation of being unable to promote and maintain positive moral values may lead to less than optimal outcomes. These are the stories that need to be explored.

Moral Proximity and Narratives

I argue that it is through narrative that ethical nursing practice can be better contextualized and thus, more appropriately and effectively supported. As suggested by Peter and Liaschenko (2013), it is the sustained proximity that nurses have with clients and families

that makes their moral responsibilities more acutely tangible than perhaps any other health profession. It is the proximity to suffering that allows nurses to become attuned to the ethical issues in their practice. These affective dimensions of nursing practice, often referred to as emotional labour, can make ethical decision making much more complicated (Jameton, 2013).

As an example of the complexities of ethical practice found in nursing practice, findings from a large, multi-site qualitative study in British Columbia, Canada revealed that, “ethical decision-making is much more than the rational, objective application of ethical principles that traditional ethical theory implies” (Rodney et al., 2002, p. 91). In that study, the process of ethical decision making was described using a nautical metaphor of navigating because the course towards the moral destinations often involved constant readjustment along the way. Perhaps it is this shifting toward the moving target of a moral destination that makes ethics so particularly challenging in professional practice.

The types of navigating approaches used to address everyday ethical issues in practice need to be further explored and articulated. It would seem that nurses are in a prime position to tell these stories about navigating ethical landscapes. However, the valued trust of clients and families, and their expectations of confidentiality, may be placed at risk if stories are told in certain ways. Also, there is the risk that narratives about moral distress will perpetuate stereotypes of nurses as powerless victims incapable of creating positive change (Johnstone & Hutchinson, 2013). Thus, there is a need to proceed with caution.

Additionally, a number of authors support the notion that moral distress must be understood from an organizational, structural, and systemic perspective and that an individual perspective deflects important questions and answers (Austin, 2012; Varcoe, Pauly, Webster, & Storch, 2012). Therefore various contexts must be considered in stories of everyday ethical

issues as well, in order to gain perspective of the bigger picture. As astutely noted by renowned ethicist Margaret Somerville (2006), “words matter. Language is never neutral in ethics...Language can be used to create walls and to demolish them, whether those walls are literal or metaphorical, sometimes just by making us aware of their presence and impact” (pp.70-71). Somerville suggests that stories are the platform on which a shared ethics must float and that the true challenge is a struggle to understand. Therefore, there is a need to understand experiences of everyday ethical issues and moral distress more fully, in order to carefully and appropriately utilize narrative for the purpose of this research.

Introduction to Moral Distress

According to the Canadian Nurses Association (CNA, 2008), moral (or ethical) distress, ...arises in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm. When values and commitments are compromised in this way, nurses’ identity and integrity as moral agents are affected and they feel moral distress. (p. 6)

Moral distress is different from an ethical issue or moral dilemma as it is an individual experience related to the contextual factors of each unique situation (Epstein & Delgado, 2010). Using Somerville’s (2000) metaphor, moral distress is the ethical canary (in the coal mine) whose presence indicates toxins in healthcare environments (Austin, 2012). Although every ethical issue does not lead to moral distress, and although people experience moral distress over different situations, when moral distress is experienced, it is closely tied to an ethical issue.

Although first noted by Jameton (1984) among nursing students, it would be incorrect to assume that moral distress is entirely a nursing phenomenon. As Hannah (2004) observed, a

predominance of literature on moral distress is based on nurses; however, in the years to follow, moral distress has been identified among many other health care professionals including: physicians (Austin, Kagan, Rankel, & Bergum, 2008; Chen, 2009; Forde & Aasland, 2008; Hamric & Blackhall, 2007; Lee & Dupree, 2008; Lutzen, Johansson, & Nordstrom, 2000), pediatric residents (Hilliard, Harrison, & Madden, 2007), medical students (Lomis, Carpenter, & Miller, 2009; Wiggleton et al., 2010), pharmacists (Sporrong, Hoglund, & Arnetz, 2006; Sporrong, Hoglund, Hansson, Westerholm, & Arnetz, 2005), nutritionists (Chen, 2009), psychologists (Austin, Rankel, Kagan, Bergum, Lerner, 2005), social workers (Chen, 2009), chaplains (Chen, 2009), cardiovascular implantable electronic device (CIED) industry-employed allied health care professionals (IEAPs) (Mueller, Ottenberg, Hayes & Koenig, 2011), healthcare managers (Mitton, Peacock, Storch, Smith, & Cornelissen, 2010), and respiratory therapists (Karen, 2006; Schwenger & Wang, 2006). These studies give credence to the need for educational interventions on moral distress for all members of inter-professional health care teams, including and beyond acute care settings. Since experiences of moral distress have been documented among many different types of health care professionals, it is important to explore how this concept was first identified and how it was and is conceptualized by various scholars in the field.

Conceptualizing Moral Distress

Moral distress is a complicated personal experience that may involve physical and/or psychological manifestations in response to an ethical situation. Jameton (1984) wrote that every ethical issue could be placed into one of three categories: 1) moral uncertainty (i.e., ethical issue and/or action is unknown); 2) moral dilemma (i.e., clear ethical issue with conflicting choices for action), and finally; 3) moral distress (i.e., clear ethical issue, clear choice for action, but one

cannot act). He wrote about moral distress as a negative experience and felt that it was closely tied with institutional barriers that had an impact on ethical nursing practice. These barriers include time constraints, power imbalances, limitations due to policy or laws, and lack of supervisory support. Further, Jameton (1993) identified two subsets of moral distress that he called initial and reactive moral distress. Initial moral distress was defined as the emotional reaction to one's values colliding with institutional barriers or conflicting with those of others. Reactive moral distress was described as occurring when inaction takes place and negative feelings brew over time. His work has been widely criticized for being too narrow for a working definition of moral distress. For example, Repenshek (2009) contends that Jameton's concept of moral distress does not take into consideration the moral views of patients. Johnstone and Hutchinson (2013) maintain that Jameton's theory of moral distress, is too subjective and based solely on the assumption that nurses know the right thing to do. However, a more clearly articulated definition has not been widely accepted and the original and modified definitions (Jameton, 1984; Jameton, 1993) continue to provide a common ground for many contemporary studies on moral distress in the academic literature. It is likely that the recent surge in academic writing on moral distress over the last ten years has been in response to the building need among many health care professionals for a critical appraisal of this concept, its dimensions, and its scope.

As a departure from Jameton's (1993) focus on institutional barriers, Sporrang, Arnetz, Hansson, Westerholm, and Hoglund (2007) describe moral distress as a process beginning with a moral stressor that implies the need to fulfill a professional obligation. They describe experiences of moral distress as manifesting with physical, emotional, cognitive, and behavioural signs and symptoms. Mental and emotional responses may include isolation/alienation, a sense of grief,

self-doubt, self-blame, self-criticism, decreased self-esteem, a sense of powerlessness, self-disappointment, fear, anxiety, depression, despair, anger, guilt, sadness, frustration, silence, hopelessness, and loss of meaning (Corley, 2002; Hamaideh, 2013; Nathaniel, 2006; Kelly, 1998; Ramber, Vallett, Cohen, & Tarule, 2010; Rushton, 1992; Sundin-Huard & Fahy, 1999; Wilkinson, 1987/88). Examples of physical symptoms related to ongoing moral distress have been documented as including, for instance, varying degrees of aches and pains (e.g., headaches), nightmares, heart palpitations, as well as digestive problems (Gutierrez, 2005).

Certain root causes of moral distress were first identified in the literature among acute care nurses but remain as common findings in studies across various health care settings and cultures. These include: 1) clinical situations such as end-of-life care decisions (Browning, 2013); 2) internal factors for the individual such as fear, lack of confidence, perceptions regarding self-efficacy and safety, and self-doubt (Hamric, Davis, & Childress, 2006); and 3) external factors such as institutional policies and procedures, fiscal pressures, lack of autonomy, power issues, work environment, ethical climate in the work place, unethical practices in the work setting, poor communication, legal consequences, and lack of administrative support (Hamric, 2012; Hamric, Borchers, & Epstein, 2012; Jameton, 1993). Commonly cited situations related to experiences of moral distress for nurses include: futile or inappropriate treatments, communication issues (i.e., with patients, with families, within interprofessional teams), lack of resources including staffing issues, and incompetence of colleagues resulting in unsafe patient care (Browning, 2013; Corley, 2002; Epstein & Delgado, 2010).

In her work involving interviews with hospital nurses in acute care, Wilkinson (1987/88) further defined the concept of moral distress “as the psychological disequilibrium and 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” (p. 16). She identified a negative impact on almost all her participants’ sense of individual wholeness, either personal or professional. Wilkinson’s research highlights three significant contributions to understanding moral distress (McCarthy & Gastmans, 2014). These contributions include: 1) clinical issues linked to moral distress experiences, such as lying and futile treatment; 2) external and internal constraints to ethical practice, such as professional socialization, past failures to enact change, fear, and self-doubt; and 3) that moral distress stems from what one fails to do and/or what one does, against their better judgement (McCarthy et al., 2014). Further studies and reviews have confirmed the results of Wilkinson’s work on moral distress (such as Huffman & Rittenmeyer, 2012). Wilkinson’s description of moral distress as a lack of balance (disequilibrium) is an important description for beginning to understand this concept and for separating it from other, and possibly everyday, stressors normally associated with nursing practice.

Additional Theories about Moral Distress

In my review of the literature, I discerned three additional theories about moral distress. The first theory, moral reckoning, was described by Nathaniel (2006), an American nurse researcher, to conceptualize the process of moral distress and its related sequelae from a grounded theory perspective. According to her, moral reckoning involves a three-stage process: 1) ease (i.e., sense of balance), 2) resolution (i.e., action), and 3) reflection (i.e., emotional impact of consequences). Nathaniel describes a point of critical juncture, an experience of moral distress, which interrupts the stage of ease. An internal conflict between values and situational forces occurs; however, a decision is required. The second stage of resolution (giving up, or going along, or taking a stand, or bending the rules) describes the action (or non-action) that is taken. Finally in stage three, reflection occurs. Nathaniel describes this stage as the resulting

emotional impact on the individual, which can be positive or negative and may be ongoing. The process of moral reckoning as described speaks to the complexities of the phenomenon of moral distress, the various actions that may be considered, and the resulting sequelae that can result upon reflection on the moral distress experience.

The second theory is moral residue. First identified by Canadian ethicists Webster and Baylis (2000), moral residue may remain after values and ideals have been compromised in an experience of moral distress. It is often experienced as pain that is lasting, powerful, and felt deeply. In further research exploring moral residue, a concept known as the crescendo effect was coined by Epstein and Hamric (2009). They attempt to explain how moral distress levels may not return to zero (baseline) after the window of opportunity for a personal decision has passed because of the presence of moral residue. Rather, repeated exposures to moral distress experiences builds a crescendo effect and future responses to morally distressing experiences become more intense and are thus increasingly difficult to process. The crescendo effect model is based on the nursing literature and has not been tested empirically (McCarthy and Gastmans, 2014).

The third theory is moral outrage. One outcome of an experience of moral distress can be the development of moral outrage (Rushton, 2013; Pike, 1997; Wilkinson, 1987/88) in response to violations of integrity and core ethical principles. Moral outrage can be described as justified anger that arises after thoughtful reflection on values such as compassion, empathy, discernment, and humility. Rushton (2013), an American nurse researcher and ethicist, describes moral outrage as a possible catalyst for appropriate action (i.e., compromise, awareness through discussion, refusal to participate, whistle blowing, or exiting from the workplace or situation). However, if the individual's personal judgement of the situation and assessment of appropriate

timing of a decision do not support necessary action, moral outrage can leave a residue that will not heal on its own. Consequences such as apathy and becoming morally mute (Bird, 2002) can be the result of unresolved residue from experiences of moral distress.

These three additional theories about moral distress help to guide further understanding of this complex phenomenon. Moral reckoning theory identifies that experiences of moral distress do not happen solely at a single, discrete point in time. This theory encourages moral distress researchers to ask questions about actions and non-actions, reflective processes, emotional responses, and behaviours. Theory about moral residue and the crescendo effect highlights moral distress as a difficult concept to measure, as previous experiences can have unexpected and undetermined cumulative effects. Finally, moral outrage theory posits that moral distress can have residual effects that can be useful or harmful. Researchers can utilize moral outrage theory for practical application by exploring ways to support positive outcomes from negative moral distress experiences.

Measuring Moral Distress

Studies have explored the phenomenon of moral distress from a variety of vantage points. The first measurement instrument for assessing levels of moral distress was created by Corley, Elswick, Gorman, and Clor (2001), who investigated moral distress amongst American critical care nurses. Called the Moral Distress Scale (MDS), it consists of 38 items and was designed to measure the frequency and intensity of moral distress experiences using a seven-point Likert scale. This tool was foundational in moral distress research because it was the first attempt to measure the concept. It remains as the most widely used quantitative measure for moral distress (McCarthy & Gastmans, 2014).

Many revisions have occurred since the original moral distress scale was created. However, this tool was designed specifically for nurses in critical care settings and was deemed not suitable by the authors for use in other care settings or with other health care providers due to its specific content and context. In 2012, Hamric, Borchers, and Epstein created the Moral Distress Scale-Revised (MDS-R), for use with a variety of health care professionals in acute care settings. Changes to the MDS included shortening the length, updating the expectations for the role of the health care professional, creating more frequently encountered issues for a broader range of care providers, articulating the concepts more clearly, and adding content that the previous scale did not address. The resulting MDS-R had 21 items, used a five-point Likert scale, and had six parallel versions (for use with nurses, physicians and other providers in adult and pediatric acute care settings). The development and testing of the MDS-R included only physicians and nurses. Unfortunately, none of the subsequent adaptations of the scale will allow for the appropriate use of this tool in the wide range of community nursing settings because the revisions remain as context and content specific as the original version.

Corley's work with this tool (Corley, Elswick, Gorman, & Clor, 2001) found moderately high levels of moral distress among 214 critical care nurses in the United States. The highest scores correlated with inadequate staffing levels. Corley, Minick, Elswick, and Jacobs' (2005) study of 106 surgical nurses found a low level of moral distress frequency and a moderate level of moral distress intensity. Similar findings, using the MDS, for the frequency of moral distress and its largely negative impact have been reported in a number of subsequent studies (Hamric, 2012; Pauly, Varcoe, & Storch, 2012). Browning's (2013) study of 277 critical care nurses found a moderate to low frequency of moral distress and a high intensity of moral distress. The translation of findings from the studies noted here indicate that these nurses perceived that moral

distress experiences did not happen to them very often, but when they did, the experience was intense.

Criticisms of the limitations of the MDS and MDS-R include that it is time consuming and it may be measuring moral residue versus a one-time moral distress experience (Wocial & Weaver, 2012). Repenshek (2009) issued a warning regarding the wealth of literature that claims to measure moral distress. He noted that researchers must be careful and clear as to whether or not they are measuring the contexts in which moral distress experiences occur or measuring the concept of moral distress itself. This is an important warning to consider when reviewing the moral distress literature. This was a warning that I heeded when planning the design of this study. In this doctoral research, I make it clear that I am qualitatively assessing the contextual situations in which CHNs may experience moral distress and these are represented in the meta-narratives developed.

In order to address the shortcomings of the moral distress scale, Wocial and Weaver (2012) developed and validated the Moral Distress Thermometer (MDT). This screening tool was created for nurses working in acute care hospital settings. With 529 participants from three hospitals in the United States, the MDT results were tested and correlated against the MDS (2009, adult and pediatric versions). The MDT uses a visual analogue design and a 0-10 rating scale for self-perceptions of moral distress over a two-week period including the present day. It is described as a quick and easy tool to identify nurses presently at risk for leaving their job due to moral distress and as a means of evaluation for moral distress interventions. According to Wocial and Weaver, the moral distress thermometer requires further testing to determine reliability. As such, I did not consider its use for this study.

Other scholars explore moral distress using interviews (such as Baxter, 2012; Fry, Harvey, Hurley, & Foley, 2002; Gunther & Thomas, 2006; Hanna, 2005; Wilkinson, 1987/88) or a grounded theory approach (such as Gutierrez, 2005, Neil, 2010). Some scholars attempt to more accurately define moral distress (such as Hamric & Blackhall, 2007; Pauly, Varcoe, Storch, & Newton, 2009) by allowing for sections of surveys to have open-ended questions for participants to use their own words to express their moral distress experiences. This is an important strategy and one that has been used in other studies (such as Jessiman, 2008). As revealed in a study by Wilson, Goettemoeller, Bevan, and McCord (2013), open-ended responses on a moral distress questionnaire indicated more moral distress present than the statistical results from the survey did. The findings from this study by Wilson et al. have implications for the reliability and validity of studies that claim to measure levels of frequency and intensity of moral distress experiences using number scales alone. By far, most of the studies on moral distress have a strictly quantitative design with emphasis on nurses in acute care settings. Therefore, there is a need for further qualitative research on the concept of moral distress, particularly in non-acute care settings.

Possible Effects of Moral Distress

Moral distress is a complex phenomenon with potentially dynamic effects from micro-level concerns for nurses as individuals, both personally and professionally, through to macro-level concerns for communities and health care systems. As noted in the previous section of this chapter, these multiple influences are difficult to account for, and even more difficult to address without an understanding of the layers of relationships that may be involved. Through my analysis of the literature, I have identified three levels of relationships that are useful for broadening the perspective of the potentially multi-layered effects of moral distress experiences.

Micro-level effects of moral distress occur at the individual level and can sensitize individuals to important ethical issues in practice (Austin, Lerner, Goldberg, Bergum, & Johnson, 2005). Ramber, Vallett, Cohen, and Tarule (2010) wrote about moral eustress (eu-meaning good) and its potential contribution to moral growth and development. However, if compromise to one's personal and professional values occurs, then positive coping mechanisms can only mitigate negative effects for a finite amount of time. The significant physical and emotional effects of moral distress can contribute to feelings of loss, dissatisfaction, and suffering (American Association of Critical Care Nurses, 2008). Eventually, the nurse's sense of accountability to the patient, responsibility for the outcome, and perceived obligations will require a response, such as avoidance behaviours (e.g., depersonalization), denial, or surrender (Epstein & Hamric, 2009). Studies have correlated nurses' experiences of moral distress with leaving a job (such as Corley, 1995; Corley, Elswick, Gorman, & Clor, 2001; Hamric & Blackhall, 2007) as well as with the phenomenon of burnout (such as Meltzer & Huckabay, 2004; Gustafsson, Eriksson, Strandberg, & Norberg, 2010; Sundin-Huard & Fahy, 1999). Burnout, as described by Maslach and Jackson (1981), is a process of emotional, physical, and psychological exhaustion.

Meso-level effects of moral distress occur at relational levels. Moral distress experiences can have an impact upon relationships between nursing colleagues, have an effect on inter-professional team functioning, and manifest in patient and family care outcomes. These are costs and burdens that cannot be readily measured. The most vital meso-level effects are those involving negative outcomes for the quality of relationships amongst health care professionals, on health care provider-patient-and-family relationships, as well as on the level of engagement in meeting professional obligations, ethically and competently. Decreased job satisfaction may also

become an issue for successful nurse retention (Severinsson & Hummelvoll, 2001) within a particular job or within the profession itself, where moral distress is a factor in the health care work setting. Moral distress contributes to increased sick time in the workplace and increased employment turn-over rates (American Association of Critical Care Nurses, 2008; Corley, 2002). Moral distress has, for over twenty-five years, been closely linked to statistics on nurse attrition (American Association of Critical Care Nurses, 2008; Millette, 1994; Wilkinson, 1987/88) and thus contributes to nursing shortages within health care systems.

Macro-level effects occur at organizational and systemic levels. As the effects of moral distress experiences ripple out from the individual, to the health care team, and toward the patient and family, the overall health care system itself is also affected (Kalvemark, Hoglund, Hansson, Westerholm, & Arnetz, 2004; Clarke et al., 2001). Given the adverse impacts on multiple levels, moral distress should be considered a critical issue in contemporary health care. However, the cumulative influences of the micro-, meso-, and macro-level effects of moral distress are difficult to objectively evaluate. If one cannot accurately measure the effects of moral distress, it is difficult to know the full extent of the problem. And furthermore, this measurability issue affects the potential for evaluating interventions designed to address, resolve, or prevent moral distress. Thus it is necessary to continue to broaden and deepen our understanding of moral distress from a qualitative perspective.

Acute Care Nurses and Moral Distress

As noted, research on moral distress experiences and nurses has been largely focused on acute care settings. Reviewing the literature from acute care settings is important for this study for two reasons: 1) to identify the spectrum of nursing specialty areas in acute care in which researchers have identified nurses' moral distress experiences; and 2) to highlight potential

variables that appear to correlate with moral distress experiences. Many specialty areas of nursing practice, within acute care settings, are linked to studies on moral distress. For example, perinatal/neonatal nursing (Cavaliere, Daly, Dowling, & Montgomery, 2010; Curl, 2009; Kain, 2007; Hefferman & Heilig, 1999; Jameton, 1993; Janvier, Nadeau, Deschenes, Couture, & Barrington, 2007; Ondeck, 2009; Penticuff & Walden, 2000; Rogers, Babgi, & Gomez, 2008; Tiedje, 2000), intensive care/critical care nursing (Badger & O'Connor, 2006; Baxter, 2012; Beumer, 2008; Browning, 2011; Corley, 1995; De Villers, 2010; Elpern, Covert, & Kleinpell, 2005; Fogel, 2007; Gutierrez, 2005; Maiden, Georges, & Connelly, 2011; McClendon & Buckner, 2007; Meltzer & Huckabay, 2004; Mobley, Rady, Verheijde, Patel, & Larsona, 2007; Puntillo et al., 2001; Wilson, Goettemoeller, Bevan, & McCord, 2013), intensive care nursing (Hamric & Blackhall, 2007), medical/surgical and operating room nursing (Corley, Minick, Elswick, & Jacobs, 2005; Hanna, 2005; Regehr, Kjerulf, Popova, & Baker, 2004; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008), certified nurse anesthetists (Radzvin, 2011), mental health nursing (Austin, Bergum & Golberg, 2003; Lutzen, Blom, Ewalds-Kvist, & Winch, 2010), pediatric intensive care nursing (Austin, Kelecevic, Goble, & Mekechuk, 2009; Lee & Dupree, 2008), military nursing (Fry, Harvey, Hurley, & Foley, 2002), nurse practitioners (Laabs, 2005), and oncology nursing (Ferrell, 2006). Clearly, the academic literature supports the presence of the phenomenon of moral distress among nurses in acute care settings.

Within this rather vast field of scholarship, a number of variables are suggested as possible correlates of moral distress in acute care settings. Studies have used the MDS or a revised version of it with the Psychological Empowerment Instrument (PEI) (such as Browning, 2013), the Ethical Work Environment Survey (such as Corley, Minick, Elswick, Jacobs, & 2005; Hamric & Blackhall, 2007), Olson's Hospital Ethical Climate Scale (HEC) (such as Hamric,

Borchers, & Epstein, 2012), the Hospital Ethical Climate Survey (such as Pauly, Varcoe, Storch, & Newton, 2009), the Burnout Scale (such as Meltzer & Huckabay, 2004), and the Impact of Events Scale (IES) (such as De Villers, 2010) to measure moral distress and identify relationships among variables.

Moral distress is found to positively correlate with age and critical care training (Browning, 2013); years of experience (Elpern, Covert, & Kleinpell, 2005; Hamric, Borchers, & Epstein, 2012); unsafe staffing levels and futile care (Zuzelo, 2007); and avoidance (De Villers, 2010). However, Pauly, Varcoe, Storch, and Newton (2009) report findings from their research based on 374 acute care nurses that reveal no correlation between moral distress and demographics. Corley, Elswick, Gorman, and Clor's (2001) work also reveals no correlations between moral distress and demographic or professional variables. The fact that the variables that may correlate positively with moral distress have proven difficult to identify speaks to the complexity of the phenomenon of moral distress.

On the other hand, moral distress is found to be negatively correlated with continuing education, collaboration in patient care conferences, and psychological empowerment (Browning, 2013); retention, altered patient care, and spirituality (Cavaliere, Daly, Dowling, & Montgomery, 2010); age (Corley, Minick, Elswick, & Jacobs, 2005); spirituality, job satisfaction, self-image, retention, and well-being (Elpern, Covert, & Kleinpell, 2005); and ethical climate (Hamric, Borchers, & Epstein, 2012). The diversity among the variables that appear to negatively correlate with experiences of moral distress also speaks to the complexity of this phenomenon.

One common denominator for moral distress experiences among acute care nurses involves end-of-life care issues, specifically being required to provide futile or unnecessary care (American Association of Critical Care Nurses, 2008; Corley, 1995; Browning, 2013; Elpern,

Covert & Kleinpell, 2005; Gutierrez, 2005; Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004; Mobley, Rady, Verheijde, Patel, & Larsona, 2007; Piers, Van den Eynde, Steeman, Vlerick, Benoit, & Van Den Noortgate, 2012; Puntillo et al., 2001; Wilkinson, 1987/88; Williamson, 2007). Within the context of acute care settings, these findings make sense. The range of technological interventions possible in acute care settings, particularly in critical illness situations at or near the end of life, could create prime conditions for nurses to experience moral distress.

Community Health Nurses and Moral Distress

The contexts of community health care settings are very different from that of acute care because the setting itself, for example a patient's home, is borrowed and care interactions may require negotiation (Stulginski, 1993). A borrowed environment, such as a patient's home, changes the dynamics of power for health care professionals, patients, and families, and can set the stage for everyday ethical issues. In community health care settings these issues, according to MacPhail (2001), "are made more complex because of the influence of the setting (isolation from nursing colleagues, role ambiguity, the shift in control, family dynamics, and the increased need to collaborate)" (p. 2). Key everyday ethical issues for nurses in community care settings may include lack of time, increased client autonomy, the need for client support systems, variable family support, health care team communication issues, and lack of resources (Burger, Erlen, & Tesone, 1992).

There is a paucity of empirical research and academic literature on moral distress for nurses working and caring for patients and families in community health care settings. Moral distress has, however, been explored in community settings in a handful of studies. For example, among community learning disabilities nurses in England and Wales (Holloway, 2004), Dutch

nurses (Schoot, Proot, Legius, ter Meulen, & de Witte, 2006), nurses working in Canadian long-term care facilities (Pijl Zieber et al., 2008), and tele-health nurses in Canada (Rutenberg & Oberle, 2008). Also, Magnusson and Lutzen (1999) found high levels of moral distress among mental health nurses in home care settings in Sweden. They identified that patient privacy issues, the home care setting itself, and feeling isolated in decision making were key issues related to nurses' experiences of moral distress.

In my master's work, which involved health care professionals (nurses and social workers) in community health care settings in Northeastern and Northwestern Ontario, the participants described a moderate to high level of frequency of encountering everyday ethical issues in their professional practice (Jessiman, 2008). These participants also described a moderate to high level of confidence in their own perceived ability to recognize, address, and resolve ethical issues in their practice. However, in terms of their moral distress experiences, the participants reported moderate to high levels of both frequency and intensity. This research supports the notion that while nurses in community health care settings report that they generally feel confident in their capacity to managing everyday ethical issues, there remains a very significant underlying issue of moral distress experiences that may create a dissonance effect.

As another example from the community care setting, Brazil, Kassalainen, Ploeg, and Marshall (2010) examined experiences of moral distress among care providers in home-based palliative care settings in Southern Ontario, Canada. Interviews were conducted with 18 care providers from five home-visiting organizations. The care providers included personal support workers (PSWs), rehabilitation therapists, social workers, and nurses. Three themes on moral distress experiences emerged from the analysis of the data: 1) the role of the informal caregiver that involved caregiver burden, neglect or abuse, or competency to provide care; 2) challenging

issues in practice such as respect for patient decision making, inappropriate treatment, pain and suffering, unanticipated death, and communicating information about death and dying; and 3) the service delivery system, noting issues such as lack of resources, incompetence among colleagues, and lack of timely client information delivery to care providers. That research reveals the unique relationships between informal caregivers and professional health care providers in home-based care environments as a key source of moral distress. The relationships were described by the researchers as “a co-dependency towards ensuring quality of care of the patients in the home” (p. 1690).

In addition, there are a number of further barriers to ethical nursing practice that have been identified in the academic literature which may contribute to moral distress experiences. Bowman (1995) asserts that, “contextual constraints, professional and organizational expectations or protocols, and perceived powerlessness often determine how, and to what extent nurses respond to ethical issues” (p. 33). Roles and responsibilities for nurses in community care settings may compete and conflict with patient needs, patient choice and autonomy, family or caregiver requests and expectations, organizational/agency demands, requirements of the job (i.e., working extra hours unpaid), and individual nurse’s personal and professional needs (Schoot, Proot, Legius, ter Meulen, & de Witte, 2006). These findings also reflect work done by Meaney (2002) on the concept of multiple masters, where the needs of a variety of stakeholders make decision making complex and context-laden.

Educational Interventions for Moral Distress

Despite the complexities of moral distress experiences for nurses across many health care sectors, there are means to support nurses to practice within the highest standard of ethical care and to cope with experiences of moral distress. Recent literature on moral theory and ethics

education identifies a philosophical shift towards an emphasis on process versus content alone and an adherence to ethics principles (such as Walker, 1993). While this shift is important, there is a need for caution. As McCarthy (2003) points out, there are historical and cultural constraints that must be considered whenever the parameters of ethics are redrawn. The search continues for theories, processes, and educational approaches to nursing ethics that are salient, timely, and responsive to everyday nursing practice. Next, interventions for moral distress will be discussed within the context of the quality of nursing practice environments, inter-professional dialogues, and ongoing education and professional development opportunities.

The Canadian Nurses Association (2003) notes that, “quality professional practice environments is a primary value central to ethical nursing practice and plays an important role in decreasing the hazards caused by ethical distress and moral residue” (p. 4). Leading Canadian experts on moral distress Varcoe, Pauly, Webster, and Storch (2012) suggest a need to develop moral community as “a place where values are made explicit and shared, where values direct action, and where individuals feel safe to be heard” (p. 970). Considering the strong evidence in the research literature for correlations between moral distress and ethical climate/ethical work environment (such as Corley, Minick, Elswick, & Jacobs, 2005; Hamric & Blackhall, 2007; Hamric, Borchers, & Epstein, 2012; Pauly, Varcoe, Storch, & Newton, 2009), a renewed focus on supporting quality nursing practice environments may be one important strategy to consider.

Canadian researchers Austin, Lemermeyer, Goldberg, Bergum, and Johnson (2005) acknowledge that, the interdisciplinary team itself can be a source of moral distress as well as a resource for resolution of moral distress. Thus, in the development of quality health care practice environments, all members of the team must be considered. It will be within those collegial relationships and dialogues that dynamic changes may occur. The academic literature suggests

enhancing opportunities for shared practice models and inter-professional education (such as Ulrich, Hamric, & Grady, 2010).

Ethical discussions can be facilitated using informal or formal approaches (Helft, Bledsoe, Hancock, & Wocial, 2009) such as establishing an ethics committee, having pastoral support, or designating ethics consultants (Ulrich, Hamric, & Grady, 2010). The emphasis should be on supporting these important, and ideally inter-professional, dialogues on a regular basis. Sporrang, Hoglund, and Arnetz (2006) write of the “daily moral wear and tear” (p. 417) of everyday ethical issues and experiences of moral distress in the health care environment that should not be ignored.

Walsh (2010) warns of the tendencies for ethics education to be focused on rational decision-making processes (i.e., algorithms and frameworks) and the use of ethics principles to analyze dilemmas. This approach overlooks the contextual and emotional aspects of moral distress, specifically the role of moral agency (Hamric, 1999; Rodney, 1997). Do nurses feel accountable for participating in ethical decisions? Do nurses feel responsible for the outcome of ethical decisions? From a humble and empathetic perspective, where are the limitations for a client’s care and a nurse’s obligations? These are important questions because the emotional nature of moral distress can affect nurses personally as well as professionally. As Frank (2004) keenly notes, this shift in thinking about ethics from decision-making to potentially identity-breaking affects “who I become as a result of making this decision” (p. 357).

Ongoing education and professional development opportunities offer nurses avenues to find the words to describe their moral distress experiences and explore tangible solutions to very complex ethical dilemmas in practice that are compounded by issues such as lack of communication, poor collaboration, and power imbalances (Ulrich, Hamric, & Grady, 2010).

Education may be delivered via a variety of modalities, such as workshops, seminars, support groups, or journal clubs (Astrom, Furaker, & Norber, 1995; Beumer, 2008; Burger, Erlen, & Tesone, 1992; Sporrang, Arnetz, Hansson, Westerholm, & Hoglund, 2007).

Historically, teaching strategies for nursing ethics education have included a principles-based approach (Beauchamp & Childress, 2001), ethical decision-making models (Aroskar, 1980; Crisham, 1985; Curtin, 1978), and case study analysis (White, Beardslee, Peters, & Supples, 1990). None of these have been found to be particularly helpful for wrestling with complex everyday ethical issues in nursing practice. I argue that there are at least three reasons for limited success with these approaches, including that: 1) they do not generally consider the significance of relationships (e.g., between health care professionals and patients, between professional colleagues); 2) they do not generally take proper account of the context of each unique situation; and 3) they are limited in the scope of understanding of the many factors, from a holistic perspective, that may contribute to an ethical issue (e.g., physical, emotional, mental, social, political, spiritual, cultural, and financial). Although the above mentioned teaching strategies are not as effective as one would ideally desire, there may be ways to enhance these approaches that could positively contribute to supporting nurses with ethical practice and moral distress experiences.

An alternate approach to educating nurses on the issue of moral distress is one that emphasizes “educational opportunities where they can not only voice their moral concerns and predicaments, but also learn various constructive ways to deal with moral distress” (Eizenberg, Desivilya, & Hirschfeld, 2009, p. 891). In nursing, the theory-to-practice gap in relation to coping with moral distress in the health care work place appears to be a wide and deep divide. I propose that efforts to support ethics education have the potential to successfully bridge that gap

for nurses in community health care settings. In my master's work (Jessiman, 2008), only a small percentage of the respondents (6%) disagreed that educational initiatives about ethics would be considered particularly helpful to them personally and professionally. The opportunity for practice to drive theory and theory to support practice is a necessary iterative process in order to adapt educational strategies to best fit the fast-paced, dynamic environment of the Canadian health care system. As Buchholz and Rosenthal (2001) suggest, "the ultimate goal of the educational process is the development of the ability for ongoing self-directed growth" (p. 30). The goal for my doctoral research on the topic of moral distress then is to stimulate, support, and sustain the resilience of CHNs through ethics education.

Moral Distress and the Context of this Study

Everyday ethical issues in nursing practice, experiences of moral distress, and opportunities for continuing education all contribute to the quality of nursing care provided to individuals, families, and communities. The academic literature reveals the existence and widespread prevalence of moral distress for nurses in a variety of health care settings (such as Zuzelo, 2007). Caring too much is not the root of the problem for moral distress just as caring less is not going to promote protection from, prevention of, or healing after moral distress experiences for nurses regardless of their practice setting. Circumstances that limit nurses' capacity to make key decisions, within their competence and scope of practice, and to meaningfully contribute to the quality of patient care set the stage for the development of moral distress experiences (Severinsson, 2003; Benner & Wrubel, 1989). It is precisely the close proximity to patients and families and the relational nature of nursing practice that places nurses in a position to recognize dis-ease within ethical decisions and give a voice to morally distressing

situations (Baxter, 2012; Peter & Liaschenko, 2004). Therefore, moral distress is a phenomenon that deserves immediate scholarly attention.

However, there are tensions amongst moral distress scholars. One of these tensions involves the fact that most of the studies have been done exclusively with nurses in American critical care units using Jameton's theories. The second tension is that many studies on moral distress sometimes use the MDS questionnaire inappropriately and out of context in an attempt to measure the frequency and intensity of moral distress experiences. The third tension involves a general lack of recognition for the effects of relational variables (e.g., ethical climate, moral agency). And finally, there is a tension involving the gaps in knowledge and evaluation of data about interventions that may address moral distress (Pauly, Varcoe, & Storch, 2012).

With these tensions in mind, I designed this study to explore experiences of everyday ethical issues and moral distress and identify educational opportunities for Canadian nurses working in community health care settings. Thus, this study addresses a gap in the current literature on moral distress specifically with the study of non-acute care settings, using a narrative approach that acknowledges relational aspects of ethical nursing practice and offers an educational intervention strategy. Chapter three follows, with rich, thick descriptions of the methodology and methods for this research.

Chapter Three: Research Methodology and Methods

In this study, I employed narrative inquiry to explore everyday ethical issues, experiences of moral distress, and educational opportunities with 20 CHNs using individual, semi-structured telephone interviews. Narrative inquiry is a methodology that uses stories to better understand how people create meaning in their lives through narrative. As described by Connelly and Clandinin (2006), narrative inquiry is “the study of experience as story” (p. 479). It is both a vantage point and a way of thinking. I maintained a narrative vantage point and thought process throughout this research.

For this study, I used the lens of narrative inquiry, both for the collection and the analysis of data. From my analysis of the transcribed interviews, I created meta-narratives to support an educational intervention on moral distress. The meta-narratives were created from individual stories of personal experiences that were broken down into categories for key ethical issues and common themes and, then, re-storied to create stories that reflect real-life experiences. As explained below, I chose to use meta-narratives in order to respect and protect confidentiality and anonymity of both storytellers and those whom the stories are about.

This chapter fully describes the methodology and the methods used in this study. Beginning with the originally proposed research design, the transformational process of this research is explored to describe how many aspects of the study required adjustment in order to be responsive to CHN practice realities. This section includes the study setting, sample size, participant inclusion criteria, ethical considerations, recruitment strategies, amendments to the original research plan, data collection and management, data analysis procedures, and final data synthesis.

Narrative Inquiry

Narrative inquiry (Connelly & Clandinin, 1990; Clandinin & Connelly, 2000) was the methodology used for this study. As such, it was the compass for this work based on its relational and collaborative underpinnings. Narrative inquiry uses stories as data and data as stories to create an iterative data collection and analysis process. And thus it was foundational for this study because it is a dynamic and complex process grounded in the power of story. Research that meets the criteria for this methodology should begin with respect for the meaning and value inherent in ordinary experiences. This includes respect for the participants who entered into the researcher-participant relationship and bravely shared stories about their community health nursing experiences. It also encompasses respect for those persons, places, and situations within the stories (Milton, 2004). Respect and a keen sense of responsibility permeated my efforts to use narrative inquiry as a methodology in this study.

As suggested by Xu and Connelly (2009), narrative inquiry has its theoretical foundations in work on experiential learning done by Dewey (1938) and personal knowledge done by Polanyi (1958). Blending the philosophies of life experiences as education and the inherent value of individual knowledge, studies that utilize narrative inquiry intrigue me with their potential application to everyday nursing experiences, reflective practice (such as Leppa & Terry, 2010), undergraduate and continuing nursing education, and relational ethics (such as Clandinin, 2006; Conle, 2000; Conle, 2001; Conle, 1999; Conle, 1997; Connelly & Clandinin, 2000; Connelly & Clandinin, 1990; Craig, 2007; McAllister, 2001; Sandelowski, 1994; Sandelowski, 1991; Xu & Connelly, 2010; and Xu & Connelly, 2009). Narrative inquiry was an appropriate choice as the methodology for this study, which sought to explore CHNs' professional practice experiences. I did not want to attempt to measure or quantify such things as frequency, intensity, or duration of

moral distress experiences, in light of the practical difficulties of this as highlighted in the academic literature.

Research Design

Studies in the academic literature have explored experiences of everyday ethical issues and moral distress in many settings but rarely in the community health sector. I wanted to hear, explore, and analyze CHNs' stories of practice-related moral distress, and identify educational opportunities. Therefore the broad question asked was, "What guides us here?" And more specifically, I investigated using narrative inquiry: 1) key ethical issues and possible themes relating to moral distress in a community setting; 2) the needs for education about moral distress for CHNs; and 3) how the use of meta-narratives might support and enhance ongoing learning for CHNs about moral distress and how to best cope in their nursing practice.

The available tools for measuring moral distress have not been tried, tested, and validated in community health care settings. Therefore, a quantitative approach would require modification of an existing tool for measuring moral distress in this setting. Even with a valid tool, comparing quantitative data across various health care sectors would not necessarily be appropriate without knowing if the contributing factors for moral distress were comparable across the different care settings. Given the paucity of research on issues of everyday ethical issues and moral distress among CHNs, my preferred methodology was a qualitative research strategy that would generate rich contextual details to highlight the nuances of everyday ethical issues and moral distress experiences in community health care settings. Based on this preliminary investigation, I developed an educational intervention using meta-narratives to bring real-to-life stories about community health nursing forward to promote discussion and reflection about ethical and moral issues in this setting. The ultimate objectives were to, a) explore CHNs' experiences of everyday

ethical issues and moral distress in the context of contemporary practice; and b) to identify effective strategies for education for CHNs experiencing ethical and moral challenges in community health care settings.

Original Study Design

The study was originally planned to take place in a community in Northern Ontario. The desire to conduct research in this particular setting was due to an interest in generating data with northern, rural-specific content. This interest related to previous work done in my master's thesis (Jessiman, 2008) on moral distress in the Northwestern and Northeastern regions of Ontario where issues such as social isolation, expansive geography, and winter weather conditions were identified as unique variables often contributing to everyday ethical issues in northern and rural communities.

Many adjustments were required prior to the completion of this study and ultimately the study design acquired a national setting. The changes are explained in the next section of this chapter. The original study design consisted of two phases. All nurses from four local community health nursing agencies in a northern community were to be offered the opportunity to participate in one or both phases of the study. For each phase of this study, 16 (up to a maximum of 20) participants were anticipated, which allowed for approximately four to five nurses from each agency. Inclusion criteria for potential participants included being a registered nurse (RN) or registered practical nurse (RPN) and being currently employed at a community health nursing agency for a minimum of six months.

In phase one, individual semi-structured, face-to-face interviews were to take place at a mutually agreeable time and location in Fall 2011. Data collected in phase one was to include the content from audio-recorded interviews as well as my field notes. The audio data from the

interviews was to be transcribed and sent back to the participants for review and input, also known as member-checking. Data collection and data analysis were to occur concurrently. From the data, stories of everyday ethical issues and experiences of moral distress were to be re-storied. In this study, re-storying involves combining personal stories of community health nursing practice that reflect key issues and common themes rather than presenting individual nurses' personal stories verbatim. These re-storied stories (meta-narratives) were then to be used in phase two of the study, a moral distress workshop. Also from the interview data, insight into the participants' educational needs and preferred modes of delivery related to ongoing ethics education was to be sought.

In phase two, a workshop on moral distress was to be developed, offered, and evaluated in Winter 2012. The workshop was planned to be a full day session, approximately seven hours in total length. Data collection would have included a pre- and post-workshop evaluation completed by the participants as well as the contents of my field notes. The agenda of the workshop as originally planned would have been driven by two factors. First, the learning needs identified in the phase one interviews were to be integrated into the workshop content. Second, the structure of the workshop was to include four key components developed by Noddings (2002). The components were modeling, dialogue, practice, and confirmation. The meta-narratives derived from individual interviews were planned to drive small group discussions and learning.

Summary of Changes

Due to a variety of recruitment challenges, the study developed an emergent design and phase one was transformed into individual, semi-structured, telephone interviews with 20 CHNs across Canada who met the previously stated inclusion criteria for the study. Phase two (a moral

distress workshop) was changed due to a lack of participants (only three interested participants) and replaced with a self-directed e-learning module (e-module). The need for these adjustments reflects contemporary community health nursing practice realities (for example, heavy workloads and busy schedules), which have been noted in chapter two and will be more thoroughly explored in chapters four and five. As well, the topic itself of everyday ethical issues and moral distress may have stirred agency and/or individuals' fears and anxieties related to the risks of speaking out in a local setting about these issues. The many occasions during this study when emails and phone calls went completely unanswered perhaps reveals a reluctance to openly discuss moral and ethical issues that other researchers may wish to explore. A national study, the end result of an unsuccessful attempt at a local research endeavour, has, however, much more potential to contribute to the inherent benefits of creating truly anonymous voices who can speak difficult truths about what actually happens in community health nursing in Canada and the resulting experiences of moral distress. The final research design for this study, thus, was well suited to answer the key research questions originally posed.

Participant Recruitment

A total of 11 local, provincial, and national community nursing agencies and professional organizations were invited to take part in the recruitment efforts for this study. On many occasions it was not possible to track where a participant had been recruited from because often they couldn't specifically remember where or when they had heard about the study. Therefore, that information was not sought. Table 3.0 highlights each of the community health nursing agencies and professional nursing organizations that were approached for recruitment for this study. These aspects about recruitment offer insight into locations, preferred recruitment strategies, timeframes for phase-specific activity in the study, and requirements for permission to

access their CHNs. This is valuable information about some of the initial recruitment challenges associated with this work and the types of difficulties that may be encountered by other researchers.

Table 3.0

CHN Agencies and Professional Organizations

Agency/ Organization	Location	Recruitment Strategies	Timeframe for Participation in Study	Requirements
Agency A	Local	In-person presentation, email distribution of recruitment materials	December 2011- October 2012 Phases one and two	Internal REB application (1-day turn around)
Agency B	Local	In-person presentation, email distribution of recruitment materials	April-October 2012 Phase one and two	Internal REB application (2-month turn around)
Agency C	Local	Refused	n/a	n/a
Agency D	Local	Refused	n/a	n/a
Agency E	Local	Email distribution of recruitment materials	May- October 2012 Phase two only, recruitment closed for Phase one prior to internal ethics approval	Internal REB application (1-month turn around)
Organization F	National	Email distribution of recruitment materials	April- May 2012 Phase one only	No internal REB, permission from Manager
Organization G	Provincial	Recruitment materials posted on organization's website	March- May 2012 Phase one only	No internal REB, permission from President
Organization H	National	Email distribution of recruitment materials	May 2012 Phase one only	No internal REB, permission from Communications Officer
Organization I	Local	Email distribution of recruitment materials	May 2012 Phase one only	No internal REB, permission from Director and Board
Agency J	Local	In-person presentation, email distribution of recruitment materials	May- October 2012 Phase two only	No internal REB, permission from Executive Director
Agency K	Local	Email distribution of recruitment materials	September- October 2012 Phase two only	No internal REB, permission from Director

Participant Selection

A purposive sampling selection approach was used. Recruitment for the study began in November 2011 and concluded in May 2012. Initial recruitment efforts included phone and email contact with each agency or organization for permission to electronically disseminate information about the study to their CHNs. Each agency or organization was provided with the research information letter (Appendix B), phase one recruitment poster (Appendix C), and agency consent form (Appendix D). Local agencies were offered an in-person recruitment presentation. All interested potential participants were instructed to contact the researcher directly via phone or email for further information about how to participate in the study.

Ethical Responsibilities

In sum, measures for ethical protection of participants according to the Tri-Council Policy Statement 2 (TCPS-2) were followed. Recruitment for this study was not initiated until approval had been granted from the Lakehead University research ethics board (LU REB) in November 2011. Three amendments were requested and accepted by the LU REB for all changes from the original proposal as well as for the one-year renewal (see Appendices E, F, G). The first amendment requested a change to the title since the location of the study was no longer exclusively in Northern Ontario. It also requested the addition of more nursing agencies and organizations for recruitment purposes and extended the REB's deadline date for completion of the study. The second amendment requested the inclusion of a final additional agency for recruitment. The third amendment requested a change in phase two, from an on-site workshop to an e-module. A final summary report has been submitted to the LU REB regarding the completion of this research study.

There were no anticipated potential risks of harm for participants in any phase of this research study as practicing nurses are expected as professionals to reflect on and discuss ethical concerns with relevant supervisors and/or peers as the situation demands. Nevertheless, to ensure maximum protection for participants, all participants were informed that counselling opportunities were available through their workplace employee assistance program (EAP) and that these services should be accessed if they felt that discussions about experiences of everyday ethical issues and moral distress in their professional nursing practice may have exposed underlying psychological distress during or after participating in the study.

Individual participants signed consent forms prior to participation in the study, which provided the opportunity to be fully informed of their rights as participants in a research study and made aware of the research procedures. Participating agencies and organizations were also requested to sign a consent form (Appendix D) prior to recruitment of their employees or members.

All participants were informed that participation was entirely voluntary, that they could withdraw from the study at any time without penalty of any kind, and that they could choose not to answer any question(s) during the course of the study without adverse consequences. This information was highlighted on the research information letter, noted on the signed consent form, and discussed during all recruitment presentations.

All data collected for this research study remains confidential and anonymous. Pseudonyms chosen by each participant were used and identifying information was removed. General demographic data was collected for phase one of the study. Audio recordings and transcription documents have been stored digitally with encryption and password protection. All

hard copy data is securely stored in a locked cabinet in an office at Lakehead University. This data will be securely stored for a minimum of five years following completion of the study.

The proposal for this research was reviewed, revised, and approved by my doctoral committee (PhD in Educational Studies, Faculty of Education, Lakehead University) on August 29, 2011. Committee members include Dr. Sonja Grover (supervisor/chair, Lakehead University), Dr. Gerald Walton (Lakehead University), and Dr. Shijing Xu (University of Windsor).

Data Collection and Management

All interested potential participants contacted me directly via email or phone. The initial reply was always to thank them for their interest, review the purpose of the study, answer any questions they had, and email them a copy of the research information letter (Appendix B) and the participant consent form (Appendix H). If they met the inclusion criteria for the study and wished to participate, they were asked to email or fax the signed consent form back to me. Of the 64 potential participants who expressed initial interest, 27 did not reply back after receiving my email response. Eight participants said that they did not meet the inclusion criteria for reasons that included, not currently working in a community health setting (but did at one time), no longer working in Canada, currently a nursing student, currently a new graduate nurse (i.e., less than six months experience), retired from nursing, and reasons not stated.

Participants were accepted for the study and scheduling for interviews continued until I had completed a total of 20 telephone interviews. This number (20) was chosen as a maximum for the number of interviews to allow for a balance in the depth of inquiry while still remaining manageable for data collection and analysis for this dissertation. I anticipated some attrition for this study and hoped that I would secure a minimum of 16 interviews for data analysis. However,

there was no such attrition. By the end of May 2012, all 20 of the phase one telephone interviews had been completed. By that time, there were 13 remaining potential participants who had expressed interest and met the inclusion criteria of the study, but an interview date and time had not been scheduled for reasons that included timing issues for the participants (e.g., too busy right now, required an interview during evening hours, and currently on summer holidays) and personal issues (e.g., family needs, maternity leave, and surgery). I emailed these participants to let them know that phase one of the study had closed and thanked them for their interest and support of nursing research. I also contacted each of the participating agencies and organizations and let them know that recruitment for phase one had now closed and thanked them for their kind support. Into June 2013, I continued to receive emails from interested participants (17 more emails received, total of 81 interested potential participants for this study, 64 within the time frame of the recruitment period). I emailed each of them individually to let them know that recruitment had closed and thanked them for their interest in supporting this research.

Phase One

Phase one involved data collection from individual, semi-structured, telephone interviews with 20 CHNs across Canada over a four month period from March 23, 2012 until July 10, 2012. Each audio-recorded interview was on average one hour in length. The audio files were transcribed verbatim and stored digitally with encryption and password protection.

Interviews were negotiated and scheduled with each participant at a date and time mutually agreeable to both parties. After receiving the signed consent form, I emailed the participant the toll-free number and the access code required to join the audio-recorded teleconference where the interview would be held. This was a secure connection between me and the participant. I emailed the participants the questions and the quotes before the interview

(requested by the first participant and then I did this for all subsequent participants). Each interview began with introductions, reminding them that the conversation was being audio-taped, thanking them for their participation, asking if there were any questions that needed clarification, and then moving on, quite directly, to the demographic questions (see Appendix I: Semi-Structured Interview Guide). Although most text books on interviewing techniques indicate that an interview should never be started cold, I did start the interviews quite abruptly in the interest of time, respecting that these participants were very busy CHNs who were usually calling during their work hours. I had established an introductory relationship and rapport with participants in the email communications that we exchanged during recruitment activities and scheduling for the telephone interview. My status as a fellow nurse gave me common ground with the participants that did not need to be negotiated. To use colloquial language, I had a certain degree of street cred as a registered nurse. For most interviews, I felt that the participants were eager to tell their stories and did not feel that I needed to invest time upfront to establish a level of comfort or familiarity. However, if this had not been the case for these interviews I would have adjusted my approach towards the participants and meet their needs in that regard.

My experiences with the study participants during the semi-structured telephone interviews were highly interactive and a collaboration between the participants and myself. The structure of each interview was negotiated (e.g., the use of pre-selected quotes to guide the discussion [or not] was at the discretion of the participants), all participants were aware that they would have an opportunity to review the transcripts, and that data could be removed, added, or clarified in the transcripts. At the end of the interviews, the participants often said how thankful they felt to be part of a study on such an important topic. Not only were the participants willing to share their experiences with me, they said that they wanted to share them. Participants came to

the interview with their stories ready and often expressed satisfaction after the interview about having had an opportunity to share their experiences. This may be in part due to the participants themselves (e.g., motivated, expressive, and passionate about their nursing work) and partly due to the emotional subject matter of moral distress in their community health nursing practice and the heartfelt experiences they had responded to. The participants expressed gratitude for the opportunity to share their stories of moral distress with a person who also has experience as a nurse.

During each interview, I jotted down notes with a pen and paper (average of three double-sided pages per interview) in order to remain actively engaged in the narrative process and to create an ongoing, iterative data analysis. Therefore preliminary analysis of the data was concurrent with data collection in phase one. Taking field notes allowed me to capture the context of the conversation in the moment, as well as note themes that were emerging across interviews. As well, this process allowed me to explore my own personal practical knowing as it relates to this narrative inquiry. The field texts included the key points of the participant's story, my thoughts at the time, as well as additional questions to clarify my understanding. Two questions that came to mind frequently were, "why do you continue do this work?" and "if you had a magic wand, what type of ongoing education do you think is needed and how would it be delivered?" The responses to these questions are explored in chapter four. The field texts were particularly valuable during a few occasions when the audio portion of small segments of some of the recorded interviews failed for technical reasons and verbatim data was lost. Participants were advised of this, reviewed these gaps in the transcripts, and were reassured that their stories would still be told as the key points remained in the field text notes in hard copy.

Phase Two

Phase two involved an educational intervention. Originally planned as a small-group, face-to-face moral distress workshop, a self-directed e-learning module (e-module) was produced instead during December 2012 using academic literature and resources on nursing ethics and moral distress. The e-module has three learning objectives:

- 1) to define and explore the concept of moral distress;
- 2) to situate experiences of moral distress in the context of community health nursing in Canada using meta-narratives; and
- 3) to highlight tools, supports and resources that may be helpful for nurses in community care settings.

The e-module contains descriptions of sources of moral distress, barriers to ethical nursing practice, ethical decision-making tools, moral distress tools, self-care options, suggested topics for reflection and further discussion, and online resources. In addition, nine meta-narratives were created by re-storying the phase one interview data and three of these were included in the e-module. The three meta-narratives used in the e-module were titled: 1) Conspiracy of silence; 2) Autonomous choices; and 3) The care I deserve (see Appendix J: Self-Directed E-Learning Module).

Data collection for the phase two evaluation of the e-module took place from January 9, 2013 until January 31, 2013. Phase one participants received the e-module and an evaluation form (Appendix K: Participant Feedback Form for E-Module Evaluation) via email and were requested to give their feedback before the January 31, 2012 deadline. Of the 20 participants, three completed the evaluation form on the e-module. Two participants requested permission to

share the e-module with colleagues in their workplace for further discussion. I agreed to this and encouraged further feedback. No additional feedback was received.

Data Analysis

Data collection and data analysis were iterative processes in this study. After each interview and upon completion of transcribing, the transcript of the interview was provided to each participant for review (member-checking) from September through to November 2012, which allowed for confirmability of the content from each interview. The average length of an interview was one hour and the average transcription document was 13 pages long (single-spaced, one-sided). Participants were given a two-week period to read the transcript of their interview, make corrections if they noted transcription errors, remove any content that they did not feel comfortable with, and add additional information if they felt it was needed. Then, participants selected a pseudonym if they had not already done so. Some participants chose to select a pseudonym that was very meaningful to them. Particular attention was paid to ensuring the correct spelling of the pseudonym chosen. If that name had already been selected, I used Roman numerals to differentiate between the names. Therefore you will note in chapter four that there are participants named Alison and Alisen, and Josephine I and II. Participants responded very positively to this process with over half of the participants responding back with thanks for receiving the transcript and seven noting some form of change or addition for the purpose of clarification. None of the participants asked for removal of content from the transcripts.

Some participants expressed concern, either during the interview or at some time after when they contacted me again, that they might be recognized in the final reports of this study. Reassurance was always given that confidentiality and anonymity would be maintained. Many participants wanted to make sure that their story about a patient, family, or co-worker would not

be told as is. Also they sought reassurance that certain details would be changed in the final summaries, even though the study was conducted on a national level, and were assured that this would be done. Thus, re-storying the interview data into meta-narratives, instead of using verbatim personal stories, appears to be an important feature in this study.

After each participant had an opportunity to review their transcribed telephone interview, audiotapes were listened to and each transcript was re-read along with the field notes. Demographic data was compiled, from the first part of the interviews, into raw data charts and final product tables were created.

There was a large amount of data gathered from the 20 interviews. In total, 72 stories about everyday ethical issues were gathered from the participants and analyzed using narrative inquiry methods. Initially it was noted that there was some distinct variability in the roles of a CHN as described by the participants. Thus, I created a raw data chart with three sub-headings, which included public health nurses, home care nurses, and indirect care nurses. Into those three sub-headings, I noted the roles, responsibilities, and relationships as described by the participants. Also, I compiled data about the meaning of being a nurse in community care settings in order to provide a relational context and better understand why the CHNs continue to do this work.

With the three research questions in mind, notes were made about key everyday ethical issues, moral distress experiences, and educational needs from the second part of the interviews. This occurred by colour-coding sections of the transcripts according to these three areas of interest.

Next, the data was re-storied. As Creswell (2008) describes it, “restorying is the process in which the researcher gathers stories, analyzes them for key elements of the story (e.g., time,

place, plot, and scene), and then rewrites the story” (p. 519). Re-storying was done using a problem-solution-narrative structure (as described by Ollerenshaw, 1998), which facilitated organization of the stories into the following categories: setting (i.e., context, environment, and time), characters (i.e., people, personalities, and behaviours), actions (i.e., movements, thinking, and behaviours), problem (i.e., questions, phenomena, and situation), and resolution (i.e., answers, outcomes, and strategies). A raw data chart format was created, with the headings of setting, actions, problem, and resolution, to analyze each story from the interview data. From this chart, storied data were then put into categories that explored key ethical issues.

I struggled to decide on how to best categorize the data. I recognized that one of the most frequently used ethical theories is known as principlism (Beauchamp & Childress, 2001). I chose to analyze the data using principlism in order to provide a common and recognizable language for discussion. This allows for the unique qualities of ethical issues and moral distress experiences in community settings to be expressed and translated using the accepted terminology of biomedical ethics. Therefore I further categorized the data according to principlism, using the four headings of autonomy, beneficence, nonmaleficence, and justice.

Further to this, the data was then analyzed for common themes among the stories. After analyzing all 72 stories, six key themes were found. These included palliative/end-of-life care, refusal of care, manager/agency support, abuse, resources and services, and second-guessing. (see Appendix L: Summary of Key Ethical Issues, Categories, Themes, and Examples).

Data was collected for the evaluation of the e-module in phase two and compiled from the feedback of three participants. The findings from phase one and two are presented in full detail in chapter four.

Summary Audit Trail of Data Analysis

Eisenhart and Howe (1992) recommend that qualitative educational research should provide evidence that there is a good fit between the methods of the study and the research question(s), show that the methods have been effectively conducted, and verify the comprehensiveness of the work. With this in mind, I developed an audit trail of my raw data analysis strategies to make them open for peer examination (as suggested by Anfara, Brown, & Mangione, 2002). A summary audit trail clearly shows the inductive process (Patton, 1988) of beginning with the transcripts and concluding with application of theory, allowing categories and themes to emerge from the data. Through documentation, the transparent processes and procedures of data collection, analysis, and interpretation are outlined here:

- transcripts member-checked by participants;
- audiotapes, transcripts, and field texts reviewed;
- demographic data from the interviews compiled as descriptive statistics (for purposes of context);
- interview data analyzed for roles of CHNs, as described by participants, and three subheadings created to identify unique aspects of CHN practices;
- interview data analyzed, using colour-coding for the three research questions of the study, for key ethical issues, moral distress experiences, and educational needs;
- interview data re-storied (according to protocols identified by Creswell, 2008);
- chart of raw data created, from the interviews, with the headings of setting, characters, actions, problem, and resolution;

- summary chart created noting categories for key ethical issues, values at risk, themes developed from the common subjects noted in the stories, and specific examples (see Appendix L); and finally,
- nine meta-narratives created by re-writing (as per Ollerenshaw, 1998) the interview data from the summary chart format (see Appendix M).

In this study, a narrative inquiry approach was the compass that guided data collection as well as a method for interpretation and representation of the findings. In gathering the data, individual experiences of everyday ethical issues, moral distress, and educational needs were documented through the use of audio-recorded interviews, typed verbatim transcripts, and my field notes. Using narrative analysis, experiences were re-storied and multi-layered categories were exposed in an effort to distill meaning from the data and create meta-narratives for educational use. Thematic patterns emerged through analysis of individual and collective interview transcripts, the field notes, and research products created to document the audit trail.

Due to the reflexive nature of narrative inquiry, the iterative process of simultaneous data collection and data analysis lends further evidence of confirmability and internal coherence to this study. Upon review of the transcripts, during member-checking and also during evaluation of the e-module, participants confirmed and re-affirmed the accuracy of the data and interpretations as documented and were forthcoming with honest feedback.

Data Synthesis into Meta-Narratives

Synthesis of these stories occurred through narrative analysis. Narrative analysis invites the reader to be up-close and personal with the details of each story and hence the reader is more likely to gain understanding and insight (Bleakley, 2005). The creation of meta-narratives from the analyzed data was a responsive approach to participants' requests for a safe way to discuss

difficult ethical issues in community health nursing practice. Through narrative, a safe way to discuss experiences can be established by encouraging thinking with stories (Frank, 1995). The analyzed data from the participants' stories were combined and interwoven with each other, which allowed for important categories and themes to be highlighted while omitting identifying information for any particular person or place. Thus re-storying allowed for the protection of participants' identities and the anonymity of characters within their stories (e.g., colleagues, agencies, patients, families, and communities). This process resulted in the creation of meta-narratives that, according to Thorne, Reimer Kirkham, and O'Flynn-Magee (2004), convey important ideas and meanings in a new way.

The process of re-storying contributed to the methodological goals of this study because the resulting meta-narratives helped to more fully describe the complex phenomenon of everyday ethical issues and moral distress experiences for CHNs. The re-storied meta-narratives were originally planned for use and participant evaluation during the phase two workshop. Instead, three of the meta-narratives were used in the (modified phase two) e-module.

Taking direction from Connelly and Clandinin (2000), I endeavoured to think narratively and to create a three-dimensional (3D) space for the meta-narratives. Thus the meta-narratives were created with a depth of psychological fidelity in mind, representing much more than just a standard case study. This 3D space, referred to by Connelly and Clandinin as a common place, should be recognizable to the CHNs who read it. It should resonate with their community health nursing practice realities and past experiences. The criterion for this 3D space has its foundations in Dewey's (1938) work, which outlines four dimensions: interaction (i.e., personal, which includes feelings, hopes, desires, aesthetics, and morals); interpersonal (i.e., interpersonal relationships, as well as person to social environment interactions/relationships); temporal

continuity (i.e., past, present and future); and situational, which includes place or location (as cited in Connelly & Clandinin, 2000). Further to this, I developed meta-narratives that embedded not only individual experiences, but also included social, cultural and institutional aspects derived from the CHNs' stories (such as suggested by Clandinin and Rosiek, 2007). It was through the use of these approaches that I created multi-dimensional (3D) spaces, to encourage the reader to vicariously engage and reflect on the contextual landscape of the storied phenomenon (such as described by Silko, 1997).

Through the use of stories, narrative inquiry is also a method of personal and professional development (Conle, 2001). As Chase (2005) posits, "audiences whose members identify with the narrator's story might be moved by the researcher's interpretation to understand their [own] stories in new ways and to imagine how they could tell their stories differently" (p. 668). These meta-narratives were specifically designed for continuing professional education for Canadian nurses practicing in the community health sector. Each detail-rich meta-narrative explores a current, multi-faceted problem situation, encourages the reader to reflect on possible solutions, shares a final outcome, and encourages reflection on roles, responsibilities, relationships, and resources. Each meta-narrative is complex and unique, representing many layers of ethical principles and themes. Therefore, I developed a framework for conversations about each meta-narrative (see Appendix M). This framework was designed to encourage reflection about past practice experiences as well as to build capacity to explore new ways of approaching difficult everyday ethical issues and experiences of moral distress.

The creation of a series of meta-narratives is not meant to represent the entire ethical landscape of community health nursing practice in Canada. In telling and hearing these unique stories, there is the inherent risk that they will be taken out of context and thus entrap CHNs in

stereotypical behaviour and occurrences that are not reflective of the multi-faceted aspects of contemporary nursing practice in community health care settings. The meta-narratives presented in chapter five (also see Appendix M: Series of CHN Meta-Narratives) are the culmination of my analysis of data from the interviews with CHNs across Canada who shared their experiences of everyday ethical issues, moral distress, and educational needs in their community health nursing practice. These CHN meta-narratives are authentic representations of described experiences, although no single story encompasses the total reality of these experiences.

Dimensions of the Qualitative Data Gathered

To specifically address the dimensions of the data in this study, I employ the set of standards outlined by Richardson and St. Pierre (2005) for evaluating the quality of qualitative research. Therefore, this section addresses the need to plan for and deliver aesthetic merit, substantive contribution, reflexivity, and impact.

Aesthetic merit is the catalyst for intellectual and/or emotional engagement for the reader. The presentation of data in multi-layered categories and subsequently recurring themes (with participants' examples) allows for a broad perspective of the many key ethical issues and experiences of moral distress faced by CHNs in Canada. This contributes to a contextual understanding of the contemporary issues on micro-, meso-, and macro-levels of concern. Through narrative inquiry, credibility and believability for these issues is achieved through storytelling (Holstein & Gubrium, 2000; Lincoln, 2000).

The creative tasks, of retelling stories and exploring processes for analyzing the stories, need to invite discourse in order to further the dialectical process and ensure aesthetic merit. The re-storied meta-narratives should invite interpretive responses through their complexity and real-to-life details, as well as through strategically placed gaps that beg further questions and interest.

In the midst of these shared stories, the presence of untold versions and voices that whisper softly (or remain silent) may also be acknowledged. The aesthetic merit of the re-storied professional meta-narratives allows the reader to contemplate and reflect on their own experiences and practices, and orientates them towards further understanding.

Feedback received from study participants about the e-module indicated that a voice-over dialogue or presentation notes to accompany the power point slides could have enhanced the aesthetic merit of the three meta-narratives that were evaluated. These suggestions for modification will contribute to further development of the e-module outside of this dissertation process. The facilitation of reflexivity can be found in the aesthetic merit of the story and in the invitation to engage as both producer and product in the process of meaning making.

The presentation of data into categories and themes, re-storied meta-narratives, and an e-module makes a contribution to understanding the nature of the experiences of everyday ethical issues and moral distress for CHNs in Canada. According to Pinnegar and Daynes (2007), stories can unite members by making experiences public and by creating a repository of authentic evidence of the need for change which can be powerfully persuasive. The plausibility of the re-storied data allows for CHN audiences to say, this rings true for me, or I could see that happening (Connelly & Clandinin, 1990), while maintaining confidentiality and anonymity.

Narrative makes meaning out of past experiences and communicates emotions, thoughts, and interpretations (Chase, 2005). The process of reflexivity is an important component of qualitative research and narrative inquiry. The field notes from the individual telephone interviews are an example of how I was an active collaborator in the narrative inquiry process. These active written recordings composed during and after the interviews represent the reflexive expression of personal practical knowing through reconstruction and interpretation of the stories

(as described by Connelly & Clandinin, 1990; 1985). Reflexivity is also evident in my interpretations of the analyzed data, creation of meta-narratives, and discussions in chapter six. The dynamic and iterative processes of data collection and data analysis, for this study, required ongoing reflection as data was shared, read, transcribed, explored, re-read, and combined with new insights through connections with the academic literature.

Another important aspect of narrative inquiry is for the researcher to identify and acknowledge the role of their past experiences and the potential impact of that particular vantage point on the research. My frame of reference, as shared in chapter one, comes from being a registered nurse with a diverse professional background. Identifying my social locations, assumptions, and beliefs allowed for an opportunity to create balance in this research.

The reflexive process of re-storying (Creswell, 2008) in this study involved detailing each individual story and synthesizing those details into categories and recurring themes. The categories for key ethical issues were selected based on the common ethical language of principlism (Beauchamp & Childress, 2001). The common themes were not pre-defined before data analysis occurred, but rather emerged from the data itself. This process was detailed in a data analysis log summary to document my understanding of knowing and telling of the emerging meta-narratives. Initially, three original meta-narratives were created during the course of data collection for the study and reviewed by participants in the e-module. Later, I developed six additional CHN meta-narratives on the basis of further data analysis. All of the meta-narratives are presented in chapter five (also found in Appendix M: Series of CHN Meta-Narratives).

The meta-narratives produced in this research have the potential to make a contribution on more than one level, as the impact of stories, in general, occurs on many levels. First, the

telling of a story has an impact upon those who tell it. Second, the receiving of a story has an impact upon those who hear it. Third, there is an impact within the interaction of those telling and those receiving the story, the intertextuality (Kristeva, 1986) of the experience. Impact describes the cognitive, emotional, and/or physical results that occur and relates to the potential for change. Dewey (1938) described emotion as a force that “dyes what is selected with its color” (p. 42). In an effort to make sense of the role of impact, perhaps it could be considered that the impact of story is a force that dyes according to the experiences of those involved. Hearing, reviewing, and re-storying the participants’ stories affected me on cognitive, emotional, and physical levels. I felt dyed by the colours as I created the meta-narratives that emerged from the data.

Indicators of Trustworthiness

As Conle (2001) suggests, narrative researchers should be ready and able to answer challenging questions about the quality of the study itself, the capacity of the researcher to truthfully represent the findings and to appropriately locate oneself within that process to potentiate comprehensive construction of the resulting narratives. All researchers should speak to the trustworthiness of their data, findings, and interpretations. Trustworthiness in qualitative research can be established using the criteria of transferability, dependability, and confirmability (Anfara, Brown, & Mangione, 2002; Lincoln & Guba, 1985). Evidence of trustworthiness can be found in the logic of the analytic framework and in the audit trail of the inductive reasoning processes used for analyzing the data from the study. These factors are discussed in what follows.

Transferability speaks to the need for an accurate representation that gives an authentic voice through the interpretation of the data. Transferability recognizes the authority and power

inherent in the role of the researcher. As a narrative inquirer, I had privileged access to the stories of the CHNs who participated in this study. As the narrator of the findings and interpretations that followed the interviews, readers are asked to believe the claim, that I was truthful, sincere, and appropriate in the representation of the data, implicitly or explicitly, as it was perceived at the time of writing this work. Participants' acceptance of the transcripts, after member-checking, speaks to the accuracy of my work.

As a researcher gathering and analyzing data, I felt like an outsider among the sample of CHNs who participated in this study. However, as a registered nurse myself (with insider status by default), there was the feeling of a keen sense of responsibility to tell these stories in a way that is "clear enough to be understood" (Conle, 2001, p. 23) by other outsiders. Some aspects of the stories depict details about community health nursing that could be told to almost anyone and perhaps anywhere. These are the safe parts of the stories. Other aspects of these stories were told to me because I was a stranger, partly insider-partly outsider, and a faceless voice over the telephone. Perhaps it was an opportunity to quietly speak of things that may be viewed as unacceptable or inappropriate, but none-the-less tragically real and maybe even common in contemporary community health nursing in Canada. As a responsible researcher, it is one thing to clearly state the facts. However, it is also critical to provide an appropriate context in the telling of stories in order to be accurate, authentic, and to preserve the relational fidelity inherent in the researcher-participant relationship. The endeavour was to conduct respectful research such as Susan Tilley (1998) described, "research sensitive to individual participants and research contexts, with both researcher and participants benefitting" (p. 317).

According to Anfara, Brown, and Magione (2002), both the purpose of the research and the research questions are the scaffolding and the cornerstones for analysis and interpretation of

data and impact the dependability or meaningfulness of the findings. Positive feedback received from participants on the e-module, which included three meta-narratives, contributes to the dependability of this research and highlights the meaningfulness of the educational intervention that was created. Also, the foundations of the study's purpose and research questions guided the analysis of the data, presentation of the findings, and discussions about interpretations. Without this solid scaffolding, it would have been easy to become lost among the extensive data from this study, including the 72 stories presented by participants. Staying true to these cornerstones allowed for greater dependability in this research.

Indicators of Rigor

According to criteria for rigor in good narrative inquiry, Clandinin and Connelly (2000) describe a need for plausibility, invitation, transferability (Lincoln & Guba, 1985), and verisimilitude. This translates to a need for authenticity which invites engagement and participation through the use of rich descriptions and a sense of truthfulness gained by using the participants' own words through the use of quotes. Research processes should be systematically detailed (i.e., procedures for analysis) and reliable, and show evidence of a self-reflective lens throughout (Clandinin & Connelly, 2000).

As the researcher of this study, all aspects of the research process were conducted with regular contact with my doctoral supervisor. Doctoral committee members provided feedback, insight, and approval of the original proposal and the subsequent drafts of this dissertation. The strategies for purposeful sampling, data collection (i.e., audio-recording, verbatim transcriptions, field notes, e-module evaluations), and data analysis (i.e., completing the analysis of narratives, as well as narrative analysis) are supported with additional documentation (see appendices M to P). Through member-checking by the participants (i.e., review of written verbatim transcripts,

feedback on e-module), transparency and rigor are better assured in the findings and interpretations presented in chapter six.

Limitations and Delimitations

There are cogent challenges inherent to some degree in any research study, such as potential imperfections in the study design and the subconscious filtering of data from the researcher's point of view. Understanding of the data from this study is situated in the context of contemporary CHN practice in Canada and based on the storied and re-storied experiences of everyday ethical issues and moral distress experiences as described by the study participants and me. Some limitations of this study are reflective of my assumptions and social locations as previously identified in chapter one.

Upon reflection, the inclusion criteria for this study may have been too restrictive as it indicated the participation of nurses who were currently employed in a community health care setting. This inadvertently excluded CHNs who were recently retired or who had left a nursing position in a community health care setting (potentially due to moral distress experiences).

The original study design of face-to-face individual interviews and a local sample selection contributed to difficulties with recruitment for both phase one (interviews) and phase two (local workshop). This may have been due to concerns about privacy and/or confidentiality. With the subsequent amendments to the study design that extended the study nationally using telephone interviews, recruitment efforts yielded an overwhelming response from CHNs across Canada (81 nurses in total). Some of the ethical issues and experiences of moral distress revealed sensitive topic areas. Many participants sought reassurance from me that their name, city, agency, or particular details of their story would be protected. An example of this can be found in my conversations with Vicky,

Can I ask you a question, Kristen?...In terms of identifiers, I'm just asking that you don't put that it's agency xyz...As long as I'm not identified or my workplace not identified. Maybe you could call it like, I don't know, workplace 1 or workplace 2, or whatever it is that you have to identify it.

The desire for complete anonymity should be an important consideration in the planning for future studies on this topic. The choice that I made to not tell participant stories verbatim, but rather to create meta-narratives could be seen as a limitation of this study. Although, I see the use of meta-narratives as an added strength to this work because it created a safe way to discuss difficult ethical and moral issues in nursing practice.

These reflections about the indicators of quality, trustworthiness, and rigor for this qualitative data, describe the processes that I designed and participated in for this study. This chapter on methodology and methods represents the scaffolding beneath the interpretations of the research findings. Chapter four now follows with a presentation of the analyzed data from phase one and two.

Chapter Four: Findings

To begin, this quote from Wiszowaty (2009) brings attention to important aspects of the findings that will follow in this chapter. Specifically, concepts such as community, collaboration, communication, and the power of story come to mind.

But she reminded me of the traditional African concept of ubuntu:

I am because we are.

All humanity is interconnected, and only as a whole do we grow stronger.

We must continue to listen: to the individuals who we meet along the way, to the stories of those who go before us, to those who wish to come after us. (p. 248)

The stories shared by the CHNs in this study represent their experiences of everyday ethical issues and moral distress, and their thoughts about educational needs. I now present the findings from phases one and two. Participant introductions, the roles of CHNs, key ethical issues, themes, and moral distress experiences will be explored here. The participants' voices are heard in the analyses of the thematic findings and are supported by direct quotes from the CHNs. These findings invite reflection on the title of this study, "What guides us here?" This question will be answered in three ways: 1) through a description of the roles, responsibilities, and relationships of the CHNs to identify the meaning of "us"; 2) through the exploration of what "here" may look like in terms of key ethical issues and themes and moral distress experiences in community settings; and finally, 3) through the findings that identify the needs for education, support and resources to determine "what guides us" and what can better guide "us" (CHNs facing ethical challenges in their everyday practice and experiences of moral distress).

The final research products from the data collection and data analysis were designed in response to the three research questions for this study. This resulted in the following documents as products of this research:

- 1) a summary of key ethical issues into categories and recurring themes, that emerged from the data, supported by CHN practice examples from the phase one interviews, using participant-chosen pseudonyms (Appendix L: Summary of Key Ethical Issues, Categories, Themes, and Examples);
- 2) a series of nine meta-narratives specific to everyday ethical issues and experiences of moral distress for CHNs in Canada for educational use (Appendix M: Series of CHN Professional Meta-Narratives); and
- 3) a self-directed e-learning module (e-module) for ongoing ethics education with study participants' feedback (Appendix J: Self-Directed E-Learning Module and Appendix P: Summary of Participant Feedback on E-Module).

Analyzed Demographic Data

From the period of December 2011 until the study closed for phase one recruitment on May 30, 2012, a total of 64 potential participants expressed interest in participating. Initially, recruitment for phase one was local and then it was extended nationally across Canada in the spring of 2012. I received responses from potential participants in Newfoundland, Nova Scotia, New Brunswick, Ontario, Saskatchewan, Alberta, British Columbia, Nunavut, and the Yukon. Not everyone who was interested in the study was eligible to participate or available in the time frame set out for this study.

Participants interviewed during phase one of this study included 20 registered nurses from four provinces across Canada. Using their self-selected pseudonyms, the CHNs from this study are introduced in Table 4.0. These are the CHNs who shared their stories.

Table 4.0

Introduction of Study Participants

Pseudonym of Participant	Total Years in Community Setting/ Total Years in Nursing Practice	Province
Ann	7 years community/7 years nursing	Ontario
Tammy	3.5 years community/14 years nursing	Ontario
Janet	27 years community/36 years nursing	Ontario
Josephine I	18 years community/36 years nursing	Ontario
Alison	14 years community/18 years nursing	Ontario
Kathleen	25 years community/26 years nursing	Ontario
Christine	11 years community/12 years nursing	Ontario
May	25 years community/30 years in nursing	Ontario
Dorsa	30 years community/34 years nursing	Ontario
Glen	14 years community/14 years nursing	Ontario
Esther	22.5 years community/25 years nursing	Ontario
Vicky	5 years community/ 7 years nursing	Ontario
Alisen	30 years community/32 years in nursing	British Columbia
Sarah	15 years community/16 years nursing	Ontario
Elizabeth	25 years community/29 years nursing	Ontario
Yvonne	35 years community/42 years nursing	Alberta
Josephine II	23 years community/23 years nursing	Ontario
Valerie	8 years community/37 years nursing	Ontario
Rachelle	0.5 years community/ 0.5 years nursing	Saskatchewan
Mary	37 years community/37 years nursing	Ontario

Participant demographics for age, gender, employment status, number of years in professional nursing practice, and location are found in Table 4.1. Summarized briefly here, the table indicates that the average participant for this study was a female registered nurse in the 40 to 50-year-old age category with full-time employment status, with over 30 years of nursing experience, and who is currently working in a community health care setting in Ontario. At least half of the interviews described CHN experiences that took place in rural Canadian settings.

Table 4.1

Participant Demographics

Demographic Characteristics	# of Study Participants	% of Total Study Participants
Age		
20-30	1	5%
30-40	5	25%
40-50	6	30%
50-60	5	25%
60-70	3	15%
Gender		
Female	19	95%
Male	1	5%
Employment Status		
Full time	17	85%
Part time	1	5%
Casual (may include multiple positions)	2	10%
Years in Practice		
6 months-10 years	3	15%
11-20 years	5	25%

21-30 years	4	20%
31-40 years	7	35%
41-50 years	1	5%
Location-		
Province/Rural or Non-Rural		
Ontario- Rural	7	35%
Ontario- Non-rural	8	40%
Ontario- Both (rural AND non-rural)	2	10%
British Columbia-Rural	1	5%
Saskatchewan-Rural	1	5%
Alberta- Rural	1	5%

Nursing specializations in the following areas were described by the participants, with some nurses having more than one specialty area: palliative care (n=5), older adults (n=2), maternal-infant health (n=4), children (n=4), youth/teens (n=1), immunization/infectious disease (n=3), vulnerable populations (n=1), oncology (n=1), and education (n=2).

Participants' religious affiliation was asked about as part of the demographics because it has been shown in the literature to have correlations with ethical decision making and moral distress, particularly in the context of coping strategies (such as Cavalier, Daly, Dowling, & Montgomery, 2010; Elpern, Covert, & Kleinpell, 2005; Maluwa, Andre, Ndebele, & Chlemba, 2012). Slightly over half (approximately 55%) of the study participants said they wanted to identify their religious affiliation. These were noted using the terminology that was used by the participants. Religious affiliations included Catholic, Protestant Christian, Roman Catholic, Catholic-not practicing, Catholic Christian, Christian, Baha'i, and United.

To determine educational backgrounds, I asked the participants about their entry-level nursing education, their highest level of education, and their history of previous education (in

any form) on everyday ethical issues and ethics, ethical decision making, and moral distress. All of the participants in this study were registered nurses (RNs). Although registered practical nurses (RPNs, which is the professional designation in Ontario) were part of the inclusion criteria for this study, none of the study participants currently holds that designation. One participant had a college diploma as a licensed practical nurse (LPN, which is the professional designation in British Columbia). However, she was educated and employed as an RN at the time of this study. Of the 20 participants in this study, two participants had an entry-level nursing education with a college diploma only (both participants were currently working on obtaining a university degree), five participants had both a college diploma and a university degree, 13 participants had an entry-level nursing education with a university degree and two of those participants also had a master's degree (also three master's degrees were in progress at the time of this study). Table 4.2 provides a summary of participants' educational backgrounds.

Table 4.2

Summary of Participants' Educational Backgrounds

Source of Education	RN Education	Ethics Education	Ethical Decision Making Education	Moral Distress Education
College Diploma	7	0	0	0
University Undergraduate Degree	18	9	5	1
University Graduate Degree	2	3	1	1
Continuing Education (e.g., workshops, conferences, and in-services)	0	11	4	5
Informal discussions (e.g., critical thinking with colleagues, and team meetings)	0	1	2	0
Unknown source	0	1	3	0

When asking about their knowledge and previous educational experiences on ethics, I posed this question to study participants "Have you ever received previous education (in any

form) on everyday ethical issues, ethical decision making, and/or moral distress?” Just under half (45%; n=9) of the participants stated that they had received ethics education during their undergraduate nursing degree, 15% (n=3) in their graduate education, 55% (n=11) through continuing education (e.g., conferences, workshops, in-services), and 10% (n=2) through informal discussions or from an unknown source (e.g., participants couldn’t recall where or when, but believed that they had received training in this area). Specific examples of ethics education that stood out in the participants’ minds when asked included College of Nurses of Ontario (CNO) training in ethics (n=3), a de Sousa Institute advanced care planning (ACP) course, a grief and loss workshop, a workshop on ethics by Dr. Paddy Rodney, a Bridges out of Poverty workshop, and palliative care conferences. Three study participants stated no, they had never received any education on ethics or everyday ethical issues.

In regards to education on ethical decision making, 25% (n=5) of participants recalled receiving training in their undergraduate nursing program, only 5% (n=1) received training in a graduate program, 20% (n=4) recalled training in ethical decision making through continuing education opportunities, and 25% (n=5) believed their training was from informal discussions or unknown sources. One participant noted that training in ethical decision making was received through the CNO. Another participant stated that her workplace had an ethical framework, although she did not use it due to time constraints.

When asked about previous education on moral distress, 65% of study participants (n=13) felt that this was a fairly new term and stated no when asked if they had training in this area. One participant who had graduated less than one year ago indicated receiving education on moral distress in an undergraduate nursing program. Another participant stated training was received on moral distress in a graduate program. Specific examples of topics or situations which

included moral distress education were palliative care conferences, vicarious trauma workshops, a de Sousa Institute training session on nursing burnout, national nursing conferences, workshops on compassion fatigue, training in trauma counselling, and in-services on caring for the caregiver (specifically noted was work done by Dr. Mary Vachon on caregiver fatigue). One participant spoke of first learning about moral distress, although did not feel that this qualified as training, from informal discussions with a friend working on a graduate degree on the topic of vicarious trauma.

Phase One Findings

For the second part of the semi-structured interviews, conversations between each study participant were guided by a series of quotes. I provided the questions and quotes to participants before the interview in response to a request made by the first participant. She wanted to know what I would be asking in order to have time in advance to think and reflect on possible responses and experiences. I continued this practice of sending the questions and quotes in advance of the actual interview with all 19 subsequent participants. However, this structure (see Appendix I: Semi-Structured Interview Guidelines) was only a guideline and the direction of the dialogue was always unique to each narrative interview experience.

Roles of CHNs

To begin the interview dialogue with each participant I read the first quote, “often we find out what we think by listening to what we say. Telling stories helps us to find out who we are” (Tirrell, 1999, p. 117). Then I asked the participant to describe their role as a CHN to me, to help me to understand the roles and responsibilities of the CHNs and how they viewed themselves in relation to others. Here, I will use quotes from the participants to substantiate the content of my analysis, and so that the participants’ voices can be heard in this presentation of the findings.

The first quote I presented to the participants was purposefully chosen to encourage an open-ended discussion. I did not want to make any assumptions about the roles of the CHNs whom I interviewed. With a genuine sense of inquiry, I wanted to gain an understanding about each participant and their experiences. When Alison responded to the first question, she said, “I think often times community nurses are overlooked. I think that people don’t realize what they do... it’s still hard to find that fit where you are in nursing because people don’t see that as nursing.”

I have reflected on Alison’s comment and on the definition of the roles of a CHN, according to the Community Health Nurses of Canada (2011) that I cited in chapter one. Given such a broad context, I wondered about the gap in knowledge about what a CHN does/is, in addition to the goals of this study to identify key ethical issues and recurring themes within this area of nursing practice. I decided that I could not write about exploring the ethical issues without first placing them within the context of the roles of a CHN, as told to me by the participants.

Three broad professional categories emerged from the CHNs descriptions of their roles: 1) public health nurses (PHNs); 2) home care nurses; and 3) in-direct care nurses (i.e., case managers, care coordinators, nurse consultants). Common threads among the various roles of the CHNs included health promotion, illness and injury prevention (safety), and attention to risk factors related to the social determinants of health, especially among vulnerable populations.

Public health nurses. A total of 11 public health nurses (PHNs) participated in interviews. These PHNs described that their diverse roles have changed significantly over the years, from the tea-drinking images of nurses attending to new mothers for well-baby visits from days gone by, to being infection control experts in the wake of severe acute respiratory syndrome

(SARS) and global flu pandemics. They noted that their work is mandated by the provincial government and encompasses the lifespan from babies in the womb to the frail elderly. PHNs who had worked in public health settings for decades told me about fulfilling a more generalist role early in their careers. All of the PHNs told me that the contemporary role of a PHN has become more specific and specialized. These nurses described their practice to me as including specialty areas such as, infectious disease prevention and management, prenatal and postnatal support and follow-up, falls and injury prevention, promotion of early childhood development, health promotion of children and youth in schools, sexual health services, and other issue-specific activities (see Appendix Q: Summary of PHNs' Examples of Roles and Responsibilities). Roles and responsibilities for these PHNs can be distilled into two major components. One component of PHN practice was described as an educator and mentor. Another component was one of leadership. Both of these roles, educator/mentor and leader, involved a myriad of relational interconnections. These PHNs defined their colleagues and key community partners as being nursing assistants, health promoters, nutritionists and registered dietitians, dental staff (i.e., dental hygienists, dental assistants, dental health promoters), speech pathologists, audiologists, epidemiologists, occupational therapists, health inspectors, family visitors, lactation consultants, program support staff, midwives, birthing attendants, social services staff (i.e., welfare office, children's aid/child welfare), family physicians, staff at homeless shelters and second-stage housing, and community counsellors/social workers.

The roles, responsibilities, and relationships described to me by these PHN participants are only a snapshot of the complexity and diversity of contemporary nursing practice in this specialty area in the community health context. It would not be hard to imagine getting lost in the

ethical landscape of a PHN. There is so much variability in the needs for professional expertise and continuing education.

Home care nurses. The second category is based on descriptions of professional roles as told to me by three nurses who identified themselves as home care nurses. They also described that their roles have changed significantly over the years since they have been in practice. In Ontario, home care nursing work is overseen by Community Care Access Centres (CCACs) and mandated by the Ministry of Health and Long Term Care. As health care is a matter determined by the province in most cases, the governing bodies for community health care services are different in each Canadian province. These home care nurses spoke about their work responsibilities and its unpredictable nature (meaning that anything and everything can and does happen). They also shared with me that home care nursing is rewarding and important work. Tammy described home care nursing in this way,

I think that it really gives you the opportunity to be able to go out there and use your best clinical judgment and feel confident and reassured, and establish a good relationship with people that I never felt that I was able to get in the hospital. And as I said, in my frontline experience, the nursing community is limited by just work as a healthcare aide, as a nurse. So I understand how you develop that relationship with people and I think that that teaches confidence. We've had a lot of people come to us and say, "Oh, I want to come and work in the community because I find the hospital way too stressful" and then they last the least, because they didn't realize the amount of competencies and strong clinical judgment because you're out there on your own doing it. So the reward on the other side is because you develop relationships and it actually gets you to think about all you've done.

As acute care settings continue to struggle with an overflow of patients, community health care settings are responding to more acute and diverse issues than ever before, thus requiring CHNs to have strong decision-making and problem-solving capacities. These home care nurses described their nursing practice as including the specialty areas of palliative care/end-of-life care and older adults. They spoke of participating in organizational clinical leadership teams; designing, implementing, and evaluating education and services; ensuring the right provider and right level of services for clients; and requiring a significant amount of documentation requirements (see Appendix R for specific examples of the roles and responsibilities). Similarly to the PHNs, the home care nurses noted important relationships with their colleagues and key community partners. These included connections with nurse/physician teams, personal support staff/health care aides, nursing assistants/licenced practical nurses/registered practical nurses, counsellors and social workers, volunteers, nurse practitioners, case managers and care coordinators from CCAC, acute care (i.e., for discharges and admissions to emergency) partnerships, street nurses, geriatric teams, and other community resources.

This is an impressive list, which details descriptions of the roles, responsibilities, and relationships of just three home care nurses in community care settings. All three of these nurses described the bulk of their nursing practice in home care as palliative/end-of-life care. Their client caseloads ranged from 1-4 to 8-9 clients per day. In understanding the workload demands on a CHN providing home care, one must take into consideration the geography of the practice setting (i.e., urban versus rural or remote settings) and that depending on the location of practice, travel time (as well as weather conditions) will influence the number of patients it might be possible to see. These are contextual factors that nurses in acute care do not grapple with and that I learned about through my interview conversations. These CHNs in home care explained that if

they had clients with medical or other health issues (i.e., non-palliative care requirements), their caseloads would change to include up to 13 patients per day. Ann described that she is paid per visit. For her, one visit equals exactly 63 minutes, and this includes driving time, all nursing care, and charting. CHNs in rural and remote practice areas may find that travel time is a significant factor, as Janet described travelling, astoundingly, over 300 kilometers in one day.

Indirect care nurses. The third and final category identifies roles of CHNs who are not directly involved with public health or home care nursing, although they may provide direct care to clients in some instances. For this third category, I included case managers and care coordinators from Community Care Access Centres (CCACs) and nurse consultants working for government agencies. I spoke to six nurses who told me about this area of community health nursing practice. These nurses described being responsible for client caseloads in the hundreds to thousands per nurse over a specific time period, ranging from weeks to years. Many of the client-nurse relationships were time limited (e.g., clients on a case load for one year or less). As case managers and care coordinators these nurses worked with home care nurses to determine individual care needs for clients, address advocacy issues, set priorities, respond to concerns, and identify and facilitate options within the community for the delivery of services (within the protocols and guidelines set out by the provincial government agencies overseeing community health nursing). These indirect care nurses described unique roles and responsibilities that required balancing priorities including supporting staff, management, families, clients, and community partners and trying to bridge the gaps in services. Vicky describes this tension in her comment, “how do you find that happy medium, making families happy; but at the same time staying within a budget?” Vicky also spoke of the multi-factorial, competing considerations she is forced to weigh in her nursing practice,

I'm torn between keeping within the guidelines and framework that I'm given because I'm also fiscally responsible for making sure I don't go over the budget. Because at the end of the day, if we go over the budget then we won't have any money for the resources, you know, or for the employees. So by the time I get to 67 now, I don't want to be living under the bridge. So we have to be like morally responsible and fiscally responsible to make sure that we don't waste the taxpayers' dollars. But at the same time we want to keep the patients well and happy, right, and stay out of the media and the lawsuits.

These descriptions of the dynamic roles of CHNs in public health nursing, home care nursing, and indirect care nursing roles are far from exhaustive and represent only a small sample. During these interviews, I heard powerful stories about the value of community, collaboration, and communication. There were stories about nurses getting to know clients and families across generations. Valerie describes the experience of being a CHN using these words, "we find ourselves wanting to tuck people into safe places, you know, but it's just so hard."

Nursing in Community Health Care Settings

One myth about community health nursing is that it is easy. It is the place where nurses go who can't make it in the hospital setting or the place where nurses go to wait for retirement. This myth was identified and addressed many times during the interviews. One example of this is described by Alison, who is a PHN and was speaking of community health nursing generally,

We had somebody saying something again about – oh, well, you get paid well for those cushy jobs. And one of my colleagues really took it to heart and she said, "I was really upset by this." And I said, "I actually take that as a compliment." And she said, "What do you mean?" And I said, "When somebody says you have a cushy job, it's because they

don't see the hard work that's going into it. So you are doing a damned fine job because they think it's easy.”

The variable roles of CHNs as described above bring important and unique information to the academic community particularly for evaluating the appropriateness of comparisons made across nursing practice settings. In an effort to provide a more balanced understanding of CHN practice realities, I also note that there were many positive stories told to me during the interviews. In fact, after the first two interviews, I began to add a final question to the end of each conversation. I asked participants, “why do you continue to do it?” This was an effort to end each interview on a positive note, as well as to gain insight into what keeps individual nurses in the community health care sector working so hard, with so little time, resources, and support. Josephine I described her work in this way,

So doing the job I do has really enriched my life. I think it's made me a better person. I can appreciate it and understand what people are going through, so that's been really positive. I love that about my work.

Some participants spoke of their desire to create positive changes and to make a difference. They described their work in community health nursing practice as an incredibly valuable privilege. Alison described her community health nursing practice with this powerful explanation,

I can honestly say there has not been a day that I have ever woken up and not wanted to go to work...[it's] about the fact that I do the smallest thing; and the amount of gratitude that I see...how honoured I am to be brought into someone's house. Sometimes it's in the best circumstances of their life and sometimes it's in the worst; and they still want me as a part of their life. You know, I don't know if there [are] words to describe that.

Nursing in community health care settings was described to me as profoundly important and exciting. The positive relational aspects of practice were noted not only with clients and families, but also with the other CHNs on their team. Alison describes her colleagues in this way, referring to her fellow nurses,

They are amazing and that's why I do this job; because I don't think you'll find a more dedicated, passionate group of people. And I know people say that and it sounds trite. But I don't believe you will. Community health nurses are amazing. And you're right. We're not there for the notoriety or – wow, you're so great. We're just there because we are.

Some CHNs spoke of their work in community health care settings in terms of a vocation or a gift, and described how they felt about nursing using the word love. Many CHNs said they loved their jobs, the clients and the families (who sometimes became like family to them), and often their nurse colleagues. Here, Josephine II describes her work as a CHN,

I just love working with this population. It's so different working with the population in the community than in the hospital. It's the same people. You know, the structure was so different. So that's my own personal reason for not...I was offered...I was lucky...when I graduated. I was offered two jobs the same day. One was for public health and one was for [a] hospital. And I bee-lined [for] the health unit and I've never looked back. I just always knew that that was where I was meant to work.

Personal and professional boundaries were found to be porous in some of the stories that were shared. As much as clients benefitted from good nursing care, nurses described a mutual satisfaction from their interactions with clients and families. The connections between self, clients and families, other nurses and members of a community health care team, or with a

community itself, as described by participants, makes it clear that being a CHN was and is more than just a job to the participants in this study. Thus any expectation to take a dis-integrated approach to nursing practice, where professionals are told to separate themselves from the work that they do, seems counter-intuitive for community health nursing practice. When I asked Elizabeth the question, “why do you do it?” she had to pause before responding to me with this statement,

I guess because I’m going to become tearful and I’m sorry. I love my community. I was born and raised here and I want them to be as healthy as they can be and, you know, to reach their greatest potential.

In order for CHNs to be supported to reach their greatest potential, a better understanding of the key ethical issues and experiences of moral distress specific to community health care settings needs to be explored. For meaningful changes to occur there must be a concerted effort to document and name practice realities using terms and language that will make sense across health care sectors, but can be uniquely situated in the context of community health care settings in particular. Also, suggested strategies for positive change must create circumstances for collaboration and encourage community health care practitioners to work together constructively. As Alison recommends, “we as community nurses really need to promote our other community nurses and to say, we are here. We are strong. And we do make a difference.” Thus the question, “what guides us here?” is to some extent being asked and answered by the CHNs themselves. This section on three broad professional categories for CHNs contributes to a better understanding of the diverse roles, responsibilities, and relationships that make up the “us” in the question, “what guides us here?” Next, in the context of key ethical issues and themes about experiences of everyday ethical issues and moral distress in community health care

settings, an understanding about the ethical landscape for CHNs will help to clarify what the “here” may consist of in the question “what guides us here?”

Everyday Ethical Issues

In order to address the first research question, “what are the key ethical issues and themes identified by CHNs’?”, I analyzed the data from participants’ interviews to discover emergent data-based categories and then common themes. The 20 participants in this study described approximately 72 examples of experiences of everyday ethical issues in their nursing practice. Following the first question (about their role as a CHN), I asked each participant to share a story about a common everyday ethical issue in their community health nursing practice. Our conversations, for the most part, were guided by this quote by Austin (2007), “It is in asking good questions, not in having all the answers where morality resides. *Being ethical* is never something one possesses. It is the recognition of the messy and expanding interdependence of decisions, interests, and persons” (p. 85, emphasis in original).

Within the messy interdependence of the stories of everyday ethical issues shared by the CHNs, I analyzed the data into four categories in order to better explore and then describe the nature of the ethical issues. The categories, as previously mentioned, were based on the bioethical principles and included autonomy, beneficence, nonmaleficence, and justice. It is important to be mindful that none of the categories are mutually exclusive of each other, and that the stories were categorized according to their key issue even if the story contained details of some or all of the other principles. The four categories will now be explored, with attention paid to factors that may have contributed to moral distress experiences.

Autonomy. The first bioethical principle, the category of respect for autonomy, was found in this study in stories that had, at the forefront, issues of individual rights and personal

decision making based on a client's values, beliefs, or wishes, independence or freedom.

Upholding respect for autonomy traditionally becomes challenging when a person makes a risky choice or someone makes a choice on another person's behalf. Often closely related to stories with autonomy as the key issue, was the bioethical principle of justice.

Justice. The second principle of justice was noted in CHNs' stories that described elements of equity, fairness, equal distribution of benefits and burdens, and the appropriate use of resources. Upholding justice traditionally becomes challenging when trying to balance respect for the rights of the individual and respect for the rights of the community (i.e., an individual's needs or wants versus the greater good). While the CHN's duty to the client is the highest priority, duties to client's families, obligations to members of the health care team, agency policy and procedure, and regulations within the health care system can all contribute to ethical issues and to challenging decision making related to upholding the principle of justice. Autonomy and justice are both duty-based ethical principles that speak to the professional, ethical obligations of the CHN to respect and protect these rights.

Beneficence. The third principle of beneficence emerged in this study from stories with conflicts between the CHN's perception, and the client, family, manager, or agency's perceptions of what could be considered good. Providing good care for a client is an important nursing value and professional obligation. However, defining what is "good" is often situational and highly subjective. The provision of care that is beneficial to a client can occur in a variety of ways. Beneficence may include providing information or assistance, performing an action, or offering a service or resource that is perceived to contribute to a positive outcome or benefit. Data that was analyzed into the category of beneficence related to stories of ethical issues where the actions to

promote wellbeing or provide support were not agreed upon between the CHN and the other individuals involved.

Nonmaleficence. The fourth and final principle of nonmaleficence in this study was found in stories that describe not contributing to harm or avoiding harm, whether intentional or not, foreseeable, or unexpected. The medical phrase “first do no harm” speaks to another important nursing value and professional obligation. While the definition of what is harmful to a client can be debated, the stories analyzed into the category of nonmaleficence represented situations where the CHN and the client, family, manager, or agency did not agree on what was harmful. Harm to a client can occur through acts of commission or omission. The desire to protect clients from the risks of potential harm or prevent actual harm is present across the stories in this category.

These final two categories of bioethical principles, beneficence and nonmaleficence, are outcome-based ethical principles that speak to the professional, ethical obligations of CHNs to use their knowledge, skills, and behaviour towards creating the best possible outcomes. Beneficence and nonmaleficence can arguably be deemed to be two sides of the same coin and many of the stories presented in these categories could likely be analyzed through either category as the professional roles and responsibilities of ethical nursing practice require that every effort must be made to balance the benefits and burdens of care.

The four categories of bioethical principles, describing key everyday ethical issues identified by CHNs when asked to discuss their experiences within the context of their nursing practice, are further explored in chapter five with the examples of three meta-narratives. However, before proceeding it is necessary to answer the first research question (“what are the

key ethical issues and themes identified by CHNs?") more fully and identify the common themes that emerged from the data.

One participant, Josephine II, described everyday ethical issues and ethical decision making in community health nursing as "very muddy." I believe that she was referring to the complexity of the issues that CHNs often face. The complexity of everyday ethical issues in community health nursing will now be explored through common themes found in the analyzed data.

From the 72 stories shared by the CHNs, I identified six themes from the CHNs' described experiences of ethical issues and moral distress that repeated across one or more interviews. The themes were: 1) palliative/end-of-life care; 2) refusal of care; 3) manager/agency support; 4) abuse; 5) resources and services; and 6) second-guessing. For examples of each of these themes and their relationships to the four categories of bioethical principles, see Table 4.3. These themes are further synthesized and explored in chapter five with meta-narratives.

Table 4.3

Specific Examples of Categories of Key Ethical Issues and Themes

	<i>Key Ethical Issue of:</i> Autonomy	<i>Key Ethical Issue of:</i> Beneficence	<i>Key Ethical Issue of:</i> Nonmaleficence	<i>Key Ethical Issue of:</i> Justice
<i>Theme 1:</i> Palliative/End-of-Life-Care	Advanced care planning at end-of-life	Palliative client comes to town on vacation, communication is poor about care needs, client suffers	Client asks for palliative sedation	Client or family not informed of terminal diagnosis
<i>Theme 2:</i> Refusal of Care	Client's refusal of vaccination or refusal of vaccination for children	Horse and buggy community refusing prenatal care services	Elderly client refuses narcotic pain medication, afraid to be targeted and robbed	Client 'mysteriously' discharged from home care nursing services when agency investigated level of care required
<i>Theme 3:</i> Manager/Agency Support	Nurses cannot provide input to improve or change practice	Nurses told what to say/not say to clients by agency	Nurse not provided with support for grief/loss experience	Behaviour of health care team member not being addressed
<i>Theme 4:</i> Abuse	Palliative client in abusive marriage, chooses to stay, isn't always allowed to answer the phone to confirm nursing visit, at risk of having services cut	Suspected abuse, child protection services not always helpful	Client being bullied by neighbour in social housing, housing services not responsive	Elderly client, family physician not taking new, acute symptoms seriously, claims "I can't fix old"

	off due to agency's policy			
<i>Theme 5:</i> Resources and Services	Elderly client chooses to live at home, maxed out on services, cognitive decline, no family, high risk for falls, ER visits 3-5x per week, will end up in hospital and eventually long term care	Client receiving repeated treatments at clinic for sexually transmitted infections, nurse knows he is married, he refuses to use condoms	Family struggling to care for elderly client at home, no beds available in long term care facility	Client or family refuses to take on care, feels they are owed full range of home care nursing services
<i>Theme 6:</i> Second-Guessing	Client refuses to see nurse because she feels that she has not met/lived up to the nurse's expectations, client making poor life choices (i.e., dropping out of school)	Nurse had court experience that made her question 'good care'	Clients and families with complex health care and social welfare needs beyond the scope of the agency	Challenge of creating health promotion campaigns where the target industry is the town's livelihood (i.e., gambling, alcohol, tobacco)

Palliative/end-of-life care. From my analysis, examples of specific ethical issues for CHNs within the theme of palliative/end-of-life care included: euthanasia, advanced care planning, feeding/starvation, confidentiality and communication (e.g., client doesn't want family to know information or vice versa), palliative sedation, unmet care needs, supporting client autonomy (especially if perceived as increasing suffering), unrealistic expectations from clients or family, poor collaboration between agencies and services, and setting professional boundaries (particularly in rural or remote practice settings). Experiences of moral distress in these stories were related to not being able to discuss or carry out a client's wishes at end of life, circumstances which limited open, honest communication and goal setting, questioning adequate provision of good nursing care (e.g., pain and symptom management), care decisions perceived to be not in the client's best interest or against a client's previously stated request, and were particularly difficult if the client died before a decision could be made about the ethical issue. Sources of initial moral distress were found at macro- (i.e., health care system, organization/agencies, resources), meso- (i.e., client, family, health care team), and micro- (i.e., individual or self) levels. Fifteen of the 72 stories shared (approximately 21%) related to the theme of palliative/end-of-life care.

Refusal of care. The second theme, refusal of care, was described with examples such as refusal of vaccination (e.g., for self or on a minor child's behalf), refusal or termination of home care nursing services, refusal based on cultural or religious choices which place clients (especially minor children, pregnant women, and unborn babies) at high risk for injury or illness, refusal of treatment based on client's fears, refusal due to perceived lack of privacy or confidentiality of services (especially in rural or remote communities), refusal due to lack of accessibility to health care services, and poor communication with clients, family or health care team/agencies. Experiences of moral distress in these stories were related to: decisions to refuse care made by parents for their minor child (especially if based on misinformation), supporting client autonomy and supporting client choices made (especially if perceived as increasing potential for suffering and/or risk), the CHNs level of commitment to the client, and the perception of a high degree of impact for individual choice on community harm or risk. Sources of initial moral distress were found at macro- (i.e., health care system, organization/agencies, and resources) and meso- (i.e., client, family, health care team) levels. In these stories, micro- (i.e., individual or self) level sources of initial moral distress were not found. Thirteen of the 72 stories shared (approximately 18%) related to the theme of refusal of care.

Manager/agency support. The third theme I identified involves manager/agency support. Examples of these types of situations included poor handling of team member behaviours towards clients and colleagues, insufficient respect for scope and expertise of CHN role and need for input to improve practices and ensure safety, expectations for unquestioning adherence to guidelines, lack of responsive (and preventative) approaches to important issues, requirements for participating in dialogues and behaviours without questioning appropriateness (i.e., this is how we do it here), poor ability of manager to grasp everyday CHN practice realities

and challenges that impact workload capacity (especially if the manager had a non-nursing background), and poor communication between the manager and staff. Experiences of moral distress in these stories were related to: promoting unsafe or unacceptable nursing practices, fear of reprisals for speaking up, powerlessness inherent in short term contract positions (versus full-time, permanent CHN status), under-staffing, work overload, and the degree of emotional and/or physical isolation felt. Situations were particularly difficult if the CHNs perceived that their role contributed to negative outcomes for clients or families. One mitigating factor for moral distress related to manager/agency support was described in stories where CHNs pushed back and contributed to changes in practices or policies and procedures and eventually gained manager/agency support. Sources of initial moral distress were found at macro- (i.e., health care system, organization/agencies, resources), meso- (i.e., health care team only, client and family not noted here), and micro-levels (i.e., individual or self). Nine of the 72 stories shared (approximately 13%) related to the theme of manager/agency support.

Abuse. The fourth theme, abuse, was described by the CHNs with examples that included spousal abuse (with risks to both client and CHNs), suspected child abuse or neglect, abuse of power over client through behaviours of health care providers (CHN's agency team member or those from other agencies), elder abuse, pressures from large pharmaceutical companies, client experiences with social services and community resources (i.e., social services) that are punitive or degrading, and being aware that clients themselves are abusing the social services system. Experiences of moral distress in these stories were related to: requirements to strictly adhere to agency policy and procedure, past negative experiences with other community agencies or health care providers, not wanting to ruin strong nurse-client relationships and cause more harm than good, and non-nursing colleagues who were unable to see a situation from a nursing perspective.

One mitigating factor for moral distress related to abuse was described in stories where CHNs advocated for clients with team members within the agency, with other health care providers from community agencies, or by working with and through the health care system. Sources of initial moral distress were found at macro- (i.e., health care system, organization/agencies, resources), meso- (i.e., health care team only, client and family not noted here), and micro- (i.e., individual or self) levels. Ten of the 72 stories shared (approximately 14%) related to the theme of abuse.

Resources and services. I identified resources and services in the community health care setting as the fifth theme. Examples of specific ethical issues for CHNs within the theme of resources and services included: lack of available resources, long waiting lists for service provision, no services available to meet client needs (e.g., nothing to offer), clients who over-utilize resources, clients who fall between the gaps and don't qualify for needed services, privacy and confidentiality during service related to conflict of interest for the CHN (especially in rural and remote communities), variable quality of community services, and challenges related to serving vulnerable populations (e.g., clients experiencing mental illness, poverty, or addiction issues). Experiences of moral distress in these stories were related to: knowing that families are not coping well (e.g., at their wits end) with caregiving, frustration with a dysfunctional system of community social and health services, concerns for clients at high risk, strong nurse-client relationships, CHN strike conditions, and unrealistic client or family expectations about community health services. Sources of initial moral distress were found at macro-, meso-, and micro-levels. Nineteen of the 72 stories shared (approximately 26%) related to the theme of resources and services.

Second-guessing. Finally, the sixth theme I identified is second-guessing. Examples of specific ethical issues for CHNs within the theme of second-guessing included attending court for an inquest, perceiving that CHN participation as part of a dysfunctional health care system contributes to negative outcomes for clients and families, serving clients with needs beyond the scope of the agency (but who else will help them?), creating health promotion campaigns where the target is an industry related to community livelihood (e.g., casino, alcohol, tobacco), and providing care to clients with compromised capacity to provide informed consent and make safe choices. Experiences of moral distress in these stories were related to strong nurse-client relationships and maintaining professional boundaries, knowing that other clients must remain on the waiting list while a CHN works with hard-to-serve clients that are less likely to engage, and values conflicts between personal and professional standards. Sources of initial moral distress were found at macro-, meso-, and micro-levels. Eight of the 72 stories shared (approximately 11%) related to the theme of second-guessing.

Moral Distress

After hearing stories about everyday ethical issues with some expressing experiences of moral distress (as noted above with examples), I prompted each participant to share a story specifically about an experience of moral distress. Sometimes they referred back to the story that they had just told me. Sometimes they told an entirely different story. For the discussions on moral distress experiences I began by reading the following quote to participants,

Being ethical...has less to do with making a single decision than with initiating a process- often a very slow process- of a person or persons coming to feel that how they acted was a good as it could have been, given the inherent impossibility of the situation.
(Frank, 2004, pp.355-6)

There was often no clear distinction between moral distress experiences and everyday ethical issues; however, importantly, participants did not experience moral distress related to every ethical issue that they told me about. Yvonne describes her experiences of everyday ethical issues and moral distress with the following comment,

I suspect I will never clean up the messes that I find here. And that, for me, causes a great deal of moral distress. Because I feel like I can't, no matter what I do, I can't make this better because the attitude of many people is, "Oh well. I can't handle that, oh well."

Nature of moral distress. One participant, Josephine II, described how she feels sometimes as a CHN, using the metaphor of knitting. She said, "it is like trying to knit a sweater but it is being unravelled one stitch at a time." This struck me as a unique way to view the concept of moral distress, as working towards a desired outcome but having your efforts undone along the way. Perhaps it is not so much the loss of a single stitch, but rather the constant unravelling day by day of important issues related to self and others. Therefore it is not surprising that nurses expressed experiencing distress not only for those who they were trying to help but in response to their own contributions (or lack of) to ethical situations.

Contributing factors. Participants described the following as factors contributing to their experiences of moral distress. These factors included strict agency policies and procedures, for example, a strict attendance management policy requiring CHNs to be written up by a manager after two sick days even if they had legitimate medical issues. Also described were situations that created conflict with personal beliefs, such as being a Catholic and trying to manage a client's request for an abortion. Sometimes moral distress experiences were related to limitations by the employer or provincial health care system and the need to navigate structural factors. Some agencies paid CHNs by the visit no matter how long the visit took. In another

example of a contributing factor; a nurse was told “this is how we do it here” without further explanation or support. At other times clients themselves contributed to moral distress experiences, especially when the nurse recognized that the client was making poor choices or placing themselves at risk. Some nurses described feeling moral distress after referring clients to other services, especially after establishing long-term relationships where clients had begun to feel like family. Not being able to know about clients’ final outcomes was difficult because nurses didn’t know if the clients found the help they needed or if they (the nurses) did the right thing. These CHNs also described working with unique cultural populations that the government has not accounted for or considered in addressing how to meet their needs (i.e., people not in government data bases with no identification, people without a health card). Finally, moral distress was closely associated to feeling overwhelmed because there are just so many people that need a lot of help. Sometimes the CHNs described that they were being limited in what they could or could not say to clients and families. At other times, there was a sense of underlying fear that the moral responsibility (such as described by Lindh, Severinsson, & Berg, 2007) of caring was not shared (i.e., feeling like the only one who can help this client/family). Sarah mentioned that for her, “moral distress is not so much about knowing what to do and not being able to do it as it is about making those hard decisions about what you are not going to do.”

Coping. Often, participants described moral distress to me indirectly, in terms of how they coped with it. One participant, Dorsa, described coping with moral distress as a need to “readjust her sights.” Glen had a similar description in “finding my bearings in the midst of the mess.” And Dorsa said that she needed to “lift my eyes up to look at the horizon for a while.” Mary described it as “walking the line” and “being not too intrusive but helpful.” Many

participants spoke of the value of having peer support and mentorship, especially to guide reflective practice. Vicky described her experiences with this comment,

I struggle with it. I go home some nights and sometimes I cry. Sometimes I'll go on the internet or some of my course readings, or even some of the previous books and stuff that I've come across and read some other nurses' stories on how they dealt with it, or some other case scenarios to just get some peace of mind. I sleep. I try to go to sleep early so I don't have to think about it anymore... just distractions. That's sometimes how I'll deal with it, or I'll speak to one of my colleagues about it.

Valuable strategies noted were setting realistic expectations, knowing one's limitations and resources, and the healing potential of receiving affirmation (i.e., having someone recognize that you did the best you could with a tough situation), validation (i.e., hearing someone say, "I know how you feel"), and confirmation (i.e., acknowledgement that all of the possible options were explored). In the words of Yvonne, one place to start is with self-reflection,

I think one of the questions I would ask would be purely the kinds of questions you asked today to me. Have you had a time in your life when something has happened where you've questioned how you feel about it morally? I think that would be a really solid question to ask. And by morally, I don't mean religious affiliation. I mean how it makes you feel in your gut. And that could be at any time, right? It could be any instance. And I think the answer to that question would probably hold a lot of information.

As well, moral distress has a strong relational component because it involves the nurse being with clients (and families) during a time of need, not being able to adequately meet that need, and living with knowing (or never knowing) the outcomes. For instance, Ann described her strategies for managing moral distress in her nursing practice with this comment, "you have to

learn what your limitations are and what your resources are so that you can make it through the day." Participants spoke about many strategies to reduce or prevent moral distress. They noted the value of building strong, therapeutic nurse-client relationships (i.e., the value of continuity of care) and having good communication with clients and families (i.e., reassurance, asking important questions early, giving clients/families control). The need to have a holistic perspective and be aware of the many relationships which are impacted by ethical decisions (cost-benefit ratios for all stakeholders involved) was highlighted.

Some CHNs felt that key factors included knowing the currently available community resources and services, knowing how to access them (quickly), and working to advocate within the system. Others felt supported by adhering to nursing best practice standards and guidelines (i.e., assessments, documentation) and being aware of the boundaries and limitations of one's professional role. Some participants believed that being proactive, when possible, in planning care and being upfront about risks helped them to avoid or reduce moral distress.

Finally, seeking support for self and others that will provide acceptance and understanding may be the most important mentioned strategy of all. As May described during her interview, "we (CHNs, clients, families, teams, agencies) need to take time to acknowledge that sometimes things work out differently than we had planned, hoped for, or intended."

Not all participants described struggling with experiences of moral distress. Although, the unresolved, inner tensions which are often not considered, may be the shadows of moral distress experiences even if they are not named as such. As Valerie noted, "I think that nurses don't label how they feel as moral distress." Of course, it is possible that some CHNs were in denial or simply not fully aware of the indicators of their moral distress experiences, or it may be that they, in fact, did not personally experience any significant moral distress in their community

health nursing practice. Glen spoke of taking comfort in working through the process of ethical decision making and feeling secure in having explored all the options in an ethical situation. Best described in Glen's own words, he said,

I find that if I adhere to a process, that I can take satisfaction in knowing that I followed the steps that I should have taken – I applied an ethical decision-making tool. I'm a very logical person and I have to say I actually don't find that I feel a great deal of moral distress, personally...I take comfort in the process that I take to assess the situation and I have an understanding of my professional obligations. I understand the issues around ethical crises and so on, and the steps that should be taken to resolve those situations. And if I feel that I have done my due diligence; if I feel that I'm comfortable that I've explored the issues and that the information's been presented, then I'm okay with that.

Yvonne spoke of a learned practice of "separating reality" (i.e., separating professional from personal realities) and having realistic expectations about one's role and responsibilities as a CHN as mitigating factors for moral distress. In her own words, Yvonne explained,

I've had this terrible thing happen to me – I think why didn't I fall apart?...some people, for whatever reason, are able to overcome this type of thing better than others. I really can't tell you why. I don't know why. Maybe it's a lifelong practice. Maybe it's the way I was brought up. Maybe I can separate reality. Maybe I can separate what I can do to help and where there is no chance that I can help with a certain situation, but maybe I can help those people related to the situation...maybe it's resilience...not every nurse comes with that set of assets. I don't know what brings it. I really don't. I don't know that it's experience. I don't know that it's education. I don't know what it is... every day is a new

day. You know, you can't change some things, so you might as well accept it. And there's other things that there's a hope.

Further to this comment, Yvonne gave this advice, "sometimes you need to adjust your thinking and ask, can you live with it?" As an example of how to cope Josephine II recommended, "you need to give yourself permission to put boundaries around your work." And finally, Esther wisely advised, "take time to re-evaluate what is important and what isn't. Don't take work home (in a bag or in your head). Take your breaks. Your lunch hour is sacred."

Ethics Education

With the hope that education can support nurses to work towards positive change, participants were asked to identify professional development ideas and topics that they felt would be most helpful to assist them with everyday ethical issues and moral distress. These findings make an important contribution to the academic literature because options for ethics education described by Canadian CHNs have not been previously published. I also asked for specific examples of professional development experiences that participants found helpful for their practice and why they thought it was helpful. For participants who indicated that they had limited exposure to educational opportunities, I posed the question in this way, 'if I gave you a magic wand and you could wish for any type of education on ethics or moral distress, what would you ask for, that might be helpful?' (see Appendix O: Summary of Participant Identified Ethics Education Options).

Findings from the analyzed data suggest the need for ethics education on a wide variety of topics. Training and continuing education with other disciplines and with individuals and teams from other community health and social services agencies were noted as important learning opportunities. Josephine II suggested, "we should really be part of a community

strategy, not kind of like the add-on to what the hospital is doing. It should be more collaborative.” Modes for delivery of group-based education about ethics and/or moral distress included conferences, workshops (half to full day), presentations, on-line webinars, and both formal and informal opportunities in the workplace for discussions about ethical issues and moral distress experiences in practice. Participants also suggested a variety of opportunities for self-directed professional development related to ethics and moral distress such as reflective practice, mentorship, development of a broader awareness of roles and responsibilities, knowledge of community resources, and processes for referral.

Nursing education. Participant-suggested ethics education topics for undergraduate and graduate nursing education included religion, environmental ethics, moral issues, biomedical ethics, problem solving, conflict management, moral distress, nursing practice standards (ethics), and use of ethical decision-making tools and processes. Participants expressed the need to prepare nursing students for practice realities such as home care, palliative care, and public health settings. One participant spoke of the need for awareness of wounded healers (i.e., individuals with unresolved emotional issues), and not just program admissions based on high academic standing. Opportunities for students to be mentored were recommended. Participants expressed a preference for case-based learning and an inter-professional approach.

Continuing education. Participants also talked to me about continuing education options that would be external to the workplace. Examples of these include conferences, workshops, and presentations on the following topics: palliative care, caregiver fatigue, trauma, vicarious trauma, post-traumatic stress disorder (PTSD), advanced care planning, compassion fatigue, burnout, grief and loss, guided imagery sessions, gerontology, and geriatric assessment. Key presenters such as Dr. Paddy Rodney (nursing professor and ethicist, University of British Columbia), Dr.

Bashir Jiwani (ethicist, British Columbia), Dr. Mary Vachon (consultant, psychotherapist, professor at the University of Toronto), and Claire Edmunds (program leader at the Wellspring Centre at Sunnybrook) were noted. Excellent professional training opportunities were highlighted at the following locations: the International Congress on Palliative Care (conference held biannually in Montreal, Quebec), the de Sousa Institute, the Care for the Professional Caregiver program at Sunnybrook Wellspring Centre, certification of nursing specialties through the Canadian Nurses Association, the Community Health Nurses of Canada (CHNC) national conferences (held annually), and the Registered Nurses Association of Ontario (RNAO) conferences. Participants noted that they did favour regional conferences over travel to larger urban centres due to time and cost considerations. The opportunity to train with other disciplines and with individuals and teams from other community health agencies was noted as an important learning opportunity. Half to full day workshops or online workshops with case-based learning were the preferred mode of delivery for continuing education external to the workplace.

As previously noted, time and cost for travel are often limiting or prohibitive factors for nurses seeking continuing education external to the workplace. However, Esther noted that if an educational opportunity is free, there is a perception that it has no value. Therefore, if the workshop doesn't cost anything or an agency isn't willing to pay for the nurse to attend, then the general uptake of that content may be very poor. Also raised for consideration is how to bring the knowledge and (perhaps more importantly) the energy from an educational experience back to the workplace when only one or two nurses from a team or from an agency attend. Josephine II described how her community health agency has specifically addressed this issue,

...when they go to the conference, they're required to complete a conference template to share that information with the rest of the division...[it is then posted] on an electronic

message board in a conference folder so that people can check back within two weeks after the conference, they can go and read about the conference and what they learned and what resources are available, [our] manager selects and registers for concurrent sessions based on relevance to [this] agency's work, so everything is relevant to almost everybody.

Further to their suggestions about continuing education opportunities that are external to the workplace, participants suggested some internal education options as well. These include, in-house workshops, in-services, presentations, education sessions, and meetings on the following topics: palliative care, ethical issues and evidence-informed decision making, healthy workplace activities, advanced care planning, stress management, dealing with difficult people, team-building, poverty, addictions, mental health, the social determinants of health, multiple ways of knowing and the nursing process, documentation and legal factors (i.e., for an inquest), support for management, team work and shared responsibility, available community resources and services and referral processes, narrative solution-focused approaches, emotional intelligence, nursing ethics standards, communication strategies and therapeutic relationships, and mentorship. Key presenters such as a mental health specialist, an ethicist, a supportive nurse manager, and a lawyer were noted. Excellent educational opportunities were highlighted: a weekly email about an ethical issue to ponder and discuss, reading the book *Bridges Out of Poverty*, having guest speakers during nurses' week, opportunities for ethics consultations, a mentoring pilot project using Blackberry/email, and "Storytelling Initiative" training.

Participants noted many ways to deliver and receive continuing education within the workplace. These suggestions included having a monthly education topic, creating a journal club, using voicemail for information sharing, creating a buddy system (i.e., for coverage of case

load and mentorship, having access to short online modules (e.g., 15 minutes each) and peer-reviewed literature, and encouraging informal opportunities for peer support (i.e., networking with colleagues before meetings). Organizational approaches to workplace education included ideas such as scheduling round table discussions (e.g., using videoconference, teleconference, having an online webinar or webcasts), having interdisciplinary rounds and training in teams, having quarterly managers' meetings, participating in case-study/anonymous case review discussions (need to hear end of the story, include the client outcomes), having ethical issues on the agency's meeting agenda (this makes it important), having timely debriefing of difficult ethical issues (i.e., open door policy with manager), having an agency requirement for a certain number of education hours each year, creating an ethics committee, supporting better organization of care rounds with team members, having mandatory paid training for new employee orientations, providing lunch and learn sessions (i.e., short education session during lunch hour where everyone brings their own lunch), having a toolkit of brief scenarios and key discussion points (i.e., facilitated by local organizational champion), providing a safe, private space to have difficult discussions (especially for those working in environments with little privacy, i.e., pods), compiling a resource list of ethics education opportunities, and creating policy that is responsive to individual client needs.

Even with this extensive list of opportunities for in-house education, there are barriers that restrict education from being delivered and received. For example, agency morale can determine how educational opportunities are received. Mary said that the "moral responsibility of care should be a shared responsibility." Perhaps if an in-house opportunity for continuing ethics education were presented as a "shared responsibility," as opposed to a mandatory training session or just another meeting, it might be received differently. Esther and Alisen each noted

that morale is very management-driven and that management needs to hear and respond to employee distress. Therefore if management is not listening and supportive of the learning needs of CHNs, the education provided may not be what is needed to support CHN practice at that time.

Another example is the barrier of time, or more accurately the lack of time. With increased workloads and staffing shortages, there are time-pressure barriers to providing and receiving additional education/training opportunities. Vicky talked about how her agency had instituted an ethical decision-making framework but it was just too time consuming in addition to all the other work she was required to do. May also mentioned the challenges of information overload and too many meetings; however she did note that, in her opinion, a CHN is given more educational opportunities than a “hospital nurse.” Thus, there is a continuing issue of time constraints as well as a need to engage staff to participate in the spirit of a positive morale. Esther suggested making in-house education optional, but paid (to give it value).

Self-directed professional development. Participant-suggested continuing education options for self-directed professional development included: reflecting on your own values and beliefs; seeking support from your team (i.e., choose people with similar values); knowing where to go for advice, support and help (i.e., employee assistance program- EAP); recognizing your community resources (and being aware of changes to services); understanding your personal and professional limitations; improving time management; reflecting on acceptance and respect for client choice; improving communication skills (i.e., respect, relationships); and knowing your scope of practice and professional standards. Participants also noted many ways to discover and receive continuing education for ongoing professional development and personal growth. Opportunities to do this included: ethics education and ethical decision-making tools from

provincial college of nurses; webinars; online workshops (i.e., CATIE, Ministry of Health); and reading provincial nursing magazines.

These individual options for continuing ethics education present options that are not largely time or funding dependent. Associating a cost to something may give it the perception of value; however some resources have been described as invaluable. Mentorship is one of those resources. Alison describes her mentor-mentee relationship as, “my mentor, my lifeline.” It is through a mentorship relationship that a CHN can receive important advice and feedback about difficult everyday practice issues.

These findings indicate an expressed desire for more, responsive nursing education on ethics and moral distress for CHNs, and perhaps for nursing general. As described from Yvonne’s perspective, “I don’t think we hit ethics in the face hard enough.”

Phase Two Findings

One option for continuing education that is not largely time or funding dependent is an e-module. Thus, an e-module was created for this study using academic literature and resources on nursing ethics and moral distress. The purpose of the self-directed e-learning module (e-module) was to provide a safe way for CHNs to explore everyday ethical issues in community health care settings and to facilitate reflection on personal experiences of moral distress. The e-module was presented to the phase one participants for evaluation and feedback (see Appendix K: Participant Feedback Form for E-Module Evaluation) via email in January 2013. Participants were given a one-month time frame for completion of the evaluation. Two participants requested permission to distribute the e-module to their colleagues for professional development purposes. Permission was granted. Three participants provided the feedback on the evaluation form provided.

Participants' feedback reflected comments from 15% of the total study participants. The data were consistent from all three respondents and contained detailed and specific examples. From the positive feedback received on the evaluation of the e-module, participants felt that the intended purpose (as noted above) was achieved and the three professional meta-narratives presented were relevant to everyday ethical issues in community health nursing.

Participants who evaluated the e-module also agreed that the content was relevant to experiences of moral distress in their nursing practice. On the e-module evaluation form, Kathleen described moral distress experiences as "overwhelmingly complicated situations that are difficult to provide good care for" and that despite the application of extensive amounts of time and resources, often result in poor outcomes. Yvonne expressed that moral distress experiences cannot always be shared with or fully appreciated by non-nursing staff and management.

In his feedback, Glen described the e-module and meta-narratives as relevant because they gave examples of community health nursing practice that demonstrated, "constantly trying to balance the desire to do more, to help more, and do it with less- less resources, less time, and sometimes less energy. It gets fatiguing to constantly try to squeeze water from the stone."

The e-module was deemed to be helpful by the respondents due to ease of use; the resources that were provided; opportunities for reflection; and recognition of the everyday ethical issues in community health nursing practice. Suggestions for further development of this e-module included having more examples and adding accompanying audio or written speaker's notes to enhance further discussion and reflection. The participants noted that the e-module could be used to facilitate individual reflective practice, peer support, and team/colleague discussions about everyday ethical issues and experiences of moral distress that may lead to a number of

opportunities for positive, proactive changes to occur in community health nursing practice in order to address these issues. Personal learning outcomes upon completion of the e-module were highlighted as: felt reassured and supported; re-enforced the need for self-care; reminded of the importance of peer support; reminded about proper documentation practices; and will continue to reflect on moral distress in practice (for self and others needing support). Glen noted this reason for finding the e-module helpful,

Because we don't allow ourselves the time to "stop and smell the roses" in our day to day practice, so we certainly don't take the time to "sniff" when things don't "smell" very pleasing... We deserve and need to take the time to reflect on the ethical dilemmas we face in daily practice, to learn from those others have faced, appreciate their impact on us as professionals and compassionate human beings, and learn effective ways to navigate in the moral and ethical darkness we sometimes find ourselves in (and to be "ok" with the outcomes at the end of the day, even when they are less than ideal).

A summary of the e-module evaluations, complete with participants' comments is available in the appendices (see Appendix P: Summary of Participant Feedback on E-Module).

To close the presentation of the findings for this chapter, I wish to highlight the words of Yvonne as she talked to me about community health nursing practice, everyday ethical issues, and experiences of moral distress,

I think the thing is that no matter what your education, no matter what your experience, as a nurse it's going to be moral distress and ethical challenges throughout your career. I don't think you can ever say, "I've reached my peak now. I don't have to worry about ethical issues anymore." Or, "I'm really ethical and I'm not going to have any more problems with things of moral distress." That's not true. I believe that I will have moral

distress in nursing forever. It's how you cope with it. It's trying not to be horribly critical of people who are a challenge to you. How can you adjust their thinking for them to see the issues that are there? And I think, of all things, we will always have ethical issues and moral distress. And if you can live with that, then I think you will do just fine as a nurse.

Chapter Five: Synthesis of Findings

The synthesized findings of this study, in terms of the categories of key ethical issues and common themes, are presented here using meta-narratives to provide examples of the complex contexts of the CHNs stories. Initially, I present the three meta-narratives from the e-module to more fully describe the four bioethical principles. Then, I present a meta-narrative for each of the six recurring themes that may potentiate experiences of moral distress for CHNs. These meta-narratives intertwine aspects of community, collaboration, and communication, through the power of story.

Categories for Key Ethical Issues and Themes

As previously described, the meta-narratives (or re-storied stories) are derived from data from the phase one interviews. Each meta-narrative has two parts. The first part introduces the key aspects of the story and situates the reader within the context of the narrative (i.e., setting, characters, actions, problems). In the e-module, the presentation of each of the meta-narratives is followed by a series of questions that are intended to guide reflection and further discussion on experiences of everyday ethical issues and moral distress. The general question is asked, “what guides me here?” and then a series of three questions are posed.

- Is the “correct” course of action clear to me?
- What do I wish I had more information about?
- What supports, tools, and/or resources might I use?

The second part of each meta-narrative provides an outcome or resolution. The addition of an outcome for each meta-narrative was in direct response to a comment by Tammy. She said that it is very important to hear the end of the story. I would argue that a negative outcome

contributes to nurses' experiences of moral distress and as such these meta-narratives do not have happy endings in order to encourage discussion about moral distress experiences.

Autonomy and Justice

In order to contextualize the principles of autonomy and justice, the following meta-narrative is provided. The setting is a Canadian city, where a homeless client lives with concomitant chronic and acute health care needs. His competency and capacity to make his own decisions are in question. Like all Canadians, he is entitled to have his health care needs attended to, in a dignified and timely manner. Jack's story is titled, *Autonomous Choices*.

Jack is a 63-year old client who is homeless in an urban Canadian setting. He has a history of alcoholism, is a heavy smoker, and has no family. Three months ago he suffered gangrene in his left foot, which required surgical intervention and amputation. Upon discharge, social services were able to arrange for him to stay in a local rooming house. The first nursing visit revealed horrible, inhumane conditions- vermin and bug-infested, filthy conditions, foul odours, not a light bulb to be found, a stained mattress on the floor as Jack's only furniture, windows that won't open creating a fire trap/hazard, and sketchy roommates. However, Jack stated that he was thrilled with his new home and the friendships he had created. He has an obviously declining capacity for his personal decisions, yet is not fully incapable at this time. Jack has recently met a lady friend named Nancy who is keen to advocate for pain medications for Jack's "phantom limb pain." She indicates that only oxy's will do.

This meta-narrative about Jack provides opportunities for CHNs to reflect on ethical principles, such as autonomy and choice, as well as social justice principles. This meta-narrative broadens understanding about how everyday ethical issues can be very difficult and complex.

The inclusion of issues such as homelessness, addiction, and declining competency make answering the question about a correct course of action that much more challenging. CHNs reading this meta-narrative should be questioning and reflecting on the many details that have not been provided here. The reader may wonder about Jack's previous history from a holistic perspective, such as the physical, mental, emotional, social, cultural, and spiritual aspects. This story also has an added element of risk in that the lady friend named Nancy may not be much of a friend at all to Jack. Thus, the seed is planted for reflection on the added burdens for CHNs who work with vulnerable populations.

In addition this meta-narrative has been structured with other purposeful gaps, such as lacking the details of the actions of the nurse who is caring for Jack. This allows for the reader to immerse themselves in this story, in essence, to place themselves in the shoes of Jack's nurse. The reader can then apply their own judgements, expertise from past professional experience, and knowledge of local supports and resources to this story. Filling in all the gaps for this story may make it less likely to be immersive for the reader. Also, as the purpose of these meta-narratives is to stimulate reflection and discussion about moral distress, the fact that the nurses' actions are not detailed makes it less likely for the reader to blame the outcome on the actions of the nurse in the story. This allows for a wider scope of reflection on the possibilities and the recognition that sometimes, despite best intentions and actions, negative outcomes can and do occur.

The outcome for this meta-narrative describes what happened to Jack and indicates the passing of time since the first part of the story. This outcome encourages CHNs to reflect on the possible consequences that autonomous choices can result in, particularly if those choices involve increased risks for harm. The invitation for reflection is intended to go beyond this meta-

narrative and bring forward similar stories from past practice experiences that the CHN may want to reflect on.

As part of the complexities found in everyday ethical issues, the nurse must reconcile his/her care of the client with unexpected or unintended outcomes. This meta-narrative speaks to the inherent difficulties of knowing how and when to support and respect the ethical principles of autonomy and justice. This is the outcome for Jack,

Jack was unavailable for a series of nursing follow-up visits over the next month. On Christmas Eve, Jack was found unconscious in a snow bank. His right foot was visibly gangrenous and he had been badly beaten.

Since autonomy and justice are often considered to be outcome-based principles, the outcome for Jack in this story sets the stage for reflection on moral distress experiences. Sometimes hindsight judgements and criticisms about the ethically “correct” course of action (or lack of) are dependent on outcomes.

Beneficence and Nonmaleficence

To further situate the discussion about key ethical issues, using principlism, into the context of community health nursing practice, I provide a meta-narrative titled, *The Care I Deserve*. The setting is rent-geared-to-income housing, where Sandra and her foster son Tommy live and are currently receiving visits from home care nursing. This meta-narrative describes the problem at hand in terms of efforts toward promoting good and avoiding harm,

Sandra is a 43-year old female client who is morbidly obese and was recently diagnosed with Type I diabetes. She receives funding from the provincial welfare program. Home care nursing has been ordered for diabetic teaching as well as an occupational therapy/physiotherapy (OT/PT) assessment. Sandra is the primary caregiver and foster

parent of a 3-year old boy, Tommy, who is autistic. During a routine chart audit, it is noted that two months after discharge from hospital, Sandra continues to receive nursing services twice a day. The nursing staff tried to explain to the case manager that Sandra refuses to learn how to do her own insulin and that Sandra is consistently not available for health care providers when they come to the house for her appointments. She adamantly refuses to go to the outpatient diabetic clinic. Management gives an ultimatum: tell Sandra this is her last visit, unless she wants to pay for it out of her own pocket.

This meta-narrative provides opportunities to reflect on ethical principles such as beneficence and nonmaleficence. It helps to broaden the perspective, and perhaps challenge assumptions, about what it means to “do good” and to “not cause harm.” For the home care CHN in this situation, the correct course of action may or may not be clear. There are competing needs between the client and the case manager. Since beneficence and nonmaleficence are often considered to be duty-based principles, the CHN may also be reflecting on the roles and responsibilities of the nurse in these circumstances. Further to this, from a client and family-centred care perspective, the needs of Tommy, her autistic foster child, should also be considered. More information, again from a holistic perspective, would be helpful in this case. However, as in real life, CHNs do not always have all the details and important information at hand prior to ethical decision making. The outcome for this client, Sandra, unfortunately holds many unknowns and this aspect of the story makes the meta-narrative ripe for reflections on moral distress. I have ended this meta-narrative with the following:

Sandra and her foster son moved away without telling anyone where they were going.
No follow up was possible.

Perhaps this is the most difficult of outcomes for an ethical situation, as it is not possible to reconcile the outcome when one does not know it. If so, then CHNs may not be able to come to terms with whether or not their duty to care was met in ways that are ethically and/or morally acceptable. This type of experience may set the stage for moral distress.

The final meta-narrative, provided here to contextualize all four of the bioethical principles, depicts a CHN experience where many actions could have taken place to respect and support the client in this ethically-problematic situation, but very little occurred. It is a story about a veteran living in a rural community awaiting placement in a long-term care (LTC) facility. This meta-narrative speaks to the importance of timely action and good communication among the client, family, health care team members, and the health care system. Often ethical issues cannot be hummed and hawed over. Sometimes inaction, slowed decision making, and poor communication occur. This meta-narrative is titled, *Conspiracy of Silence*.

Joe is a WWII veteran who lives in a rural Canadian community. He lives at home alone and is on a waiting list for long-term care (LTC). There are only two LTC facilities in his community. He is supposed to be a priority client for the next available bed, but other clients have been placed ahead of him due to a series of miscommunications. Joe has a son named Michael and daughter-in-law Francesca who live in an apartment nearby. Recently, Michael and Francesca attended a doctor's appointment with Joe. Due to increasing shortness of breath, various tests were done. The doctor said that she would call the house with the results. Francesca was the one who took the call from the doctor and the news was not good. Joe was diagnosed with advanced lung cancer. Francesca and Michael absolutely insist that Joe not be told about this diagnosis or any prognosis until he is at least settled in LTC facility. You have just received the call that the LTC facility

has now denied Joe's veteran status on the waiting list for LTC, stating that he must now be on the list for palliative residents instead. A team meeting is called. The team has mixed priorities about Joe's situation and a heated discussion occurs.

The point that is highlighted here is that health care professionals have a duty to apply ethical principles with the intention to achieve the best possible outcome for the client. How these principles are applied can be up for debate by key stakeholders such as health care providers, families, and sometimes clients themselves. Without defined goals for care with clear communication, more harm than good can be the final outcome. Here is the resulting outcome for Joe:

Joe died in his sleep while the team was in the midst of advocating for his status on the waiting list for the LTC facility. His palliative diagnosis was never communicated to him.

The preceding three meta-narratives contextualize the ethical principles of autonomy, justice, beneficence, and nonmaleficence using re-storied experiences from community health nursing practice. These examples are especially relevant for public health nurses, home care nurses, as well as indirect care nurses who may have these types of clients on their caseload. Arguably though, all of the meta-narratives tell complex stories that involve all four of the bioethics principles. The complexity of the ethical issues in the data posed a challenge during analysis. Therefore, I decided to further analyze the four categories of key ethical issues according to common themes across the 72 stories. Next, the six themes from the data are explored using meta-narratives.

Palliative/End-of-Life Care

There are inherent elements of all four of the bioethical principles in this meta-narrative with the theme of palliative care. Again, I note that the key ethical issues related to autonomy,

beneficence, nonmaleficence and justice cannot always be broken down and addressed independently of one another. Thus, the use of a theme supports the exploration of complexity within categories of key ethical issues in the relational context of community care settings.

This meta-narrative, with the theme of palliative/end-of-life care, is about a very ill, elderly man and his adult daughter who live in rural Ontario. There are ethical tensions on multiple levels and communication suffers. Ultimately, a promise is made by a CHN to this client to ensure, that when death comes, every effort will be made for the client to be as comfortable as possible. To contextualize the first theme, of palliative/end-of-life care, I share a meta-narrative here titled, Palliative Promise.

Antonio is a 92-year old Portuguese immigrant who lives with his widowed daughter Maria in a rural community in Ontario. He has not seen a doctor in the last ten years and refuses to see one now, even though he is clearly quite an ill man. He has not left the house in at least five years due to severely limited mobility (likely stroke), chronic joint pain (likely arthritis due to heavy manual labour and work related injuries), and shortness of breath on exertion (likely cardiac complications). A referral was received by the Community Care Access Centre (CCAC) through the family's parish priest related to concerns that Maria was no longer able to cope with her father's health issues. He did allow the nurse practitioner to do a house call and was open to receiving services if he could be assured that "the nurses knew what the hell they were doing." You are the nurse assigned to Antonio's care; he is on the palliative caseload and not expected to live longer than 6 months. When you meet him, he calls you close and whispers, "When time comes, you make it nice for me, right? I don't want no suffer, ok?" He looks at you with big, pleading brown eyes, and you pat his hand, "ok," you tell him quietly. You attempt

to include Maria in his care, but she refuses, saying, “I don’t want to know, you do what you have to do.” However, Maria has made many calls to the nurse manager to complain about the “terrible care” that the nurses have provided. The next time you visit, Antonio has lost consciousness. This is not unexpected, and the plan of care is to keep him as comfortable as possible, as per Antonio’s wishes. As you administer his pain medications as ordered, Maria turns to you and yells, “My Father never took drugs in his whole life and he is not starting now! He has only gotten worse since you people have started coming into this house- get out!” You try to reason with Maria but three days pass before she will let anyone back in to see her father.

This meta-narrative has a number of characters whose actions can be reflected upon, for example the client, the daughter, the family doctor (from 10 years ago), the nurse practitioner, care coordinators at the Community Care Access Centre, the parish priest, the nurse manager, and the home care CHN (reader). This scenario sets the stage for complex discussions about many actions that collectively have contributed to the current state of affairs for Antonio. The setting of this scenario, in a rural community, also may place additional constraints on what may be available and/or accessible. As in a real life example, more information could be provided on a number of fronts to give perspective to the complex issues at hand. While, the arguments about which principles apply where may lead to valuable discussions among CHNs, also important are consideration for the supports, tools, and/or resources that may be helpful. In order to maintain a broad applicability for the meta-narratives (including this one) among Canadian CHNs, details about supportive resources have been intentionally left out of the stories. Further discussion regarding these important aspects are encouraged via the reflective questions and thus will emerge among CHN readers with a more relevant and specific local context.

The final outcome in this meta-narrative for Antonio speaks not only to the ethical principles at stake, but also to the values at risk, and the unique contextual factors within the palliative care setting where time is of the essence. This meta-narrative sets the stage for developing a better understanding of moral distress and how it can have profound short-term and long-term effects on both personal and professional levels. Here is the ending of Antonio's story:

When you next see Antonio he is in excruciating pain, struggling with every breath he takes, and drowning in his own secretions. He dies later that day in agony despite your best efforts to re-establish his comfort protocols.

Examples of core nursing values that are at risk in this meta-narrative include, providing compassionate care, promoting well-being (up to and during end-of-life care), preserving dignity, promoting justice, and being accountable. These values represent the foundation that underpins ethical nursing practice. Perceived shortcomings in these areas, with respect to care of clients and families, may challenge the nurse's concept of professional self. This palliative care example highlights the finality of the outcomes for this ethical situation. There can be no further opportunities with this client to redeem relationships, to provide more or better care next time, or even to explain or apologize.

From a personal perspective, this meta-narrative describes the CHN's close proximity to pain and suffering, in fact the agony endured in the last hours of Antonio's life. Proximity can be experienced physically and/or psychologically. The details about the nurse making a promise (or at the very least appearing to agree) to the client to provide a peaceful passing is important to potentially stimulate reflection on moral distress experiences. A promise or agreement can be professional and/or personal. It can be something that two human beings agree to on a more-than-verbal level. Failure to meet this type of obligation may challenge one's personal values and

beliefs, sense of power, or perceptions about integrity. Perceived shortcomings in these areas, with respect to moral identity, may erode the nurse's self-concept. Thus, a deeper reflection on moral distress experiences can be stirred by the nuances of this palliative care meta-narrative.

Refusal of Care

In order to begin to understand the complexities involved in the refusal of care theme, I have provided a meta-narrative titled, Sanctimony and Stereotyping. Refusal of care as an emergent theme is an important finding in this study and it is perhaps more likely to occur in the community sector, than in institutional environments such as acute care hospitals. In hospitals, there is an assumption that patients are there to receive some type of care. If they are not, then they are most often discharged. In community settings, the refusal of care from one agency may signal a need for other services and resources to be provided. What follows, then, is a story about two PHNs working with an immigrant family. This meta-narrative speaks to some of the ethical issues found in conflicting knowledge, attitudes, values and beliefs.

Today you are training Kelly, a nurse from another part of your agency. You are a seasoned community health nurse visiting an immigrant family who has been on your caseload for the past twelve years. The parents have refused routine childhood vaccinations for all of their seven children on religious grounds. This family lives in poverty (e.g., often no hydro, depending on food bank hampers). The mother seems to be developing symptoms of depression over the past few months and is not looking after the kids like she used to (borderline neglect). Today, you identify that the two youngest children have head lice. Due to a language barrier it is hard to be certain if health teaching information comes across properly. You also have been wondering why the husband has not been at home lately. You ask the client where her husband is but she just

says, “he no here.” Even though the family has almost nothing, it is obvious that they are very close and love one another dearly. Kelly, the colleague you are orientating, is absolutely horrified to see the living conditions of this family. You explain that this family is doing the best that they can, all services that are available are in place, and that the mother is on the waiting list for counselling. Upon arrival back at the office, Kelly immediately makes a complaint against you to your supervisor and calls Children’s Aid. Since her desk is not far from yours, you overhear her phone call to the child welfare office: “Well they are not from here, so what do you expect? Yes filthy, absolutely filthy, like dogs really. Having one baby after another on the tax-payers’ dime. Seriously! Laziness really. That’s all there is to it.”

Here, the key ethical categories of autonomy, beneficence, nonmaleficence and justice are present and interwoven. The context is that of public health nurses and their care of a young family. There are added layers of interpersonal communication difficulties at the collegial peer, managerial, and inter-agency levels in this meta-narrative. These added layers of complexity are further explored in the final outcome.

You are called to your supervisor’s office first thing the next morning. Kelly is also there and she is crying. She states that she has never worked with such an incompetent nurse and that she feels traumatized by the living conditions that she witnessed. Your supervisor hands you a document to sign that indicates you have been advised to review the standards for nursing ethics and given a warning. “I don’t think you need it, or it’s fair really, but it’s policy.”

This meta-narrative speaks to the potential harm that can occur when ethical principles, policies, and procedures are applied without consideration for context. Approaching ethical

decision making as a process is important at many levels, in this case from micro- to meso-levels. As previously mentioned, it is the contextual process of ethics versus the content of the decisions that should be our greatest focus for attention.

From a relational perspective, this meta-narrative unlocks many layers of interactions and power dynamics. The client and family are clearly identified as being vulnerable and at risk due to various social determinants of health, such as poverty, insufficient supports, environment, and culture. The seasoned CHN has a long standing relationship with the family members and has perhaps invested a lot of time and energy into negotiating their care. The seasoned CHN may also have a long standing relationship with the supervisor. Kelly, the nurse in training, is beginning to form relationships in a new department and in a different sector of community health nursing. There are power dynamics present in the nurse-client relationships and the nurse-supervisor relationships.

Manager/Agency Support

To highlight the contextual factors of the third theme of manager/agency support, I provide this meta-narrative titled, Manage Your Moral Distress. The context of this story is one of a new CHN, fresh out of school, and recently hired by a home care nursing agency. In this snapshot, the nurse experiences bullying and a lack of support, on multiple levels.

You are a newly hired graduate working as a CHN in a community health care setting. You have been called in to see the nurse manager today to determine if your performance warrants a move to a permanent contract with the home health care agency. Your manager asks you how you like it so far. You decide to answer honestly, “It’s intimidating, really. I never know what I’m going to walk into and things can go badly pretty fast out there. I watched my best friend die of cancer in high school, he suffered so

much...sometimes I think about that, especially with the oncology patients. I just want to provide the best nursing care that I can.” Your manager laughs quietly, “Hey, better get used to that around here... you do what you can then you call it a day!” She gives you a password to complete mandatory online modules on catheterization and pain pumps on the agency’s website. You want to mention that you are also having a very difficult time with Steve, a nurse who has been orientating you. He has been rude, condescending, and has even embarrassed you a couple of times in front of other nursing staff calling you stupid. As you are leaving her office she calls you back and says, “I think you are good to go on your own now. So no more shadow shifts, got it?”

The theme of manager/agency support or lack of, as is the case in this scenario, speaks to the many layers of potential difficulties that can have an impact on ethical nursing practice. In this instance, the nurse’s lack of full-time status and potential financial implications of speaking out are added moral stressors. This meta-narrative draws attention to issues and experiences that may profoundly affect novice nurses, in particular, that more experienced nurses and managers may not be immediately aware of. Power differentials can occur among and between CHN and other members of the team, as well as with managers. The outcome of this story highlights that it is not only clients, families, and co-workers who may feel the impact of ethical issues. Here is the end of this story,

Your manager passes you by for this round of permanent hiring and leaves you on the casual rotation list without further explanation. You overhear Steve at the next staff meeting telling the team, “stupid is as stupid does” and you have no doubts about who he is referring to.

This theme, and the resulting meta-narrative, links closely with the fourth theme of abuse. Although this meta-narrative could have been used to describe abuse, I have not highlighted it as such in this presentation of the data. However, I wish to note that, as with the four bioethical principles, it is difficult to present these meta-narratives in a way that does not overlap with other themes. This is not due to a problem with analysis. It speaks to the real-to-life complexities that the meta-narratives have been designed to describe.

Abuse

I share below a meta-narrative to illustrate the theme of abuse. I use a palliative/end-of-life care-based example to describe some of the complex issues found in CHN practice in home care nursing related to abuse of a client. It is titled, *Starving for Palliative Care*.

Linda is a 38-year old wife and mother of two young girls aged 3 and 7. An honour roll university student, she was one year away from graduating with her social work degree when she could no longer ignore her symptoms. She was diagnosed with stage-four breast cancer with metastasis to her brain and lungs. She initially wanted to die in the hospital so that her children didn't have to see her suffer. However, her husband refused this plan of care and convinced Linda to discharge herself from hospital and receive home care services. They live in a basement apartment in a rent-geared-to-income housing complex in the downtown area, well known for crime and drug trafficking. Prior to arrival, the nurse always calls the home to ensure the client is available and ready for the visit (as per agency policy). Linda often does not answer the phone. This is distressing to the nurses who care for her since they know how much she needs pain and symptoms management. Even though the policy states that if clients don't answer the phone the visit must be cancelled, many nurses ignore this and bang on Linda's door until

her husband opens it. Often, they have heard him yelling at Linda before he opens the door, but he usually calms down after a little while. The nurses have begun to go in pairs to see Linda because they don't feel safe (just a gut feeling), even though management indicated only one nurse would be paid. Yesterday, Linda asked about receiving palliative sedation in her last days (which will likely be very soon) as she is clearly in excruciating pain.

The theme of abuse may seem on the surface to have very clear obligations when it comes to ethical nursing practice. This meta-narrative highlights some of the intricacies that can be involved in abuse situations. Often, the categories of beneficence and nonmaleficence are not entirely clear. This meta-narrative highlights a need to respond in a timely manner as this client has only days to live. Here is the outcome for Linda,

When you call about Linda's request, the physician refuses to discuss it any further stating that, "We don't do palliative sedation here, never have never will! Ain't gonna happen." Linda says she does not wish to be admitted to hospital during her last days. She tells you, "It's ok, I know you tried to help me. I will just stop eating and drinking. It will be over soon." Over the next few days, Linda becomes semi-comatose and her husband insists on subcutaneous re-hydration. He will not accept that his wife is dying of thirst. Linda dies slowly over the next two weeks with poor pain and symptom management and intermittent home nursing services.

As is the case in many abuse situations, issues of power surface in this meta-narrative. The power of the client's husband, the attending physician, and the agency's policies all contribute to making this situation all the more dire. The client also exercises her own sense of power and control in her decision to refuse food and fluids. The impact of power on the four

bioethical principles is an important contextual factor that affects decision-making and decision-making capacity, and ultimately experiences of moral distress. Those left feeling powerless in this meta-narrative may include, Linda (e.g., when her palliative care choices were not respected); the husband (e.g., powerless to his wife's cancer and death); client's two young daughters (e.g., potentially living in an abusive environment); and the nurses who cared for her (e.g., when their safety was placed at risk, when unable to provide quality care).

Resources and Services

In order to contextualize the next theme, of resources and services, I have chosen to highlight rural and remote practice issues using a meta-narrative titled, Home Is Where the Heart Is. In this story, an elderly, female client is being cared for by a CHN in a rural/remote location. This client lacks direct family involvement in her care, but the nurses' are well aware of her wishes and wants for care provision. This lady is described as having a spunky character and one might picture her with bright, wise eyes and a cheerful demeanor.

Evelyn is an 86-year-old lady who lives in the remote outskirts of her rural community. She and her husband built a modest little house. Her husband, Ronald, died four years ago from pneumonia. The CHNs who work in this area know that they should "wait in the car until the dog comes around the corner" at many of the houses out here in the "boonies." Evelyn does not have running water or electricity and she says she doesn't mind it one bit. She chops her own firewood and neighbours bring her groceries every couple of weeks. She has a twinkle in her eye and a youthful spirit despite her advanced age. Her mind is sharp as a tack and she is determined to live out her very last days to the fullest here at her beloved home in the country, just as her husband Ronald did. She is at high risk for falling due to intermittent episodes of undiagnosed vertigo. Evelyn has never

had a vaccination in her life and laughs when you mention any medications, especially the flu shot, “Not starting that business now! I’m ready when the good Lord takes me!”

This meta-narrative speaks to the challenges of interpreting bioethical principles, such as autonomy, beneficence, nonmaleficence, and justice, in the context of an elderly woman’s own definition of quality-of-life in a rural environment. The availability and accessibility of resources and services must be considered in ethical decisions, and these aspects may be contributing factors in experiences of moral distress. Respecting capacity to make informed choices that impact health and acting in accordance with the client’s wishes, may blur the lines between promoting good and avoiding harm in some instances. Here is the rest of Evelyn’s story:

She recently had a serious cardiac episode when her son was visiting from Vancouver. He arranged for her to be transported to a leading cardiac centre and signed the papers for a pacemaker to be put in when she was unconscious in the intensive care unit. The last you heard was that she did not do well after the surgery and was moved into a long-term care facility. While visiting a family friend in long-term care, you are surprised to find Evelyn seated in the residents’ lounge area. She waves you over to her. With tears in her eyes she pats her chest just over her heart with her hand and says “I have to live with my son’s mistakes and it’s no life.”

This meta-narrative speaks to an ethical issue where moral distress may be potentiated by actions, circumstances, and outcomes that were not related to the nurse. While many definitions of moral distress highlight that the nurse knows what to do but cannot do so, here is an example of a retrospective situation where the nurse knew what the client wanted in terms of care but has now come to realize that those terms were not met (actually, were directly violated) by the

client's family. Again, it is important to recognize that moral proximity to suffering may place the nurse in a position to be impacted by these everyday ethical issues.

Second-Guessing

Finally, as an example of the sixth and last theme of second-guessing, the ethical practice realities of a public health setting are provided here in the meta-narrative titled, Running Pillar to Post. In this story, a young client has been in a care relationship with a PHN for a number of years. She has many holistic needs for integrative health care and a history of poor outcomes. This is a complex and challenging situation with many ethical issues embedded in the details.

Stephanie is a street smart, 17-year-old, Aboriginal girl that you have met many times over the years as the public health nurse assigned to the Catholic school board in your community. Even though you haven't always agreed with the restrictions about what can/can't be discussed in the classrooms regarding sexual health, you have always given your work 100% of your energy and commitment. In a small town, everyone knows everybody else's business. You know that Stephanie grew up in foster care and has run away from home many times. Stephanie always seems to choose to come to you for help and it just breaks your heart that a young girl should have to go through so much. Over the years you have worked with Stephanie through multiple lice infestations, abuse in her foster home (where child protective services was called), a pregnancy which ended in abortion at age 16, and recently supporting her arrangements to attend an in-patient substance use program- just to name a few. Just last week, you heard that she was picked up by the police for outstanding charges.

This meta-narrative speaks to the complexity of issues that an individual client may face, the supports and resources that are required to meet important care needs, and the challenges of

providing “good” nursing care. It also highlights the strong nurse-client relationships that may be formed and the emotional investment that nurses may feel towards positive outcomes for clients. The relational boundaries between personal and professional for the CHN may become more porous over time. Moral distress, in this situation, may not be the result of inaction. It may be the result of an “overwhelmingly complicated situation” where despite best efforts and intentions, a poor outcome may be the end result. Here is the outcome for Stephanie:

Stephanie was returned to jail for 72 hours. Unfortunately, she began using drugs again while in jail and was unable to maintain her sobriety. You agree to work with Stephanie on a one-to-one basis upon her release from jail, but your manager informs you that she has declined that offer. Apparently, Stefanie feels that she has disappointed you one too many times. She says that even though she tried to do exactly what you told her to (i.e., go to school, study hard, have an abortion, and go to residential treatment), it has not worked out. She feels she would probably be better off just figuring it out on her own.

She has indicated that she wants to work with a nurse who better understands her culture.

Ending with an outcome that appears to be negative, this meta-narrative highlights that, a CHN may question whether or not their efforts have made a positive difference (or perhaps even unintentionally harmed a client) and thus, second-guess the care they provided and/or the ethical decisions they made. This experience of delayed-onset moral distress about an ethical situation can occur when one is able to implement ethical decisions but later questions those choices and actions. Perhaps these situations are the most impactful on CHNs because they may challenge confidence and competence for ethical practice, potentially affecting one’s sense of professional and/or personal identity.

Summary

This synthesis of the findings, using meta-narratives, adds to the academic understanding of everyday ethical issues and moral distress experiences for CHNs. Specifically, my analysis and interpretations provide foundational information, using a narrative inquiry approach. In investigating the research questions, I presented the CHNs' experiences in the context of key ethical issues analyzed into categories with recurring themes. To further understanding about the findings, as described in chapters four and five, chapter six presents an in-depth discussion of my interpretations of the data in the context of relevant scholarship.

Chapter Six: Discussion

The academic literature reveals the existence and widespread prevalence of moral distress for nurses in their professional practice experiences in a variety of health care settings. I have identified the fact that experiences of everyday ethical issues and moral distress among CHNs in Canada is an understudied ethical landscape. This study had a practical, two-fold purpose for inquiry: 1) to explore the experiences of everyday ethical issues and moral distress for CHNs; and 2) to identify their self-described needs for education and ongoing learning. The strengths of the final study design and methods include an increased sense of confidentiality, anonymity, and protection for the participants because the interviews were done over the telephone, pseudonyms were used, the study evolved to have a national scope, and the data were re-storied into meta-narratives.

My analysis of the data explored four categories of key ethical issues, which were described according to the bioethical principles (autonomy, beneficence, nonmaleficence, and justice), and in terms of six recurring themes. Guided by narrative inquiry as the methodology, this study makes a significant and original contribution to scholarly knowledge as it provides insight and understanding into experiences of everyday ethical issues and moral distress faced by Canadian CHNs. This study also identifies needs and provides recommendations for education at multiple levels specific to relevant topics, options for delivery, and important considerations for engagement and sustainability of educational initiatives. These results will be disseminated to the participants and participating organizations in a summary report, and later through conference presentations and manuscript submissions to academic journals. What follows is here is a discussion of my interpretations of the findings situated within the scholarly literature on moral distress.

Thematic Interpretations of Relevant Scholarship

The conceptual framework for this study was Jameton's (1984, 1993) theory of moral distress, where one knows what to do but perceives that they are powerless to carry out that action. I found this theory to be valuable and relevant for this study, in that it was an excellent foundation for initially exploring moral distress. In essence, it gave me room to work.

In describing the participants' stories throughout this study, I found myself interchanging language about ethical issues and experiences of moral distress as if they were sometimes separate issues but often one and the same. However, Jameton (1993) was clear in his work that ethical issues or dilemmas indicate at least two or more options and lend themselves to discussions about ethical principles and theoretical decision-making processes. In contrast, experiences of moral distress are less about weighing the ethical options, and more focused on issues of organizational, social, and individual accountability and responsibility (Epstein & Delgado, 2010). This delineation between the terms, ethical issues and moral distress, was an invaluable tool during the analysis and synthesis of the data. Also helpful during analysis was the use of the term initial moral distress (Jameton, 1993). This allowed for the identification of the perceived source of the barrier (i.e., health care system, agency or organization, health care team, client or family, or self) to ethical action as described in the participants' stories of moral distress experiences.

As I mentioned in chapter two, Jameton (1993) described two types of moral distress: initial moral distress and reactive moral distress. He noted that initial moral distress was the response to the (institutional) barrier and reactive moral distress was the negative reaction of the individual. In this study, I noted that barriers to ethical practice and related experiences of initial moral distress were due to a range of barriers: health care system, agency/organization (i.e.,

policy and procedure, management support), members of the health care team, client or family, or self. Certainly, there were many descriptions of experiences where multiple barriers could be related to a single instance of initial moral distress.

Reactive moral distress (Jameton, 1993) can be described as the individual's negative response to inaction (or lack of carrying out a preferred action). Participants in this study noted two types of experiences of reactive moral distress. One type of reactive moral distress was an empathic response to the client and their family. Here the nurse felt a negative response and dis-ease with the resulting action taken on behalf of their charges. The second type of reactive moral distress was in response to self, a negative response to not being able to meet professional obligations, duties, or commitments. The nurse's sense of accountability and/or responsibility to meet needs for quality care and expected outcomes also contributes to experiences of moral distress.

Further to experiences of initial and reactive moral distress, nurses may also experience negative responses at personal and/or professional levels when values, obligations, and integrity are risked. The moral proximity to suffering can lead to the erosion of concepts of self, as a good nurse and as a good person.

Interpretations of Phase One Findings

According to a study by Burger, Erlen, and Tesone (1992), key ethical issues for nurses in the community health care setting included lack of time, increased client autonomy, level of family support, communication issues, and a lack of resources. In this study, I found six recurring themes, including moral dilemmas and distress relating to palliative/end-of-life care, refusal of care, manager/agency support, abuse, resources and services, and second-guessing. Interpretations of the findings from phase one of this study can be further distilled to more

general discussions about: 1) quality of care; 2) respecting autonomy; and navigating structural factors. The originally-defined themes from the data encompassed content, as well as process and relational areas. What follows is a discussion situating the themes into the context of the academic literature.

Quality of Care

Examples of CHNs' concerns related to the quality of care (or lack of) available to and provided for clients and families were the most frequently mentioned ethical issues and potential sources for moral distress experiences. Everyday ethical issues in palliative/end-of-life care were reported as the primary clinical situation that caused moral distress for the CHN participants in this research, representing approximately 21% of the stories shared. Ethical issues in palliative care have been highlighted in a number of research studies, particularly in the acute care sector (American Association of Critical Care Nurses, 2008; Corley, 1995; Browning, 2013; Elpern, Covert, & Kleinpell, 2005; Gutierrez, 2005; Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004; Mobley, Rady, Verheijde, Patel, & Larsona, 2007; Piers, Van den Eynde, Steeman, Vlerick, Benoit, & Van Den Noortgate, 2012; Puntillo et al., 2001; Wilkinson, 1987/88; Williamson, 2007). The issue of futile care is often cited in studies in the acute care sector. Everyday ethical issues in home-based palliative care revealed in this study, in contrast, did not specifically highlight the provision of futile care. In this study, examples of specific ethical issues for CHNs within this theme of care included: euthanasia, advanced care planning, feeding/starvation, confidentiality and communication, palliative sedation, unmet care needs, supporting client autonomy (especially if perceived as increasing suffering), unrealistic expectations from clients or family, poor collaboration between agencies and services, and setting professional boundaries (particularly in rural or remote practice settings). Differences in

context for community health care settings (versus acute care settings) must also be taken into account here. Palliative home care nurses in this study described additional challenges, such as variable client caseload, travel time in addition to client care requirements, geography and weather concerns, just to name a few.

In a recent study of palliative home care, Brazil, Kassalainen, Ploeg, and Marshall (2010) found three themes on moral distress from the data: 1) role of the informal caregiver (i.e., caregiver burden, neglect or abuse, competency to provide care); 2) challenging issues in practice (i.e., respect for patient decision making, inappropriate treatment, pain and suffering, unanticipated death, communicating information about death and dying); and 3) the service delivery system (i.e., lack of resources, incompetence among colleagues, lack of timely client information delivery to care providers). The themes from the study by Brazil et al. fit well with the stories about ethical issues told by CHN participants in this study. In the current study, participants shared stories about moral distress experiences which were related to: not being able to discuss or carry out a client's wishes at end-of-life, circumstances which limited open, honest communication and goal setting, questioning adequate provision of good nursing care (i.e., poor pain and symptom management), and care decisions perceived not to be in the client's best interest or against a client's previously stated request. The latter were particularly difficult if the client died before a decision could be made about the contested ethical issue.

Also, frequent examples of quality of care concerns were found among CHNs' stories with the recurring theme of abuse. These reflected approximately 14% of the stories shared. In this study, examples of specific ethical issues for CHNs within the theme of abuse included spousal abuse, child abuse or neglect, abuses of power by health care providers, elder abuse, pressures from large pharmaceutical companies, and clients' experiences of abuse related to

accessing social service resources and systems and the quality of delivery of those social services. Experiences of moral distress in these stories were related to: the CHN being required to adhere to policy and procedure, CHNs past negative experiences with other community agencies or health care providers, and the CHN having to risk ruining strong nurse-client relationships.

One mitigating factor for moral distress related to abuse was described in stories where CHNs were able to successfully advocate for clients with team members within the agency, with other health care providers from community agencies, or by working with and through the health care system. The theme of abuse was not noted in studies that I reviewed regarding key ethical issues for nurses in other health care settings and their experiences of moral distress. However, the descriptions of futile or unnecessary care that did emerge, related to acute care nursing settings, could certainly fit into the abuse category. The link between ethical issues and moral distress related to situations of abuse in community health care settings is a significant finding in this study.

Respecting Autonomy

CHNs in this study also described the ethical and moral dimensions of respecting autonomy. These dimensions were identified in stories about clients and/or families refusing nursing care and stories where CHNs second-guessed their thoughts, decisions, and/or actions. Two issues, increased autonomy for clients and the level of family support, appear to be variables that are uniquely important for nursing in community health care settings.

The recurring theme in this study of refusal of care represented approximately 18% of the stories shared by the CHN study participants. In this study, examples of specific ethical issues for CHNs within the theme of refusal of care included: refusal of vaccination, refusal or

termination of home care nursing services, refusal based on cultural or religious choices which place clients at high risk for injury or illness, refusal of treatment based on client fears, refusal due to perceived lack of privacy or confidentiality of services (especially in rural or remote communities), refusal due to lack of accessibility of services, and refusal due to poor communication with clients, family or health care team/agencies.

Experiences of moral distress for CHNs in this study were related to decisions to refuse care made by parents for their minor child, supporting client autonomy and supporting client choices (especially if perceived as increasing potential for suffering and/or risk), the CHNs level of commitment to the client, and the perception of a high degree of impact for individual choice on community harm or risk. As many studies on moral distress in acute care settings are focused on adult client, critical care populations, refusal of care by parents or caregivers would be less likely to emerge as a key issue. Supporting client autonomy, choice and decision making as contributing to moral distress in the community nursing care setting, are important aspects in the findings of this study. Increased client autonomy (Burger et al., 1992) has been recognized as an important difference when comparing nursing in acute care settings to community health care settings. Commitment to the individual client and simultaneously to the community as a whole, are additional factors that are unique to ethical issues in the community nursing sector. As a key finding from this study, it is important to recognize that the sense of commitment (e.g., perceived or actual responsibility and accountability) and the impact of perceiving that, as a CHN, one has not fulfilled that commitment, can occur on both professional and personal levels and is a strong contributor to experiences of moral distress in the community health nursing context.

The issue of multiple commitments or conflicting loyalties (Storch, Rodney, Pauly, Brown, & Starzomski, 2002) speaks to the diversity within the role of the CHN. In a Dutch study

by Schoot, Proot, Legius, ter Meulen, and de Witte (2006), CHNs identified competing roles and responsibilities which often led to working additional unpaid hours in order to attempt to balance the support of client autonomy, providing best treatment options, the nurse's needs, meeting organizational expectations, successful time management, and requirements of health care agency financial responsibilities. These findings were echoed in the stories shared in this study where CHNs described going above and beyond in their efforts to balance competing obligations while keeping the best outcome for their clients as their top priority. These ongoing tensions are contributing factors to experiences of moral distress.

Finally, the recurring theme of second-guessing was identified by CHN participants representing approximately 11% of the stories shared. Examples of specific ethical issues for CHNs within the theme of second-guessing included attending court for an inquest, participation as part of a dysfunctional health care system, working with clients' needs that are beyond the scope of the agency, creating health promotion campaigns which target an industry related to community livelihood, and caring for clients with compromised capacity to provide informed consent and make safe choices. Experiences of moral distress in these stories were related to strong nurse-client relationships and maintaining professional boundaries, prioritizing hard-to-serve clients on waiting lists, and values conflicts between personal and professional standards. According to Jameton's (1984) description of moral uncertainty, many of the stories shared by the CHN participants, under the theme of second-guessing, described experiences that should be categorized as moral uncertainty as opposed to moral distress. "Moral uncertainty is characterized by unease and questioning when the person is not clear about the right course of action" (Hamric, 2000, p. 199). However, stories shared by the CHNs often described moral uncertainty as occurring after moral distress, not instead of or before moral distress. In these

examples, CHNs described situations where they knew what needed to be done in the moment and then later second-guessed their initial judgements. The CHNs did not look back at their practice with a hind-sight is 20/20 approach about what was the right thing to do but rather with moral uncertainty. They described situations where they thought at the time they had made a sound ethical decision, but looking back felt unsure. In fact, they often stated that if they had to do it over again they still did not know the best course of action. I appreciated this level of honesty from the CHNs. It takes an incredible level of courage as a professional to say, I don't know if I did the right thing. I believe these examples speak to the complexity of everyday nursing practice in community health care settings and the numerous interacting variables that must be considered when deciding on an ethical action with the intention of achieving the most beneficial outcome for the client. The relationships between and among moral distress, moral uncertainty, and moral residue experiences have not been fully explored in the academic literature.

Navigating Structural Factors

The last interpretation of the findings involves CHNs' stories that required the need to navigate structural factors, sometimes on many levels, in order to practice ethically and within one's moral boundaries. Examples of these experiences involved a need for supportive managers and work environments, and challenges related to a lack of available resources and services.

The recurring theme of manager or agency support reflected approximately 13% of the stories shared. In this study, examples of specific ethical issues for CHNs within the theme of manager/agency support included poor handling of team member behaviours, insufficient respect for the scope and expertise of the CHN role, the need for input to improve practices and safety, and being required to adhere to strict guidelines. These stories highlighted a lack of responsive

approaches to address important issues in practice with unreasonable expectations and poor communication. CHNs' noted that unrealistic expectations often stemmed from the poor abilities of some managers to grasp everyday CHN practice realities and challenges that impact workload capacity (especially if the manager had no nursing background). Experiences of moral distress in these stories were related to promoting unsafe or unacceptable standards of nursing practice, fear of reprisals for speaking up, powerlessness, understaffing, and work overload. In this study, most of the examples of moral distress within the theme of manager/agency support described negative experiences with a lack of manager or agency support. Nurses' positive experiences of manager support have been identified in a study in acute care by Zuzelo (2007) where managers were found to be a source of integral support for ethical nursing practice. This finding, of manager and agency support, is significant because it speaks to a specific level where education interventions may be targeted to create positive changes.

Navigating the tensions among and between resources and services, in diverse community settings, were also identified as sources of moral distress by the CHNs. The recurring theme of resources and services reflected approximately 26% of the stories shared by the CHN participants, the highest percentage noted among all the categories of themes. Examples of specific ethical issues for CHNs within the theme of a resources and services included minimal or no available resources, long waiting lists, clients who over-utilize resources, clients who don't qualify for services, perceived lack of privacy and confidentiality of service provision (especially in rural and remote communities), variable quality of community services, and challenges providing services to vulnerable populations. Experiences of moral distress in these stories were related to knowing that families are not coping well with caregiving, frustration with a dysfunctional system of health and social services, concerns for clients at high risk, strong nurse-

client relationships, CHN strike conditions, and unrealistic client or family expectations about services. Similar frustrations were noted in a study of Swedish mental health nurses (Magnusson & Lutzen, 1999) which found high levels of moral distress related to providing services in a community health care setting which was due to barriers with patient privacy/confidentiality issues and the home care setting itself. The Swedish nurses described feelings of isolation in decision making in their community health nursing practice. For nurses in community health care settings, the sense of having “nothing to offer” perhaps exists on the same continuum as providing futile care in acute care settings. The continuum of moral distress experiences relating to resources and services for the CHNs in this study, as in the Swedish study, include situations where nurses recognize what needs to be provided (or withheld) but they cannot do so for a variety of reasons and then they must provide alternative care, or they cannot provide the care at the time it is needed, or they cannot provide the care at all.

Experiences of moral distress related to resources and services were further impacted if the community health care setting was a rural or remote one. Relationships between CHNs, clients, and families were described as often intergenerational, sometimes spanning decades. Not being able to provide adequate (or any) care in a rural or remote setting meant more than just an unfulfilled professional obligation, especially when the nurse was raised and currently lived in that same community environment. Sometimes it was also deeply personal. The northern factor of rural and remote community health nursing practice is described by Dorsa as follows:

I find the people in the north are so genuine and so helpful to one another...It's quite not like the south. You know, if your car breaks down and you pull over, you might have to wait quite a while before someone helps you. Whereas my husband's truck broke down a

couple of years ago and he wasn't there five minutes and someone was there to get him to where he needed to go.

Interpretations of Phase Two Findings

The need for increased opportunities for ongoing professional ethics education for community health care professionals has been identified in the health care literature. For example, in MacPhail's research in 2001 with community-care nurses as well as in my master's work (Jessiman, 2008). Considering the complex everyday ethical issues faced by nurses working in community health care settings and the potentially far-reaching impact of those decisions, a better understanding of everyday ethical issues, experiences of moral distress, and the educational needs of these CHNs provides an opportunity to support nurses in their daily practice. The strategy of supporting nurses with story and through story is vital.

In part due to the use of narrative, the e-module was positively reviewed by three participants in this study. The e-module created in this study met its intended objectives in the following ways. The concept of moral distress was defined and explored through reference to the academic literature. Everyday ethical issues, with a high potential for moral distress, were situated in community health nursing contexts in three meta-narratives. The stories were followed by questions about perceived correct actions, needs for additional information, and potential resources and supports. The intent was to stimulate discussion and reflection by CHNs on experiences of everyday ethical issues and moral distress experiences. The three meta-narratives used in the e-module were titled: 1) Conspiracy of Silence; 2) Autonomous Choices; and 3) The Care I Deserve (see Appendix J: Self-Directed E-Learning Module). Finally, relevant resources were highlighted in the e-module, such as the tool known as the 4 A's to Rise Above Moral Distress by the American Association of Critical Care Nurses (2008), in order to support

nurses in their practice. In addition, the e-module contained descriptions of sources of moral distress, barriers to ethical nursing practice, ethical decision-making tools, self-care options, suggested topics for and further discussion, and online resources.

Additional Considerations and Reflections

This study makes a significant contribution to the academic literature in furthering understanding and insight into everyday ethical issues and experiences of moral distress for community health nurses (CHNs) in their practice in Canadian community health care settings. This study contributes findings that, in part, are consistent with the results of other published investigations on moral distress among nurses, as well as results that have not been previously identified in the nursing literature. It is inevitable that newly published work will be relevant to this discussion due to the considerable volume of research being conducted on the topic of moral distress at present. However, these findings have implications when related to the larger findings in the current academic body of literature on ethical issues, moral distress, and contemporary nursing practice.

This study uncovered the variability within the title and roles of a CHN and described snapshots of roles and responsibilities in public health nursing, home care nursing, and indirect care nursing. I have, through data-based meta-narratives, illustrated some of the key ethical issues and themes with a high potential for moral distress for contemporary CHNs in Canada. I have identified connections between experiences of moral distress and perceptions of contributing to unnecessary suffering not only for clients and families, but to a certain extent to one's own personal sense of suffering. Also, participants indicated that not knowing the outcome for a client was an important contributor to their experiencing ongoing moral distress, otherwise referred to as moral residue.

Finally, participant evaluation of the self-directed e-learning module (e-module), which utilized contextually-rich educational meta-narratives, revealed that it would support and enhance the delivery of education on moral distress for CHNs. The e-module was positively received and the feedback provided will be used to fine-tune the e-module for future use outside of this dissertation process. In addition to these research findings, a tangible outcome of this study was the production of a series of CHN meta-narratives. This contribution of knowledge to the academic literature provides powerful, authentic evidence of the experiences of everyday ethical issues and moral distress for CHNs, and the need for ongoing educational support in this regard. This information will be disseminated and made readily available to academics and health care professionals interested in creating change and ensuring continuing education opportunities related to everyday ethics and moral distress, namely CHNs, managers at all levels, and community health agencies.

Chapter Seven: Recommendations and Conclusion

There are a number of important applications for this research, which has given a voice to the unique experiences of CHNs. This study has provided an opportunity to make these experiences public, while still maintaining privacy and confidentiality for the individual nurse participants in this study, their workplaces, and the patients, families, colleagues, and communities that they work with. In this chapter, various practical implications drawn from the findings are discussed in the contexts of nursing practice, theory, education, and research.

In this dissertation, many everyday ethical issues and experiences of moral distress for CHNs have been noted including issues and experiences which may be common among nurses across multi-sector practice settings. One insight from the findings of this study is that a complex interaction of many factors should be taken into account and recognized as contributing to moral distress experiences in nursing practice, particularly in community health care settings. Practical implications listed below are expressed in terms of the potential for tangible improvements for individual nurses and other health care providers, teams, communities of practice, organizations and agencies, and the health care system as a whole. However, implementing practical strategies in challenging practice realities is often easier said than done. Taking direction from narrative researcher Carola Conle (1997), I suggest that in order to create sustainable strategies “we need our imagination for action” (p. 215). And further to this call for creativity in action (here in relation to addressing moral distress experiences in community health nursing practice), I present my recommendations based on the data and with further support from the academic literature.

Nursing Practice

Several recommendations for nursing practice at the micro-level have emerged from the findings in this study for individual CHNs to create sustainable strategies to support ethical

practice and mitigate experience of moral distress. As noted in chapter two, the International Council of Nurses (ICN, 2012) directs that nurses have four ethical responsibilities that include promoting health, preventing illness, restoring health, and alleviating suffering. Situations that prevent nurses from meeting their ethical responsibilities in their clinical practice set the stage for unnecessary suffering of clients, families, and nurses and often, experiences of moral distress.

CHN participants in this study acknowledged the challenges of community health care practice realities related to an increased pace of practice, heavy workload expectations, low autonomy, and limited resources, and described what these factors meant to them personally and professionally. These topics are not unique or exclusive to nursing practice in community health care settings. Often the time and space to consider the meaning of these experiences cannot be incorporated into a nurse's work-day. Just as Doane (2002) found in her study, "The nurses described that they most often did not have time to listen and fully engage in an inner dialogue, to think things through to reach an inner consensus" (p. 630).

Participants described a variety of personal coping strategies for maintaining ethical practice and attempting to mitigate their experiences of moral distress. They described the value of feeling connected with other colleagues, continuing to practice wholeheartedly, finding courage and compassion for self and others, and maintaining resilience.

The concept of creating sacred spaces (Edmonson, 2010; Taylor-Ford, 2013) can be undertaken by an individual nurse in order to facilitate one's own reflective practice in an effort towards self-care and healing. Such practices can be a vital component for individuals to sustain their ability to deliver compassionate care to clients and families and to continue to be an effective member of a health care team. Many CHN participants described the need for

intentional, ongoing maintenance of their personal and professional values, in response to their sense of accountability to the client, responsibility for outcomes, and perceived obligations.

The context of not being able to do what needs to be done, for CHNs, is about more than not being able to get the job done. These descriptions fit well with discussions in the academic literature on multiple masters (Meaney, 2002) related to values, commitments and roles. Also, Epstein and Delgado (2010) recommend values clarification, seeking ongoing understanding about the healthcare system itself, and targeting communication as key tools for addressing conflicting obligations in nursing practice. There is a need to encourage self-care to promote and maintain moral identity and positive self-concept, as well as to protect from the many opportunities where erosion may occur.

Micro-level recommendations for action are important, however, they cannot be the only strategies that are used to support ethical practice. As noted by Noddings (1986), “we approach our goal by living... in a caring community, through modeling, dialogue, practice and confirmation...” (p. 502). In this quote, Noddings was describing the value of relationships. The values and commitments inherent in ethical nursing practice reflect a personal process, as well as a socially-mediated, professional process (Doane, 2002; Doane, Pauly, Brown, & McPherson, 2004; Rodney et al., 2002). As noted by Varcoe, Rodney, and McCormick (2003), “The relational nature of nursing practice should not be ignored. If change is to occur, we cannot expect nurses to enact their practice in isolation” (p. 970).

Therefore, practical implications beyond the individual CHN level need to be explored. Several recommendations at the meso-level have emerged from the findings in the current study related to creating sustainable strategies for improved interpersonal and inter-professional relationships that support ethical practice and mitigate experiences of moral distress among

clients, families, and members of the health care team. These strategies have the potential to positively impact job satisfaction and retention rates (Severinsson & Hummelvoll, 2001) and to reduce nurses' sick time (American Association of Critical Care Nurses, 2008; Corley, 2002). These meso-level recommendations are discussed next, in the context of relationships, power, and leadership.

Relationships in Practice

The careful balance between the personal and professional obligations of relational practice in community health care settings allows nurses to be in a prime position to anticipate everyday ethical issues early and often (Austin, 2011). Doane (2002) believes that nurses possess the capacity to “re-imagine themselves and their practices, and to resist and effect the contextual forces in the workplace” (p. 633). Contextual forces may include a complex interplay of individuals, organizational culture, unchallenged assumptions, and power hierarchies (Varcoe, Rodney, & McCormick, 2003). A key recommendation from the findings of the current study is to strengthen the team approach, one also recommended by Baxter (2012), in order to decrease the sense of professional isolation and profound sense of individual responsibility (versus team responsibility) often described by CHNs. One strategy to begin with would be encouraging dialogue about everyday ethical issues and experiences of moral distress to foster awareness, gauge the needs of team members, and share coping strategies.

Power Differentials in Practice

One of the most critical issues in the overall discussion about nurses' everyday ethical issues and experiences of moral distress in their nursing practice is the issue of “power and differences in power” (Varcoe, Pauly, Webster, & Storch, 2012, p. 59). In many settings, nurses are positioned in a moral tension between organizations and agencies, clients, families, and other

members of the health care team (Hamric, 2001; Baxter 2012). This is not to say that nurses are without power, however “nurses often have more responsibility than authority” (Corley, Elswick, Gorman, & Clor, 2001, p. 251).

Perhaps there is a need to consider the concept of strength in numbers. Thus, another recommendation of this study is a multi-level commitment to the role of moral community (as discussed by Hardingham, 2004). The development of a moral community among CHNs, as well as among other members of the health care team, can serve to enhance ethical practice and to support professional autonomy. Moral community is defined by Varcoe, Rodney, and McCormick (2003) as “a place where values are made explicit and shared, where values direct action, and where individuals feel safe to be heard” (p.970). Strategies to support moral community must facilitate opportunities for collaborative dialogues among colleagues to foster mutual respect, discuss common care goals, and meet ethical responsibilities to self and others (Aroskar, 1995). Ongoing, interdisciplinary dialogue for health care teams is also important in order to question current and new guidelines and practices which may situate health care as a commodity governed by business ethics devoid of nursing’s core values and obligations to humanity (Aroskar, 1995).

My analysis highlights the need to support ethical nursing practice and create positive working relationships, especially among CHNs. Strategies that foster ethical leadership and build moral community within health care teams and community health care organizations can contribute to the dissemination of moral values and enhance the ethical fabric of an organization (Sama & Shoaf, 2007). Activities of this nature can reduce the knowledge-to-practice gap and empower nurses to contribute their professional knowledge more significantly to ethical decision making in their nursing practice (as highlighted by Browning, 2013).

In addition to these practical implications at micro- and meso-levels, a response must come from the leaders of organizations and health care systems as well. I have discerned several recommendations for nursing at the macro-level, from my analysis of the findings, to create sustainable strategies for changes within organizations and health care system structures to support ethical practice and mitigate experiences of moral distress for nurses. To be clear, a one-size-fits-all organizational or systems level strategy to address moral distress is not a recommendation of this study. Moral distress is a subjective, individual experience, overlaid with social, cultural, and institutional narratives and no one particular ethical issue can be defined as causing or contributing to experiences of moral distress for all nurses in all instances. An experience of moral distress for a nurse (manifested by various symptoms that can be physical, mental, emotional, and/or behavioural) is a red flag that indicates a problem (or problems). Thus, any systemic, objective, across-the-board strategy to address moral distress will be a futile attempt at responsiveness. The key to the success of the strategies suggested here, for promoting ethical nursing practice and reducing moral distress, lies within the appropriate adaptation of these strategies according to context. It involves finding the best fit within the organization or system in relation to the needs identified by members of the health care team and individualized for the social, political, and economic intricacies of each community health nursing agency.

Leadership in Practice

At the macro-level, then, there is a call to action for nurse leaders (Bell & Breslin, 2008) and managers to “support the multidisciplinary team in creating an environment that acknowledges and responds to the issues surrounding moral distress” (Taylor-Ford, 2013, p. 52). The value of nursing supervisory support and action was also noted by Millette (1994). A supportive work environment, also known as a positive ethical climate (Fogel, 2007; Hamric &

Blackhall, 2007; Hart, 2005; Pauly, Varcoe, Storch, & Newton, 2009; Schluter, Winch, Holzhauser, & Henderson, 2008), can be achieved through the development and implementation of responsive organizational policies (as described also in the current study), providing appropriate educational opportunities, and ensuring that nurses are aware of currently available resources and the processes for accessing them (Taylor-Ford, 2013). A commitment to building and sustaining quality work environments, which encourage CHNs to lead positive changes in nursing practice, is another recommendation of the current study.

Nursing Theory

Gadow (1999) suggested that the nursing profession requires a philosophy with ethics as the cornerstone. This is an important suggestion. The findings of the current study provide insight into the need for future development of nursing theory that is relevant and responsive to everyday ethical issues and experiences of moral distress, particularly in community health care settings. Austin (2007) calls for “the expansion of bioethical theory in ways that address the current moral challenges and experiences of healthcare professionals” (p. 82). My work in this study explored key ethical issues for CHNs and identified specific examples of some of the moral challenges and everyday ethical experiences described by participants from their nursing practice in community health settings. My analysis of the data, using bioethical principles as the framework, is an example of adapting and expanding bioethical theory, as Austin suggests, and placing it into context with CHN practice realities.

Nursing Education

Ongoing education and professional development can provide nurses with opportunities to find the words to describe their moral distress experiences and to begin to explore tangible solutions to very complex everyday ethical issues in their clinical practice. The findings of this

study give credibility to the value of a narrative inquiry approach for nursing ethics education. Often used in continuing education and development for teachers, the flow of the narrative approach can be described as moving, floating, shifting, changing, and harmonizing in order to respond to a variety of forces and factors (Xu, 2006; Xu & Connelly, 2009). This is an appropriate, responsive strategy for use in the dynamic care environments where CHNs work.

From Ethical Decisions to Ethical Identities

One recommendation from the findings of this study for nursing education is a shift from content to process for continuing ethics education. Also noted by Walker (1993), this concept of how to do ethics moves toward conversations about common language for ethical dialogue, moral practices and resources, and constructive processes for inquiry such as interpretation, negotiation, construction, and resolution. Also, CHN participants in this study recommended case study-based learning from and with members of interdisciplinary teams (and other community agencies) to support ethical reflection and learning that is authentic and relevant to the complexities of everyday community health nursing practice realities. For example, team education should explore available services, how to navigate the health care system (e.g., referral processes), roles and responsibilities, and opportunities for advocacy. An interactive, collaborative approach to ethics education would support an increased sense of shared responsibility and potentially result in decreasing perceptions of professional isolation and solitary decision making. Current literature validates the benefits of an interdisciplinary-based, team approach for education in response to experiences of moral distress (Deady & McCarthy, 2010; de Veer, Francke, Struijs, & Willems, 2012) and its value in further developing moral judgement (Auvinen, Suominen, Leino-Kilpi, & Helkama, 2004). Some CHN participants referred to the need, in undergraduate and graduate nursing education, for early and frequent

discussions about relevant, contemporary everyday ethical issues (e.g., suspected abuse) and experiences of moral distress in nursing practice in a variety of health care settings.

Also, in reference to a quote used in chapter one, ethics “needs to shift its orientation from decisions to identities-that is, who I become as a result of making this decision” (Frank, 2004, p. 357). Therefore, as nursing education shifts from a focus on ethics content to processes, it must also shift to focus on the ethical and moral identities of nurses (and the meaning of those identities) within contemporary nursing practice realities. These important shifts in approaches to ethics education in nursing will require support from continued nursing research in this area.

Nursing Research

Current and future research opportunities regarding the topic of moral distress, in nursing and for other care providers, are extensive. The long-term effects that experiences of moral distress may have on nurses, how it may impact clients and families, or how it ultimately manifests in patient care outcomes are not known. Therefore, there is a strong argument for more qualitative, particularly narrative inquiry-based, studies to further explore the details of individual experiences of nurses with this complex phenomenon.

In addition, as Corley, Minick, Elswick & Jacobs (2005) highlight, “research is needed on interventions that health care organizations can use to enhance the ethical environment and provide a possible approach to reducing nurse moral distress” (p. 388). From a solid foundation of qualitative research, evidence-based strategies for early interventions for moral distress and improvements for ethical work environments can be applied. In order to evaluate moral distress interventions, a reliable and valid tool is necessary to measure the variables. A revision to the Moral Distress Scale (MDS, Corley, Elswick, Gorman, & Clor, 2001; Hamric, Borchers, & Epstein, 2012) for use with nurses in community health care settings may be one viable future

option. Once the frequency and intensity of the moral distress experiences of health care providers in their clinical practice can be adequately measured, educational interventions and strategies can be evaluated more consistently.

Supporting Client Autonomy

I also recommend that further research be conducted concerning ethical issues and moral distress for CHNs relating to clients' refusing care in community health care settings. My interpretation of this finding, regarding clients refusing care as a recurring theme, is that it speaks to the increased client autonomy often found in community settings. In addition, this finding relates to shifts in perceived power and responsibility sharing between the nurse, the client, and family/caregivers in community settings. The potential ethical implications of increased client autonomy are a significant finding in this study. The link between ethical issues and situations of increased client autonomy has also been documented by Burger, Erlen, and Tesone (1992). Given that bioethical principles tend to highlight autonomy as having largely positive ethical aspects, consideration for possible ethical tensions (e.g., poor decision making or risk taking) is needed.

As previously noted, community care settings are a unique contrast to hospital settings in that the nurse is often working in the client's own space. In the context of home care nursing and indirect care nursing, as described in this study, non-institutional work environments can result in a shifting of the power dynamics and one's sense of control. Thus, the home environment can set the stage for ethical issues and moral distress experiences. The impact of the home care setting itself on moral distress experiences was also found in a study by Magnusson and Lutzen (1999).

My analysis of the findings also point to a need for research on CHNs' perspectives regarding issues related to supporting client autonomy (i.e., choice, decision making, risk taking) and the roles of family/caregivers. In addition, for CHNs who are public health nurses, such as described in this study, the ethical duty to support client autonomy must sometimes be balanced with ethical obligations to the greater community (e.g., infectious disease and vaccination). Ethical issues can also be further compounded for CHNs who often lack the time to fully reflect on practice issues and who may be working in relative isolation to other CHN colleagues and inter-professional team members (also found by Burger, Erlen, & Tesone, 1992; Magnusson & Lutzen, 1999; MacPhail, 2001).

Palliative and End-of-Life Care Contexts

Very few ethical issues have time pressures that are more serious than palliative and end-of-life care situations. Therefore, I suggest that additional studies are needed to explore everyday ethical issues and experiences of moral distress and palliative care in community health care settings. Palliative and end-of-life care ethical issues have been identified in this study as catalysts for moral distress experiences consistent with the findings in other studies noted in chapter one regarding acute care settings. Further research on moral distress and palliative care is warranted. Other topics for further attention related to ethical decision making and moral distress in community health care settings include key issues related to poor allocation of resources and community health services and strategies for improvement, and exploring professional and personal boundary issues for CHNs in rural and remote communities.

Northern, Rural, and Remote Contexts

In addition, this research highlights the need for the evaluation of strategies intended to: support individual nurses with everyday ethical issues and experiences of moral distress (e.g., the

self-directed e-learning module developed in the current study); promote positive interactions with managers and CHNs to support ethical practice; and promote dialogue and collaboration among members of a moral community of health care professionals in a supportive, quality work environment. Topics highlighted in the current study related to resources and services, especially for CHNs working in rural and remote communities, require further investigation. Issues specifically related to rural or remote nursing practice such as having nothing to offer clients/families, strong nurse-client relationships, and perceptions of reduced privacy and confidentiality are important areas for nurse researchers to explore in order to create a better understanding of these issues within the larger CHN community across Canada. There is a need for further exploration of everyday ethical issues in northern rural and remote nursing practice as highlighted in my master's work (Jessiman, 2008). Also underscored is the need for research on the CHN perspective regarding personal and professional commitments, perceptions about obligations and responsibilities, and how these factors are impacted by environmental contexts (i.e., practicing in rural or remote communities versus urban centres). As identified by Beatty (2001), I recommend further studies to explore ways to support rural nurses in their practice.

Socio-Cultural-Political Factors

Leading Canadian researchers on the topic of moral distress, Varcoe, Pauly, Webster, and Storch (2012), suggest the need for a multi-country study that goes beyond organizational barriers and examines socio-political contexts in relation to levels of moral distress of health care providers. This suggestion merits further investigation in order to gain a better understanding of individual to systemic responses to moral distress, to create and validate better measurement tools (e.g., for educators, students, and health care professionals), and to evaluate moral distress interventions beyond anecdotal accounts (Babgi, Rogers, Gomez, & McMahon, 2008; Helft,

Bledsoe, Hancock, & Wocial, 2009; Rogers, Babgi, & Gomez, 2008). Varcoe et al. (2012) also suggest the need for future research into fostering awareness of moral distress and evaluating strategies that improve, create, and support ethical practice, thus impacting moral distress experiences. Varcoe et al. recommend exploring ways to incorporate the concept of moral distress into ethical practice guidelines, organizational policies, and professional practice documents. A multi-country approach may also connect the strengths and common challenges of the international community on this globally-relevant topic.

Conclusion

I have presented evidence that the phenomenon of moral distress for a CHN often occurs when the nurse must confront an ethical issue and when there is a perceived violation of norms, values, beliefs, and/or ethics. With consideration for the findings of this study, I now add that these ethical issues are generally complex ones, where it may be difficult or impossible to provide good care and to contribute to positive outcomes. Even if a nurse perceives that he/she acted appropriately, moral distress may occur. For the purposes of this research, I defined moral distress for nurses as being a personal experience resulting in a negative reaction to a situation that compromises or constrains the ability to fulfill one's moral obligation to practice ethically, meet professional standards, or maintain personal values. I now add that initial moral distress is a negative reaction that occurs in the moment and reactive moral distress is a negative reaction that occurs after the nurse has had time to reflect. Situations contributing to moral distress may be past or present, and that one may feel moral distress over circumstances that were originally deemed to be ethically and morally sound. The negative reaction can be experienced on behalf of others, for one's own self, or for both. Moral distress experiences may be cumulative (moral residue) and unresolved moral distress can potentiate poor outcomes at many levels.

The moral implications of not being able to do what needs to be done are a key focus for this study. “What guides us here?” This is a central question for CHNs who all grapple with complex everyday ethical issues and moral distress experiences. This question was answered by CHNs in this study, who, like their colleagues, are up close, both personally and professionally, and keenly aware of the nature of these moral distress experiences. Thus, narrative inquiry was found to be a most appropriate method to explore and identify these experiences.

First, the findings identified who the CHNs were; the “us” part of the question. Within this sample of CHNs, the roles, relationships, and responsibilities of public health nurses, home care nurses, and indirect care nurses were explored. Second, the findings identified the ethical and moral landscapes of community health settings, the “here” part of the question. The findings were analyzed using bioethical principles and interpreted according to recurring themes. These stories were further explored through the creation of nine meta-narratives that describe everyday ethical issues and moral distress in community health nursing practice. Third, supports, resources, and coping strategies were identified in order to reveal the “what guides us” aspects of community health nursing practice. As a tangible outcome of this study, an educational e-module was created and reviewed with positive feedback from participants.

This study contributes to the current academic literature on moral distress in that it addresses a gap in the academic literature, specifically providing findings and interpretations on experiences of everyday ethical issues and moral distress for Canadian CHNs. This study also incorporated the use of a narrative approach, specifically recommended by Walker (1993) as an effective strategy for working with ethical issues due to its focus on “*how* values and obligations can guide particular people facing complex problems to solutions that are morally justifiable” (p. 36, emphasis in original).

My interpretations of these findings have implications for individual nurses, community health care teams, nurse leaders and managers in community health care settings, educators, researchers, policy makers, and professional nursing organizations. Specific recommendations have been offered which are embedded in current academic literature and confirmed and expanded by data from this research. These recommendations seek to support and strengthen ethical nursing practice and reflect the core values and ethical responsibilities of professional nursing.

Through this doctoral research, I created an educational intervention to encourage reflection, dialogue, and learning about practical strategies for coping with experiences of everyday ethical issues and moral distress related to community health nursing practice. The development of an e-module on moral distress designed for nurses working in community health care settings, as was used in this study, is one step towards determining how alternative types of learning opportunities might best be offered and utilized in this area.

Scholars who are researching moral distress experiences are attempting to map an ethical landscape where exploration has only just begun. As a contribution to such an effort, this study was designed with a narrative inquiry approach to further investigate the complex, dynamic experiences of everyday ethical issues and moral distress. Only through further exploration of experiences of everyday ethical issues and moral distress in the context of community health nursing practice can we successfully design, deliver, and support ongoing ethics education that is relevant, responsive, and reflective of the challenges found within the diverse ethical landscape of everyday practice for CHNs. I wish to conclude this dissertation with a quote that I used in my master's thesis. I still find it to be relevant to the topics of everyday ethics and moral distress in nursing practice.

We must constantly remind ourselves of what it is that we wish humanly to defend and preserve, always keeping in view the defining and worthy features of human life.

Nothing less deserves to be called 'bioethics', the ethics of human life as it is humanly lived. (Kass, 2002, p.76)

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APPENDIX A: ORIGINAL LAKEHEAD UNIVERSITY REB APPROVAL

Lakehead

UNIVERSITY

Office of Research

Tel 807-343-8934
Fax 807-346-7749

November 3, 2011

Principal Investigator: Dr. Sonja Grover
Student Investigator: Kristen Jones
Faculty of Education
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Dr. Grover and Ms Jones:

Re: REB Project #: 071 11-12 / Romeo File No: 1462180
Granting Agency: N/A
Granting Agency Project #: N/A

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "What guides us here?: Exploring community nurses' experiences of moral distress in Northwestern Ontario".

Ethics approval is valid until November 3, 2012. Please submit a Request for Renewal form to the Office of Research by October 3, 2012 if your research involving human subjects will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Research Ethics Board forms are available at:

http://research.lakeheadu.ca/ethics_resources.html

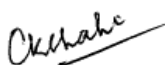
During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Completed reports and correspondence may be directed to:

Research Ethics Board
c/o Office of Research
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1
Fax: (807) 346-7749

Best wishes for a successful research project.

Sincerely,


Dr. Chander Shahi
Chair, Research Ethics Board

/scw

Lakehead Research...CREATING THE FUTURE NOW

955 Oliver Road Thunder Bay Ontario Canada P7B 5E1 www.lakeheadu.ca

APPENDIX B: RESEARCH INFORMATION LETTER



(807) 343-8079
(807) 343-8246
kristen.jones@lakeheadu.ca

Research Information Letter

"What guides us here?"

Exploring community nurses' experiences of moral distress

Dear Potential Participant,

I am a registered nurse and a graduate student in the Joint PhD. Program in Educational Studies at Lakehead University. I would like to invite you to participate in a research study. The purpose of this study is to examine and explore everyday ethical issues* in a community health care setting and experiences of moral distress**. It is hoped that the results of this study will influence professional awareness amongst nurses, physicians, and allied health care professionals of everyday ethical issues in the community care setting, identify needs for ongoing education and professional development opportunities, and promote further research studies on the impact of moral distress on professional nursing practice. You have been invited due to your current role as a nurse working in the community care setting.

*Everyday ethical issues include situations in your nursing practice in the community care setting which involve conflicting values, interests, rights or duties where the choices between right and wrong, good and bad, are not always clear.

**Moral distress may occur when a person believes they know what they 'should' do, however they are unable to do so for a variety of different reasons.

This study consists of two phases:

Phase One will consist of an individual semi-structured telephone interview with the researcher to discuss your experiences of everyday ethical issues in nursing practice in the community care setting, your experiences of moral distress related to your nursing practice in this setting, and your perspectives about needs for ongoing education and professional development. Each interview will occur at a time and date suitable to both the researcher and the participant and is expected to last for up to one hour. Each interview will be audio-recorded and then transcribed by the researcher. Demographic data will also be collected at this time (i.e. age category, gender, number of years in nursing practice, etc.). You will have the opportunity to review the transcription and remove any or all of your contributions if you wish. No identifying information will be included in any dissemination of the results. The data will be grouped and any individual data reporting will use pseudonyms and remove all identifying information. Interviews will begin in Winter/Spring of 2012.

Phase Two of the study will consist of the development, delivery, and evaluation of a moral distress workshop for nurses working in the community care setting in Thunder Bay and the Northwestern Ontario region. You will be invited to participate in this workshop which will be a full day educational experience in Summer/Fall 2012.

You may choose to participate in one, both (only if you are a resident of Thunder Bay or the NWO region), or none of the phases of this study. Should you choose to participate in any phase of this study, your name and responses will be kept in strict confidence to ensure privacy and confidentiality. At any time during the study you may request more information and will be given continuing and meaningful opportunities to decide to continue with your participation in this study or to withdraw without prejudice. The information that you provide will only be accessible to the researcher, stored securely at the researcher's office, and then destroyed after 5 years. The information gained from this study will be analyzed, interpreted, and written up in a formal doctoral dissertation. Final results of the study will likely be published in academic journals, presented at conferences, and discussed in small group presentations. As a valued participant, you can request to receive a copy of the final results of this study. No identifying information will be included in any dissemination of the results. The data will be grouped and any individual data reporting will use pseudonyms and remove all identifying information.

This study has been peer reviewed by my Doctoral Committee prior to review and acceptance by the Lakehead University Research Ethics Review Board. It is anticipated that there is minimal risk of harm for participants in this study. In the event that you feel that discussions about experiences of everyday ethical issues and moral distress in your professional nursing practice have exposed underlying psychological distress during any phase of this study or after the study, counselling opportunities can be accessed via your workplace Employee Assistance Program (EAP).

Anticipated and hoped for benefits of participation in this study may include: a sense of personal validation; access to resources and supports (workshop) regarding dealing with ethical dilemmas and moral distress in nursing practice in community care settings; and the opportunity to make a significant contribution to a developing body of research on community nursing, everyday ethical issues, and moral distress.

You may withdraw from this study completely or from any phase of this study at any time or choose not to answer any question(s). Your participation is absolutely voluntary and very much appreciated. Thank you for considering taking part in this research study. If you have any questions or concerns, please do not hesitate to contact me (Kristen) via phone at (807) 343-8079 or email kristen.jones@lakeheadu.ca. You may also contact my supervisor, Dr. Sonja Grover via email at sgrover@lakeheadu.ca. If you have any ethical concerns regarding this study please contact the Lakehead University Research Ethics Review Board at (807) 343-8283. I look forward to your participation in this study geared to developing resources for practicing community care nurses.

Most Sincerely,

Kristen Jones BScN, RN, MPH(N), PhD (Candidate)

Lakehead University 955 Oliver Road Thunder Bay Ontario Canada P7B 5E1 www.lakeheadu.ca

APPENDIX C: PHASE ONE RECRUITMENT POSTER



(807) 343-8079
 (807) 343-8246
 kristen.jones@lakeheadu.ca

Phase One Recruitment Poster

As part of Phase One of a doctoral research study titled: *"What guides us here?" Exploring community nurses' experiences of moral distress*, you are cordially invited to consider participation in an individual telephone interview to discuss everyday ethical issues* and experiences of moral distress**.

Who: Registered Nurses and Registered Practical Nurses are eligible to participate

What: Individual telephone interviews (with identity of participants concealed in dissemination of results), requesting up to one hour of your time

Where: A toll free number will be provided for a telephone interview with the researcher

When: Date/time convenient to you and the researcher (interviews will start in Winter/Spring 2012)

Why: Participation in a Research Study

Contribution to Knowledge and Understanding of Everyday Ethical Issues and Experiences of Moral Distress in Community Nursing Practice

Exploration of educational needs that could be addressed through Professional Development Opportunities

Contact Kristen Jones at 807-343-8079 or via email kristen.jones@lakeheadu.ca for more information about registration! Thank you!

*Everyday ethical issues include situations in your nursing practice in the community care setting which involve conflicting values, interests, rights or duties where the choices between right and wrong, good and bad, are not always clear.

**Moral distress may occur when a person believes they know what they 'should' do, however they are unable to do so for a variety of different reasons.

APPENDIX D: AGENCY CONSENT FORM



(807) 343-8079
 (807) 343-8246
 kristen.jones@lakeheadu.ca

Agency Consent Form

"What guides us here?"

Exploring community nurses' experiences of moral distress

Dear _____,

The purpose of this consent form is to acknowledge that you have had the opportunity to be fully informed of this research prior to allowing the researcher access to your community nursing agency. This research will explore everyday ethical issues* and experiences of moral distress**.

*Everyday ethical issues include situations in your nursing practice in the community care setting which involve conflicting values, interests, rights or duties where the choices between right and wrong, good and bad, are not always clear.

**Moral distress may occur when a person believes they know what they 'should' do, however they are unable to do so for a variety of different reasons.

I voluntarily AGREE:

___ That I have read and understood the research information letter for the study that was provided to me.

___ To allow the researcher access to invite staff of this agency to voluntarily participate in this research study.

___ To inform the researcher of any ethics protocols specific to this agency that must be followed prior to the initiation of the research study.

___ That I am authorized to sign this consent form on behalf of this agency.

I UNDERSTAND that:

___ Phase One of the study will consist of an Individual Semi-Structured Telephone Interview, which will be audiotaped and transcribed by the researcher. Each participant's identity will be concealed as will that of the agency and held in strictest confidence.

___ The Individual Semi-Structured Interview occur at a time and place mutually agreeable to the participant and the researcher. Interviews will begin in Winter 2011- Spring 2012.

___ The Individual Semi-Structured Telephone Interview will take approximately one hour per participant.

___ Participants may withdraw at any time without adverse consequences or choose not to answer some or any questions.

___ The Individual Semi-Structured Telephone Interview will be audiotaped and transcribed by the researcher. Participants will have the opportunity to review and retract any portion or all of their contribution.

___ Participants may choose to participate in one or more of the phases of the study, or none at all, without adverse consequences

___ Phase Two of the study will consist of a full day workshop offered in Thunder Bay, Ontario in Fall 2012.

___ There are minimal anticipated risks and benefits associated with participation in this research. However, as the workshop does address ethical concerns and moral distress in nursing practice arrangements for further follow-up will be made with each agency should any participant require additional support.

___ Anticipated benefits for research participants include: a sense of personal validation; access to resources and supports (workshop) regarding dealing with ethical issues and moral distress in nursing practice in a community care settings; and the opportunity to make a significant contribution to a developing body of research on community nursing, everyday ethical issues, and moral distress.

___ The data will be securely stored at Lakehead University and destroyed after a period of 5 years.

___ I can request an e-copy summary of the research findings from the researcher.

___ All agencies and participants will remain anonymous in any publications or presentations of the research findings.

Name (Please Print): _____

Signature: _____

Date: _____

Researcher's Signature as witnessed: _____

In the event that you feel that discussions about experiences of everyday ethical issues and moral distress in your professional nursing practice have exposed underlying psychological distress during any phase of this study or after the study, counselling opportunities can be accessed via your workplace Employee Assistance Program (EAP).

APPENDIX E: LAKEHEAD UNIVERSITY REB AMENDMENT #1

Lakehead
UNIVERSITY

Office of Research

(807) 343-8283

(807) 346-7749

MEMORANDUM**Date:** February 13, 2012**To:** Dr. Sonja Grover and Ms Kristen Jones**From:** Dr. Chander Shahi**Subject:** Amendment for REB Project #071 11-12 / ROMEO #1462180

Thank you for your request for amendments for your project entitled, "What guides us here?: Exploring community nurses' experiences of moral distress in Northwestern Ontario".

Your request for the following is acceptable to the Research Ethics Board:

- 1) A change in title removing "in Northwestern Ontario"
- 2) The addition of the use of the telephone for interviews
- 3) The addition of a fifth community in the recruitment plan
- 4) The addition of various nursing organizations in the recruitment plan
- 5) The amended dates

Thank you for providing the amended covering letters and consent letters. These are also acceptable to the Research Ethics Board.

Please continue to advise us of any future changes to this project.

Sincerely,


Dr. Chander Shahi
Chair, Research Ethics Board

/scw

APPENDIX F: LAKEHEAD UNIVERSITY REB AMENDMENT #2



Office of Research

(807) 343-8283
(807) 346-7749**MEMORANDUM****Date:** September 14, 2012**To:** Dr. Sonja Grover and Ms Kristen Jones**From:** Dr. Chander Shahi**Subject:** Amendment for REB Project #071 11-12 / ROMEO #1462180

Thank you for your request for amendment for your project entitled, "What guides us here?: Exploring community nurses' experiences of moral distress in Northwestern Ontario".

Your request to modify the participant recruitment to offer the opportunity for participation in this workshop to the nurses at the Thunder Bay District Health Unit is acceptable to the Research Ethics Board.

Thank you for providing the amended covering letter and consent form. These are also acceptable to the Research Ethics Board.

Please continue to advise us of any future changes to this project.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard Maundrell".

Dr. Richard Maundrell
Chair, Research Ethics Board

/scw

APPENDIX G: LAKEHEAD UNIVERSITY REB AMENDMENT #3

Lakehead

UNIVERSITY

Office of Research

(807) 343-8283

(807) 346-7749

MEMORANDUM**Date:** December 7, 2012**To:** Dr. Sonja Grover and Kristen Jones**From:** Dr. Richard Maundrell**Subject:** Amendment for REB Project #071 11-12 / ROMEO #1462180

Thank you for your request for amendments to your project titled, "What Guides us Here? Exploring Community Nurses' Experiences of Moral Distress".

Your request for amendment to revise the existing procedure of holding a moral distress workshop and change it to a self-directed e-learning module is acceptable to the Research Ethics Board. Thank you for providing the Phase Two Pre and Post Evaluations, Self-Directed E-Learning Module Evaluation Form, and the email to participants.

Please continue to advise us of any future changes to this project.

Sincerely,



Dr. Richard Maundrell
Chair, Research Ethics Board

/scw

APPENDIX H: PARTICIPANT CONSENT FORM



(807) 343-8079
 (807) 343-8246
 kristen.jones@lakeheadu.ca

Phase One Consent Form

"What guides us here?"

Exploring community nurses' experiences of moral distress

Dear Potential Participant,

The purpose of this consent form is to acknowledge that your rights as a participant have been considered and upheld by the researcher in the planning and delivery of this research. This research will explore everyday ethical issues* and experiences of moral distress**.

*Everyday ethical issues include situations in your nursing practice in the community care setting which involve conflicting values, interests, rights or duties where the choices between right and wrong, good and bad, are not always clear.

**Moral distress may occur when a person believes they know what they 'should' do, however they are unable to do so for a variety of different reasons.

I voluntarily AGREE:

That I have read and understood the research information letter for the study that was provided to me.

To participate in Phase One- Individual Semi-Structured Telephone Interview.

I UNDERSTAND that:

I will remain anonymous in any publications or presentations of the research findings. Pseudonyms will be used without any identifying information and/or the data will be presented as grouped data.

The Individual Semi-Structured Telephone Interview will be audiotaped and transcribed by the researcher.

I may request a retraction of any of my contributions after having had the opportunity to review the transcription of my contributions.

The Individual Semi-Structured Telephone Interview will occur at a time and place mutually agreeable to the participant and the researcher during the Winter/Spring of 2012.

___ The Individual Semi-Structured Interview will take approximately one hour of my time.

___ There are no foreseeable anticipated risks to this study however my agency's EAP is available should I experience distress that requires follow-up care and counselling.

___ The anticipated benefits associated with participation in this research study include: a sense of personal validation; access to resources/supports concerning dealing with ethical concerns and moral distress relating to my nursing practice via a professional workshop on such matters; and contribution to the content of a professional development workshop.

___ My participation is entirely voluntary, I may withdraw from the study at any time, and I may choose not to answer any question without any adverse consequences.

___ The data will be securely stored at Lakehead University and destroyed after a period of 5 years.

___ I can request a e-copy summary of the research findings from the researcher.

___ I will remain anonymous in any publications or presentations of the research findings.

Name (Please Print): _____

Signature: _____

Date: _____

Researcher's Signature as witnessed: _____

In the event that you feel that discussions about experiences of everyday ethical issues and moral distress in your professional nursing practice have exposed underlying psychological distress during any phase of this study or after the study, counselling opportunities can be accessed via your workplace Employee Assistance Program (EAP).

APPENDIX I: SEMI-STRUCTURED INTERVIEW GUIDE

Introduction of myself & participant (5 min)

Provide participant with a copy of their signed consent form directing participant to their agency's EAP counseling if required.

General Demographic Data (5 min)

This information will be used in the final report to describe the sample of participants who responded to this study. It will not be used to identify you in any way in the final results. All data will be grouped and discussed as grouped data.

1. Age: 20-30 30-40 40-50 50-60 60-70
2. Gender: Female Male
3. Employment status: Full time Part time Casual
4. How long have you worked at this agency?
5. How long have you worked as a nurse in the community care setting?
6. Number of years in professional nursing practice?
7. Are you an RN or RPN? (or RN with previous RPN diploma?)
8. Do you have a particular area of nursing specialization?
9. Highest level of education?
10. Have you received previous education (in any form) on:
 - Everyday ethical issues?
 - Ethical decision-making?
 - Moral distress?
11. Would you like to identify any particular religious affiliation?
12. Location of current community nursing practice? (i.e. city, province)
13. Would you consider your community nursing practice to be in a rural or remote location?

Semi-Structured Interview Guidelines (45 minutes)

“Often we find out what we think by listening to what we say. Telling stories helps us to find out who we are” (Tirrell, 1999, p. 117).

Participants will be prompted to describe their role as a nurse in the community care setting.

“It is in asking good questions, not in having all the answers where morality resides. *Being ethical* is never something one possesses. It is the recognition of the messy and expanding interdependence of decisions, interests, and persons” (Austin, 2007, p.85, emphasis in original).

Participants will be prompted to share a story about a common everyday ethical issue in their community nursing practice.

“Being ethical...has less to do with making a single decision than with initiating a process- often a very slow process- of a person or persons coming to feel that how they acted was as good as it could have been, given the inherent impossibility of the situation” (Frank, 2004, p. 355-6)

Participants will be prompted by this quote to share a story about an experience of moral distress in their community nursing practice.

Participants will be asked to describe some professional development ideas and topics that they feel would be most helpful to assist them with everyday ethical issues and moral distress.

To give all participants anonymity and protect confidentiality, each participant is asked to choose a ‘fake name’ that will be used in the final write up of this study. What would you like your pseudonym to be?

Final Question: Would you like the opportunity to review the transcription of this interview?

APPENDIX J: SELF-DIRECTED E-LEARNING MODULE



WHAT GUIDES US HERE?
MORAL DISTRESS IN COMMUNITY HEALTH NURSING

SELF-DIRECTED E-LEARNING MODULE

1

WITH GRATITUDE

- The thoughts and ideas contained in these slides are a compilation of theory, research, and lived experiences of community nursing practice.
- I wish to thank the participants who generously contributed to this research, taking the time to share their stories.

2

COMMUNITY NURSING NARRATIVES

- The narratives that you will find in this module are a combination of many true stories woven together to create real life examples for discussion while protecting the privacy and confidentiality of actual nurses, clients, and families from communities across Canada.

3

LEARNING OBJECTIVES

- To define and explore the concept of moral distress
- To situate experiences of moral distress in the context of community health nursing in Canada
- To highlight tools, supports, and resources that may be helpful for nurses in the community care setting

4

MORAL DISTRESS



- You know the ethically 'right' action to take, but **cannot** do it...
- You know the ethically 'right' action to take, but are **forced** to take **another route...**

5

YOU KNOW IT WHEN YOU FEEL IT...

- Disappointment
- Horror
- Fear
- Uncertainty/Self-doubt
- Frustration
- Anger
- Shock
- Devalued
- Unheard/Ignored
- Helpless/Hopeless

6

MORAL DISTRESS: SIGNS & SYMPTOMS

- Physical
- Emotional
- Mental
- Behavioural
- Spiritual



7

SOURCES OF MORAL DISTRESS

- **Personal**
 - Fear, anxiety, lack of confidence
 - Expectations for self
 - Expectations for a 'good nurse'
- **Interpersonal**
 - Poor communication, fiscal pressures, legal concerns, lack of supervisor support
- **Environmental**
 - Policy and procedures
 - Dysfunctional systems, gaps in service provision
 - Lack of time and/or resources

8

BARRIERS TO ETHICAL PRACTICE

- Culture of silence, fear
- Personal/professional expectations (ie. do more with less)
- Time constraints (ie. increased workload)
- Resources (ie. services, staffing shortage)
- Power dynamics- "multiple masters", non-health care supervisors/managers, among team members
- Disenchantment (ideals versus reality disconnect)
- Pace of contemporary nursing practice- "these things happen so fast, so often", become accustomed to it
- "Safety" often trumps individual rights

9

WHY DOES MORAL DISTRESS MATTER?

- It should not be a discussion about 'getting over' or 'getting past' moral distress.
- Moral distress signals **a moment of opportunity.**

10

MORAL DISTRESS: OUR ETHICAL GPS

- Our internal alarm systems often tell us when our values and beliefs about ethical nursing practice and care may be compromised.
- “Ding, ding. Recalculating. When safe, make a legal u-turn.”

11

CONSEQUENCES OF A MISSED OPPORTUNITY

- How are you going to show up and live it everyday?
- **Moral Residue** (Webster & Baylis, 2000)
- **Crescendo Effect** (Epstein & Hamric, 2009)
- The effects of moral distress can be lasting (moral residue) and can build up over time causing the impact of future experiences of moral distress to be more pronounced (crescendo effect).

12

MORAL DISTRESS: NOT JUST A 'NURSING PROBLEM'

- Medicine (physicians; medical students)
 - Pharmacy
 - Psychology
 - Respiratory care
- Studies have been conducted around the world in all of these different areas of health care . Moral distress is not because nurses “care too much!”

13

MORAL DISTRESS IN ACUTE CARE NURSING

- Perinatal/neonatal nursing
 - Pediatric nursing
 - Intensive/critical care nursing
 - Medical nursing
 - Surgical nursing
 - Perioperative nursing
 - Mental health nursing
 - Military nursing
 - Nurse practitioners
- Studies on moral distress have been conducted extensively in various specialties in acute care nursing practice.

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THE UNCHARTED TERRITORY OF MORAL DISTRESS IN COMMUNITY HEALTH NURSING



- But what about moral distress in the community health care setting?

15

CASE STUDY #1- EVERYDAY ETHICAL ISSUE

- **Conspiracy of Silence**
- Joe is a WWII veteran who lives in a rural Canadian community. He lives alone at home and is on a waiting list for long term care (LTC). There are only two LTC facilities in his community. He is supposed to be a priority client for the next available bed, but other clients have been placed ahead of him due to a series of miscommunications. Joe has a son named Michael and daughter-in-law Francesca who live in an apartment nearby. Recently Michael and Francesca attended a doctor's appointment with Joe. Due to increasing shortness of breath, various tests were done. The doctor said that she would call the house with the results. Francesca was the one who took the call from the doctor and the news was not good: advanced lung cancer. Francesca and Joe absolutely insist that Joe not be told about this diagnosis or any prognosis until he is at least settled in LTC facility. You have just received the call that the LTC facility has now denied Joe's veteran status on the waiting list for LTC, stating that he must now be on the list for palliative residents instead. A team meeting is called.

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WHAT GUIDES ME HERE?



- Is the 'correct' course of action clear to me?
- What do I wish I had more information about?
- What supports, tools, and/or resources might I use?

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CASE STUDY #1- CONSPIRACY OF SILENCE

- Outcome:

What happened to Joe?

Joe died in his sleep while the team was in the midst of advocating for his status on the wait list for the LTC facility. His palliative diagnosis was never communicated to him.



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CASE STUDY #2- EXPERIENCES OF MORAL DISTRESS

- **Autonomous Choices**

- Jack is a 63 year old client who is homeless in an urban Canadian setting. He has a history of alcoholism, is a heavy smoker, and has no family. Three months ago he suffered gangrene in his left foot which required surgical intervention and amputation. Upon discharge, social services was able to arrange for him to stay in a local rooming house. The first nursing visit revealed horrible, inhumane conditions- vermin and bug-infested, filthy conditions, foul odours, not a light bulb to be found, a stained mattress on the floor as Jack's only furniture, windows which wouldn't open creating a fire trap/hazard, and sketchy roommates. However when asked, Jack stated that he was thrilled with his new home and the friendships he has created. Jack has an obviously declining capacity for his personal decisions, yet is not fully incapable at this time. Jack had recently met a lady friend named Nancy who was keen to advocate for pain medications for Jack's "phantom limb pain". She indicated that only oxy's will do.

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WHAT GUIDES ME HERE?



- Is the 'correct' course of action clear to me?
- What do I wish I had more information about?
- What supports, tools, and/or resources might I use?

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CASE STUDY #2- AUTONOMOUS CHOICE

- **Outcome:**

- On Christmas eve, Jack was found unconscious in a snow bank. His right foot was visibly gangrenous and he had been badly beaten.



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CASE STUDY #3- CONTINUING EDUCATION & TRAINING

- **The Care I Deserve**

- Sandra is a 43 year old female client who is morbidly obese and was recently diagnosed with Type I diabetes. She receives funding from the provincial welfare program. Home care nursing has been ordered for diabetic teaching as well as an OT/PT assessment. Sandra is the primary caregiver and foster parent of a 3 year old boy who is autistic. During a routine chart audit, it is noted that two months after discharge from hospital Sandra continues to receive nursing services twice a day. The nursing staff try to explain that Sandra refuses to learn how to do her own insulin and that Sandra is consistently not available for health care providers when they come to the house for her appointments. She adamantly refuses to go to the outpatient diabetic clinic. Management gives an ultimatum: tell Sandra this is her last visit, unless she wants to pay for it out of her own pocket.

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WHAT GUIDES ME HERE?



- Is the 'correct' course of action clear to me?
- What do I wish I had more information about?
- What supports, tools, and/or resources might I use?

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CASE STUDY #3- THE CARE I DESERVE



- **Outcome:**
- Sandra and her foster son moved away without telling anyone where they were going. No follow up was possible.

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MAPPING THE ROAD AHEAD

- Everyday stress in the profession of nursing is a given.
- **Some degree** of moral distress is likely part the territory of nursing practice as well.
- How can we use moral distress as an **asset** to ethical nursing practice?
 - What tools, supports, and resources are available and accessible?

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ETHICS: TOOLS

- Incorporating Ethics into Daily Practice
- <http://www.incorporatingethics.ca/>
- Website by Bashir Jiwani, ethicist, Director of Ethics Services and Diversity Services for Fraser Health, British Columbia, Canada
- Tools available for policy makers, leaders, clinicians, and members of the public

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ETHICS: TOOLS

- **Community Ethics Network**- Case studies available for team discussion
- <http://communityethicsnetwork.ca/wordpress/?tag=moral-distress-2>
- **Community Ethics Toolkit**, Joint Centre for Bioethics
- http://www.jointcentreforbioethics.ca/partners/documents/cen_toolkit2008.pdf

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ETHICAL DECISION MAKING: TOOLS

- **Ethics Frameworks:**

<http://www.scu.edu/ethics/practicing/decision/framework.html>

- Framework for Thinking Ethically
- Framework for Ethical Decision Making

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MORAL DISTRESS: TOOLS

• **4 A's to Rise Above Moral Distress**

American Association of Critical Care Nurses

http://www.aacn.org/WD/Practice/Docs/4As_to_Rise_Above_Moral_Distress.pdf

- ASK, AFFIRM, ASSESS, ACT
- Before you **act** you must consider the **4 R's**- RELEVANCE, RISK, REWARDS, ROADBLOCKS

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SELF-CARE

• **Self-care:**

- Recognizing that there are times when you can (and DO!) make a difference
- Realistic expectations for self and others
- Accountable and responsible for **ONLY** those things within our care and control
- If possible, don't take your work home (physically or emotionally)
- If not possible, try to filter your thoughts:
 - What can I take from this experience that is good?
 - What can I leave behind?

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SUPPORTS

- Working together- team collaboration and ongoing dialogue with external agencies and services
 - Be humble enough to work with, learn from and about others
 - Build yourself a support network- informal collegial support is priceless
- Know your provincial nursing standards of practice and legal obligations
- Participate in and advocate for continuing education and training

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SELF- REFLECTION EXERCISE

- Experiencing moral distress is an important message from our ethical GPS.
- Think of a situation where you had an experience of moral distress.
- Which values and beliefs were challenged for you?
- What additional information would have been helpful?
- What were the supports and resources available to you?

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OTHER IMPORTANT TOPICS FOR FURTHER DISCUSSION

- **Compassion Fatigue-** occurs on a spectrum from mild to severe, “caring too much” about and for other while mortgaging self, deeply imbedded, mostly internal source
- **Vicarious Trauma-** often occurs after interaction with someone who shares their experience of a trauma
- **Burn Out-** ‘consumed by the fire’, mostly due external pressures, linked with nurse attrition (leaving the profession)

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ETHICS: ONLINE RESOURCES

- **Canadian Bioethics Society** <http://www.bioethics.ca/>
- **Canadian Nurses Association (CNA)
Code of Ethics**
<http://www.nurses.ab.ca/Carna-Admin/Uploads/CNA%20code%20of%20Ethics.pdf>
- **Canadian Nurses Association(CNA)
Ethics Reading Resources**
<http://www.cna-aiic.ca/en/improve-your-workplace/nursing-ethics/ethics-reading-resources/>
- **International Council of Nurses (ICN)
Code of Ethics**
<http://www.icn.ch/about-icn/code-of-ethics-for-nurses/>

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MORAL DISTRESS: ONLINE RESOURCES

- **White Coat, Black Art** with Dr. Brian Goldman: Moral Distress (2009)

<http://www.cbc.ca/whitecoat/blog/2011/03/24/moral-distress-show/>

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APPENDIX K:

PARTICIPANT FEEDBACK FORM FOR E-MODULE EVALUATION



(807) 343-8079
(807) 343-8246
Kristen.Jones@lakeheadu.ca

Self-Directed E-learning Module Evaluation Form

The purpose of this self-directed e-learning module is to provide a safe space to explore everyday ethical issues in community nursing practice and to facilitate reflection and sharing of relational narratives.

1. Did the self-directed e-learning module meet its intended purpose (stated above)?

YES NO

2. Throughout the self-directed e-learning module, narratives of community nursing practice were shared by the researcher. Did you find those stories to be generally representative of experiences in community nursing practice?

YES NO

WHY or WHY NOT? Please describe.

3. Was the self-directed e-learning module relevant to everyday ethical issues in your own nursing practice?

YES NO

IF YES, HOW?

4. Was the self-directed e-learning module relevant to experiences of moral distress in your nursing practice?

YES NO

HOW?

5. What was helpful about the self-directed e-learning module?
6. What would you suggest be changed about the self-directed e-learning module (things to add, omit, tweak)?
7. Would you recommend this self-directed e-learning module to a colleague?

YES NO

WHY?
8. As a result of completing this self-directed e-learning module, how will your nursing practice change related to addressing everyday ethical issues if at all?
9. As a result of completing this self-directed e-learning module, how will your nursing practice change related to addressing experiences of moral distress if at all?
10. Are there any other comments that you would like to share?

	JUSTICE		mysteriously discharged from service	Initial MD: Team member/Client
Yvonne/2	NON-MALEFICENCE NON-MALEFICENCE	Values: Trustworthiness Values: Trustworthiness	Resources & Services i.e. #1 families at their limits, waiting for LTC bed for loved one Manager/Agency Support- team member i.e. #2 colleague distress over clinical situation, unresolved issues of grief of loss of her own child, manager aware but didn't do anything proactive	Yes. Initial MD: HC system, Agency, Family (if waiting until the last minute to request LTC) Yes. How could the manager not address this unresolved grief, ticking time bomb. Initial MD: Agency
Rachelle/ 3	AUTONOMY	Values: Choice, Safety, Risk Values: Power, Dignity, Respect Values: Power, Dignity, Respect	Refusal of Care - vaccination i.e. #1- kids refusing HPV vaccine because scared of needle i.e. #2- parents refusing vaccine because don't want sex discussed in Catholic school, misinformation Manager/Agency Support-practice i.e. #3 Told what to say, can't deviate, sometimes too much information provided to young children about sex,	Yes, if parents/child making choice that may not be in child's best interest Initial MD: Family/Client Yes. Initial MD: Agency

	<p>BENEFICENCE</p>	<p>Values: Trustworthiness</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Choice, Safety, Risk</p> <p>Values: Trustworthiness</p>	<p>Resources & Services-unmet needs i.e. #6- German speaking children need speech/language services, only offered in English, ESL programs</p> <p>Resources & Services i.e. #7 young mother, keeps having babies she can't afford or take care of. Wants to have another baby.</p> <p>Second-guessing i.e. #8 nurse had court experience that made her question her skill and if she was a 'good nurse'</p>	<p>clients. We have failed them. Initial MD: System, Agency</p> <p>Yes. Understand that's all the client knows, but to keep having children with a thousand strikes against them is wrong. Initial MD: Client</p> <p>Yes. Questioned own decisions about 'right choices' Initial MD: Self? *Does this qualify as MD?</p>
	<p>JUSTICE</p>			

	AUTONOMY			
	BENEFICENCE			
Valerie/ 6	NON-MALEFICENCE	<p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Choice, Safety, Risk</p>	<p>P/EOL-C i.e.#1 unable to control pain and symptoms, pt requests palliative sedation, not usually done, pt dies day later</p>	<p>Yes. Questioned if had tried everything before turning to sedation for client. Initial MD: Self, Agency</p>
	AUTONOMY	<p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Choice, Safety, Risk</p> <p>Values: Power, Dignity,</p>	<p>P/EOL-C- confidentiality i.e. #2 client or family tries to limit flow of information to each other</p>	<p>Yes.</p> <p>Intial MD: Client or Family</p>
		<p>Values: Power, Dignity,</p>	<p>Resources & Services</p>	<p>Yes. Initial MD: System, Client</p>

	JUSTICE			
	BENEFICENCE			
Kathleen/3	AUTONOMY	Values: Choice, Safety, Risk	Resources & Services- unmet needs i.e. #1 frail elderly clients living at home, maxed out on services, cognitive decline, no family, high risk for falls, going to emerg 3-5x week, will end up in LTC against their will after hospitalization	Yes. Initial MD: System
	BENEFICENCE	Values: Power, Dignity, Respect	P/EOL-C i.e.#2 elderly client with Alzheimer's, many adult children, all fighting, mixed messages	Yes. Initial MD: Family
		Values: Power, Dignity, Respect	Abuse i.e. #3- elderly client not feeling well, doc says 'I	No MD. Advocated with a letter to doctor until client received proper care.

			can't fix old", puts client on new meds in blister pack, talking meds wrong, not assessed for new health issues	
	JUSTICE			
Christine/ 4	BENEFICENCE	<p>Values: Choice, Safety, Risk</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p>	<p>Abuse i.e. #1 suspect child abuse, but if call CAS will lose relationship with client and may not be able to help them, nurse knows client was in CAS as a kid and wanted that never to happen to their own children</p>	<p>Yes, tough decision. Want to call but want to help, sometimes past negative experiences with CAS not taking kids when they should</p> <p>Initial MD: Self, Health Care System</p>
	NON-MALEFICENCE	<p>Values: Power, Dignity, Respect</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Power, Dignity, Respect</p>	<p>Resources & Services i.e.# 2 nurse goes to women's shelter to provide services, client is her old best friend</p> <p>Resources & Services i.e. #3 nurse goes to visit new baby, father is nurse's ex-boyfriend (very bad abusive relationship), small community</p> <p>Abuse i.e. #4 client is single mom, on</p>	<p>Yes, what ever happened to those kids? How to limit finite resources to those who really need it?</p> <p>Initial MD: Self</p> <p>Yes. Initial MD: Self, System</p>

	NON-MALEFICENCE		welfare, immigration issues, boyfriend in the house, client seen screaming at kids at grocery store, nurse tries to discuss this, client cancels services, makes complaint, moves away	
	JUSTICE			
Esther/2	AUTONOMY	Values: Power, Dignity, Respect Values: Trustworthiness	Manager/Agency Support-practice i.e. #1 nurses forced to participate in poor practices (cheapest, fastest route), no one would listen, nurse reprimanded for speaking out	Yes. Initial MD: Agency
	BENEFICENCE	Values: Trustworthiness	Second-guessing i.e. #2 nurse feels that participation in a dysfunctional system means that her practice contributes to negative outcomes, hopeless, helpless	Yes. Initial MD: System, Agency, Self *Does this qualify as MD?
Alisen/2	AUTONOMY	Values: Choice, Safety, Risk Values: Power, Dignity, Respect	Manager/Agency Support i.e.#1-told exactly what could/could not say to new mom's about co-	Yes. Initial MD: System, Agency- but pushed back, contributed to policy, wrote new guidelines, had them

	BENEFICENCE	<p>Values: Trustworthiness</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p>	<p>sleeping with infants, limiting, no harm reduction conversations allowed.</p> <p>Abuse i.e. nurses must be aware of pressures from big companies such as formula makers, educational grants, kickbacks, advertising</p>	<p>accepted.</p> <p>Yes, if agency or health care systems accepts this support. Initial MD: Agency or System</p>
Alison/2	<p>JUSTICE</p> <p>NON-MALEFICENCE</p>	<p>Values: Choice, Safety, Risk</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Power, Dignity, Respect</p>	<p>Resources & Services- confidentiality i.e. #1 Schizophrenic client, won't sign consent to share info with other agencies, very hard to serve, falls between cracks in social services,</p> <p>Abuse i.e. #2 Client being bullied in social housing, neighbours calling police on them, policies at food bank are degrading, social services systems are punitive</p> <p>Second-guessing i.e. #3 client is young teen, new baby, drug addicted boyfriend, nurse is supporting client to finish high school,</p>	<p>Yes. Initial MD: System</p> <p>Yes. Initial MD: System</p> <p>Yes. Initial MD- self *Does this qualify as MD?</p>

		<p>Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Choice, Safety, Risk</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p>	<p>client, daughter of colleague, 10 weeks pregnant, wants to meet outside of HU, requesting abortion</p> <p>Resources & Services i.e. #2- male client keeps coming back to clinic for STI treatment, nurse knows he is married and unfaithful, refuses to use condoms</p> <p>Refusal of Care- i.e. #3- nurse teaching safe injection techniques to IV drug user, does not want treatment program, nurse wishes he would just stop doing drugs</p> <p>Resources and Services i.e. #4- 16 year old teen mom, lives with parents in abusive household, shared custody of baby, father not doing a good job (abusive), CAS involved, client asks to live with nurse, nurse on strike, has to tell client to go talk to manager, client refuses, "I want you"</p> <p>Second-guessing</p>	<p>but goes against her values, values as a parent</p> <p>Initial MD: Self</p> <p>Yes- frustrating, want to tell him off, but that would not be ethical.</p> <p>Initial MD: Self</p> <p>Yes- wishes client would help himself, can't do it for him</p> <p>Initial MD: Client</p> <p>Yes- want to help client but can't (in the short or long term)</p> <p>Initial MD: Self, Agency, System</p> <p>Yes- know that the health promotion programs are important</p>
	BENEFICENCE			
	AUTONOMY			

	<p>JUSTICE</p>	<p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Choice, Safety, Risk</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Choice, Safety, Risk</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p>	<p>i.e. #4- challenge of creating health promotion campaigns where target industry is the town's livelihood (ie. tobacco, alcohol, gambling)</p> <p>Refusal of Care i.e. #5 teen Aboriginal clients, won't come to clinic because too obvious (2 taxi town), once pregnant only culturally accepted option is to keep baby.</p> <p>Refusal of Care i.e. #6 sex workers/exotic dancers not coming to clinic for testing and treatment</p>	<p>but how to get around backlash from community? Initial MD: community (as client)</p> <p>No- nurse started to go to high school and run clinic there to provide testing, treatment, bc, condoms</p> <p>No- nurse asked permission from club owner to meet clients on site at local strip club</p>
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	NON-MALEFICENCE			
	BENEFICENCE			
Glen/ 4	BENEFICENCE	<p>Values: Choice, Safety, Risk</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p> <p>Values: Power,</p>	<p>Resources and Services-unmet needs i.e. #1- client with low cognitive ability, nurse doing health teaching for self-care of diabetes, missing meds, double dosing, missing meals</p> <p>P/EOL-C i.e. #2- palliative client, wants to be full code, husband says to nurse, when she is unconscious I will sign DNR</p> <p>P/EOL-C</p>	<p>Yes- doubtful that client can manage diabetes</p> <p>Initial MD: Agency, System</p> <p>Yes. Want to support client's autonomy. Initial MD: family</p> <p>Yes. Client died before</p>

	AUTONOMY	Dignity, Respect	i.e. #3- palliative client, refusing pain meds at home, then decides to take meds, husband admits to nurse has been giving meds secretly all along, please don't tell her.	decision could be made whether to tell her or to "give pain meds"
	BENEFICENCE	Values: Trustworthiness		
		Values: Trustworthiness	Refusal of Care i.e. #4- homeless client comes to clinic, positive for TB, refuses treatment, returning to homeless shelter for the night, says "you can't breach confidentiality"	No. Called shelter, asked about policies for cough and infection control. Helped to develop TB policy. During interm, helped to create plan if clients have symptoms, what to do.
	JUSTICE	Values: Choice, Safety, Risk		
Janet/6	JUSTICE	Values: Power, Dignity, Respect	Manager/Agency Support- i.e. #1- geography and distance, only mileage is considered not road conditions, isolation, can't get a day off, no coverage, manager tells nurses "get a thicker skin"	Yes. Management doesn't understand the challenges, even when highly organized it's next to impossible. Initial MD: Agency
		Values: Power, Dignity, Respect	Manager/Agency Support- i.e. #2- tourist town,	Yes. Schedules are very hectic, communication suffers Initial MD: Agency,

	BENEFICENCE	<p>Values: Trustworthiness</p> <p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p>	<p>population increases by 5x in summer, need to learn to scrimp, manager accepting referrals for services they don't have</p> <p>P/EOL-C-communication i.e. #3- palliative client comes to town on vacation, communication is poor about care needs (i.e. pain pump, antibiotics), no DNR-C</p>	<p>System</p> <p>Yes. Husband had unrealistic expectations, poor communication on every level meant that client suffered.</p> <p>Initial MD: family, agency, system</p>
	BENEFICENCE	<p>Values: Power, Dignity, Respect</p> <p>Values: Trustworthiness</p>	<p>Resources & Services i.e. #4 mother of child clients wants respite services, not available, when nurses do go in she criticizes care, insists on certain practices which are not always correct care.</p>	<p>Yes. But eventually started going in pairs, mother calmed down a bit.</p> <p>Initial MD: Family, Agency</p>
	NON-	<p>Values: Choice, Safety, Risk</p> <p>Values: Choice, Safety, Risk</p> <p>Values: Power,</p>	<p>Refusal of Care i.e. #5 client post-surgery with drain in place, decides to visit sister instead of seeing home care nurse, later goes to outpatient clinic and has staples and drain removed, then call nurse, "I'm bleeding all over!"</p> <p>P/EOL-C</p>	<p>Yes.</p> <p>Initial MD: Client</p>

	MALEFICENCE	Dignity, Respect Values: Trustworthiness	i.e. #6 female palliative client, husband insists on feeding her full breakfast every morning which she vomits up, client says its ok, it makes him feel better	Yes. Client making this choice, but awful to watch her suffer. Initial MD: Client, Family
	AUTONOMY			
	AUTONOMY			
Josephine I/ 2	JUSTICE	Values: Power, Dignity, Respect	Resources and Services- unmet needs	Yes. Don't know when or what services will be cut

			<p>i.e. #1- cuts to PH programs at mercy of ministry, trying to plan/be proactive, try to have some control</p> <p>Abuse i.e. #2- knowledge of clients abusing the system, working under the table while on welfare, abuse in the home, CAS doesn't take referral seriously</p> <p>Second-guessing i.e. #2- developmentally delayed female client becomes pregnant, family says they will support her but don't, nurse tried to put in every resource, CAS took baby, family moved</p>	<p>Initial MD: System</p> <p>Yes.</p> <p>Initial MD: System</p> <p>Yes.</p> <p>Initial MD: Self, Family, Agency, System</p>
	JUSTICE	<p>Values: Trustworthiness</p> <p>Values: Choice, Safety, Risk Values: Power, Dignity, Respect Values: Trustworthiness</p>		
	AUTONOMY			
May/3	AUTONOMY	<p>Values: Choice, Safety, Risk Values: Power, Dignity, Respect Values: Trustworthiness</p> <p>Values: Choice, Safety, Risk Values: Power,</p>	<p>Second-guessing i.e. #1- 16 year old female client, pregnant wants abortion, doesn't want parental involvement</p> <p>Resources and Services i.e. #2- very poor family, could give</p>	<p>Yes. Until learned about degree of family dysfunction, then no.</p> <p>Yes. Where to start?</p> <p>Initial MD: Self, System</p>

	JUSTICE	Dignity, Respect Values: Trustworthiness	resources endlessly, no hydro, no hot water, lice, filth, boy child ADHD, girl runaway on drugs, mom on crack, dad is an alcoholic	*Does this qualify as MD?
	BENEFACTANCE	Values: Choice, Safety, Risk Values: Power, Dignity, Respect Values: Trustworthiness	Abuse i.e. #3- dysfunctional family, female client pregnant, 3 kids, father in/out of the picture, known nurse for 5 years, client was foster kids herself, neglecting kids, nurse wants to call CAS in, history of being 'midnight movers' (taking off)	Yes. Called CAS. Felt she betrayed the client. Initial MD: Self, System
Sarah/2	NON- MALEFACTANCE	Values: Power, Dignity, Respect Values: Trustworthiness Values: Trustworthiness Values: Choice, Safety, Risk	Resources & Services i.e. #1- new moms with poverty/addiction issues, can only see high risk ones, what if improper screening, the ones that fall through the cracks Resources and Services i.e. #2- docs/pediatricians not up to date on best practices for breastfeeding and	Yes, but started a baby drop-in at methadone clinic Yes. Want client to make informed choices, want docs to get educated on best practices. Initial MD: System

	AUTONOMY		feeding, don't want to say that doc gave wrong information	
Tammy/3	JUSTICE	Values: Choice, Safety, Risk Values: Power, Dignity, Respect Values: Trustworthiness	Resources and Services i.e. #1- client or family refusing to take on care, feel they are owed services.	No. Had family meeting, developed contract of expectations, concerns, timelines. Handled differently by each case manager as far as leniency with 'bending the rules'
	BENEVICENCE	Values: Power, Dignity, Respect Values: Trustworthiness	P/EOL-C-confidentiality i.e. #2- palliative client, family doesn't want client told they are dying, cultural belief that once they know client will live life differently	Yes. Client died with many things left unsaid. Initial MD: Family
	NON-MALEFICENCE	Values: Trustworthiness	P/EOL-C-boundaries i.e. #3- palliative client, lives 2 blocks from nurse, family contacting outside work hours, nurse making exception and seeing client on days off	Yes. Ended up removing client from case load. Initial MD: Self, wanted to do what she shouldn't (boundaries), did it, continued to feel moral distress

APPENDIX M: SERIES OF CHN META-NARRATIVES

CHN Meta-Narrative #1- Conspiracy of Silence

Joe is a WWII veteran who lives in a rural Canadian community. He lives at home alone and is on a waiting list for long-term care (LTC). There are only two LTC facilities in his community. He is supposed to be a priority client for the next available bed, but other clients have been placed ahead of him due to a series of miscommunications. Joe has a son named Michael and daughter-in-law Francesca who live in an apartment nearby. Recently, Michael and Francesca attended a doctor's appointment with Joe. Due to increasing shortness of breath, various tests were done. The doctor said that she would call the house with the results. Francesca was the one who took the call from the doctor and the news was not good. Joe was diagnosed with advanced lung cancer. Francesca and Joe absolutely insist that Joe not be told about this diagnosis or any prognosis until he is at least settled in LTC facility. You have just received the call that the LTC facility has now denied Joe's veteran status on the waiting list for LTC, stating that he must now be on the list for palliative residents instead. A team meeting is called. The team has mixed priorities about Joe's situation and a heated discussion occurs.

Solutions: What do you think the key ethical issues are here (i.e. autonomy, beneficence, non-maleficence, justice)? Can you identify ethical issues at macro (i.e. health care system, organizations/agencies, resources), meso (i.e. client, family, health care team), and/or micro (i.e. individual nurse) levels in this scenario? What are the nursing values that are at risk (i.e. trustworthiness; power, respect & dignity; choice, safety, & risk)?

What are (could be) some of the options?

Outcome: What happened to Joe? Joe died in his sleep while the team was in the midst of advocating for his status on the waiting list for the LTC facility. His palliative diagnosis was never communicated to him.

Suggestions: What could have been done differently here? What could be changed for the next time you encounter a similar ethical issue in community health nursing practice?

Experiences of Moral Distress: Is this a situation where you might experience moral distress? If so, why? What might be some strategies that you would use to cope with the experience of moral distress?

CHN Meta-Narrative #2- Autonomous Choices

Jack is a 63-year old client who is homeless in an urban Canadian setting. He has a history of alcoholism, is a heavy smoker, and has no family. Three months ago he suffered gangrene in his left foot, which required surgical intervention and amputation. Upon discharge, social services were able to arrange for him to stay in a local rooming house. The first nursing visit revealed horrible, inhumane conditions- vermin and bug-infested, filthy conditions, foul odours, not a light bulb to be found, a stained mattress on the floor as Jack's only furniture, windows that won't open creating a fire trap/hazard, and sketchy roommates. However when asked, Jack stated that he was thrilled with his new home and the friendships he had created. He has an obviously declining capacity for his personal decisions, yet is not fully incapable at this time. Jack has recently met a lady friend named Nancy who is keen to advocate for pain medications for Jack's "phantom limb pain". She indicates that only oxy's will do.

Solutions: What do you think the key ethical issues are here (i.e. autonomy, beneficence, nonmaleficence, justice)? Can you identify ethical issues at macro (i.e. health care system, organizations/agencies, resources), meso (i.e. client, family, health care team), and/or micro (i.e. individual nurse) levels in this scenario? What are the nursing values that are at risk (i.e. trustworthiness; power, respect & dignity; choice, safety, & risk)?

What are (could be) some of the options?

Outcome: What happened to Jack? Jack was unavailable for a series of nursing follow-up visits over the next month. On Christmas eve, Jack was found unconscious in a snow bank. His right foot was visibly gangrenous and he had been badly beaten.

Suggestions: What could have been done differently here? What could be changed for the next time you encounter a similar ethical issue in community health nursing practice?

Experiences of Moral Distress: Is this a situation where you might experience moral distress? If so, why? What might be some strategies that you would use to cope with the experience of moral distress?

CHN Meta-Narrative #3- The Care I Deserve

Sandra is a 43-year old female client who is morbidly obese and was recently diagnosed with Type I diabetes. She receives funding from the provincial welfare program. Home care nursing has been ordered for diabetic teaching as well as an occupational therapy/physiotherapy (OT/PT) assessment. Sandra is the primary caregiver and foster parent of a 3-year old boy, Tommy, who is autistic. During a routine chart audit, it is noted that two months after discharge from hospital, Sandra continues to receive nursing services twice a day. The nursing staff tried to explain to the case manager that Sandra refuses to learn how to do her own insulin and that Sandra is consistently not available for health care providers when they come to the house for her appointments. She adamantly refuses to go to the outpatient diabetic clinic. Management gives an ultimatum: tell Sandra this is her last visit, unless she wants to pay for it out of her own pocket.

Solutions: What do you think the key ethical issues are here (i.e. autonomy, beneficence, nonmaleficence, justice)? Can you identify ethical issues at macro (i.e. health care system, organizations/agencies, resources), meso (i.e. client, family, health care team), and/or micro (i.e. individual nurse) levels in this scenario? What are the nursing values that are at risk (i.e. trustworthiness; power, respect & dignity; choice, safety, & risk)?

What are (could be) some of the options?

Outcomes: What happened to Sandra and Tommy? Sandra and her foster son moved away without telling anyone where they were going. No follow up was possible.

Suggestions: What could have been done differently here? What could be changed for the next time you encounter a similar ethical issue in community health nursing practice?

Experiences of Moral Distress: Is this a situation where you might experience moral distress? If so, why? What might be some strategies that you would use to cope with the experience of moral distress?

CHN Meta-Narrative #4- Home Is Where the Heart Is

Evelyn is an 86-year old lady who lives in the remote outskirts of her rural community. She and her husband built a modest little house. Her husband, Ronald, died four years ago from pneumonia. The CHNs who work in this area, know that they should ‘wait in the car until the dog comes around the corner’ at many of the houses out here in the ‘boonies. Evelyn does not have running water or electricity and she says she doesn’t mind it one bit. She chops her own firewood and neighbours bring her groceries every couple of weeks. She has a twinkle in her eye and a youthful spirit despite her advanced age. Her mind is sharp as a tack and she is determined to live out her very last days to the fullest here at her beloved home in the country, just as her husband Ronald did. She is at high risk for falling due to intermittent episodes of undiagnosed vertigo. Evelyn has never had a vaccination in her life and laughs when you mention any medications, especially the flu shot, “Not starting that business now! I’m ready when the good Lord takes me!”

Solutions: What do you think the key ethical issues are here (i.e. autonomy, beneficence, nonmaleficence, justice)? Can you identify ethical issues at macro (i.e. health care system, organizations/agencies, resources), meso (i.e. client, family, health care team), and/or micro (i.e. individual nurse) levels in this scenario? What are the nursing values that are at risk (i.e. trustworthiness; power, respect & dignity; choice, safety, & risk)?

What are (could be) some of the options?

Outcomes: She recently had a serious cardiac episode when her son was visiting from Vancouver. He arranged for her to be transported to a leading cardiac centre and signed the papers for a pacemaker to be put in when she was unconscious in the intensive care unit. The last you heard was that she did not do well after the surgery and was moved into a long-term care facility. While visiting a family friend in long-term care, you are surprised to find Evelyn seated in the residents’ lounge area. She waves you over to her. With tears in her eyes she pats her chest just over her heart with her hand and says “I have to live with my son’s mistakes and it’s no life.”

Suggestions: What could have been done differently here? What could be changed for the next time you encounter a similar ethical issue in community health nursing practice?

Experiences of Moral Distress: Is this a situation where you might experience moral distress? If so, why? What might be some strategies that you would use to cope with the experience of moral distress?

CHN Meta-Narrative #5- Manage Your Moral Distress

You are a newly hired graduate working as a CHN in a community health care setting. You have been called in to see the nurse manager, today to determine if your performance warrants a move to a permanent contract with the home health care agency. Your manager asks you how you like it so far. You decide to answer honestly, “It’s intimidating, really. I never know what I’m going to walk into and things can go badly pretty fast out there. I watched my best friend die of cancer in high school, he suffered so much...sometimes I think about that, especially with the oncology patients. I just want to provide the best nursing care that I can.” Your manager laughs quietly, “Hey, better get used to that around here... you do what you can then you call it a day!” She gives you a password to complete mandatory online modules on catheterization and pain pumps on the agency’s website. You want to mention that you are also having a very difficult time with Steve, a nurse who has been orientating you. He has been rude, condescending, and has even embarrassed you a couple of times in front of other nursing staff calling you ‘stupid’. As you are leaving her office she calls you back and says: “I think you are good to go on your own now. So no more shadow shifts, got it?”

Solutions: What do you think the key ethical issues are here (i.e. autonomy, beneficence, non-maleficence, justice)? Can you identify ethical issues at macro (i.e. health care system, organizations/agencies, resources), meso (i.e. client, family, health care team), and/or micro (i.e. individual nurse) levels in this scenario? What are the nursing values that are at risk (i.e. trustworthiness; power, respect & dignity; choice, safety, & risk)?

What are (could be) some of the options?

Outcomes: Your manager passes you by for this round of permanent hiring and leaves you on the casual rotation list without further explanation. You overhear Steve at the next staff meeting telling the team, “stupid is as stupid does” and you have no doubts about who he is referring to.

Suggestions: What could have been done differently here? What could be changed for the next time you encounter a similar ethical issue in community health nursing practice?

Experiences of Moral Distress: Is this a situation where you might experience moral distress? If so, why? What might be some strategies that you would use to cope with the experience of moral distress?

CHN Meta-Narrative #6- Running Pillar to Post

Stephanie is a street smart 17-year old Aboriginal girl that you have met many times over the years as the public health nurse assigned to the Catholic school board in your community. Even though you haven't always agreed with the restrictions about what can/can't be discussed in the classrooms regarding sexual health, you have always given your work 100% of your energy and commitment. In a small town, everyone knows everybody else's business. You know that Stephanie grew up in foster care and has run away from home many times. Stephanie always seems to choose to come to you for help and it just breaks your heart that a young girl should have to go through so much. Over the years you have worked with Stephanie through multiple lice infestations, abuse in her foster home (where child protective services was called), a pregnancy which ended in abortion at age 16, and recently supporting her arrangements to attend an in-patient substance use program- just to name a few. Just last week you heard that she was picked up by the police for outstanding charges.

Solutions: What do you think the key ethical issues are here (i.e. autonomy, beneficence, non-maleficence, justice)? Can you identify ethical issues at macro (i.e. health care system, organizations/agencies, resources), meso (i.e. client, family, health care team), and/or micro (i.e. individual nurse) levels in this scenario? What are the nursing values that are at risk (i.e. trustworthiness; power, respect & dignity; choice, safety, & risk)?

What are (could be) some of the options?

Outcome: Stephanie was returned to jail for 72 hours. Unfortunately she began using drugs again while in jail and was unable to maintain her sobriety. You agree to work with Stephanie on a one-to-one basis upon her release from jail but your manager informs you that she has declined that offer. Apparently Stefanie feels that she has disappointed you one too many times. She says that even though she tried to do exactly what you told her to (i.e. go to school, study hard, have an abortion, go to residential treatment) it has not worked out. She feels she would probably be better off just figuring it out on her own. She has indicated that she wants to work with a nurse who better understands her culture.

Suggestions: What could have been done differently here? What could be changed for the next time you encounter a similar ethical issue in community health nursing practice?

Experiences of Moral Distress: Is this a situation where you might experience moral distress? If so, why? What might be some strategies that you would use to cope with the experience of moral distress?

CHN Meta-Narrative #7- Palliative Promise

Antonio is a 92-year old Portuguese immigrant who lives with his widowed daughter Maria in a rural community in Ontario. He has not seen a doctor in the last ten years and refuses to see one now, even though he is clearly quite an ill man. He has not left the house in at least five years due to severely limited mobility (likely stroke), chronic joint pain (likely arthritis due to heavy manual labour and work related injuries), and shortness of breath on exertion (likely cardiac complications). A referral was received by the Community Care Access Centre (CCAC) through the family's parish priest related to concerns that Maria was no longer able to cope with her father's health issues. He did allow the nurse practitioner to do a house call and was open to receiving services if he could be assured that "the nurses knew what the hell they were doing". You are the nurse assigned to Antonio's care; he is on the palliative caseload and not expected to live longer than 6 months. When you meet him, he calls you close and whispers, "when time comes, you make it nice for me, right? I don't want no suffer, ok?" He looks at you with big, pleading brown eyes, and you pat his hand, "ok", you tell him quietly. You attempt to include Maria in his care, but she refuses, saying, "I don't want to know, you do what you have to do." However, Maria has made many calls to the nurse manager to complain about the "terrible care" that the nurses have provided. The next time you visit, Antonio has lost consciousness. This is not unexpected, and the plan of care is to keep him as comfortable as possible, as per Antonio's wishes. As you administer his pain medications as ordered, Maria turns to you and yells, "My Father never took drugs in his whole life and he is not starting now! He has only gotten worse since you people have started coming into this house- get out!" You try to reason with Maria but three days pass before she will let anyone back in to see her father.

Solutions: What do you think the key ethical issues are here (i.e. autonomy, beneficence, non-maleficence, justice)? Can you identify ethical issues at macro (i.e. health care system, organizations/agencies, resources), meso (i.e. client, family, health care team), and/or micro (i.e. individual nurse) levels in this scenario? What are the nursing values that are at risk (i.e. trustworthiness; power, respect & dignity; choice, safety, & risk)?

What are (could be) some of the options?

Outcome: When you next see Antonio, he is in excruciating pain, struggling with every breath he takes, and drowning in his own secretions. He dies later that day in agony despite your best efforts to re-establish his comfort protocols.

Suggestions: What could have been done differently here? What could we change for the next time we encounter a similar ethical issue in community health nursing practice?

Experiences of Moral Distress: Is this a situation where you might experience moral distress? If so, why? What might be some strategies that you would use to cope with the experience of moral distress?

CHN Meta-Narrative #8- Starving For Palliative Care

Linda is a 38-year old wife and mother of two young girls aged 3 and 7. An honour roll university student, she was one year away from graduating with her social work degree when she could no longer ignore her symptoms. She was diagnosed with stage-four breast cancer with metastasis to her brain and lungs. She initially wanted to die in the hospital so that her children didn't have to see her suffer. However, her husband refused this plan of care and convinced Linda to discharge herself from hospital and receive home care services. They live in a basement apartment in a rent-geared-to-income housing complex in the downtown area, well known for crime and drug trafficking. Prior to arrival, the nurse always calls the home to ensure the client is available and ready for the visit (as per agency policy). Linda often does not answer the phone. This is distressing to the nurses who care for her since they know how much she needs pain and symptoms management. Even though the policy states that if clients don't answer the phone the visit must be cancelled, many nurses ignore this and bang on Linda's door until her husband opens it. Many times they have heard him yelling at Linda before he opens the door, but he usually calms down after a little while. The nurses have begun to go in pairs to see Linda because they don't feel safe (just a gut feeling), even though management indicated only one nurse would be paid. Yesterday, Linda asked about receiving palliative sedation in her last days (which will likely be very soon) as she is clearly in excruciating pain.

Solutions: What do you think the key ethical issues are here (i.e. autonomy, beneficence, non-maleficence, justice)? Can you identify ethical issues at macro (i.e. health care system, organizations/agencies, resources), meso (i.e. client, family, health care team), and/or micro (i.e. individual nurse) levels in this scenario? What are the nursing values that are at risk (i.e. trustworthiness; power, respect & dignity; choice, safety, & risk)?

What are (could be) some of the options?

Outcome: When you call about Linda's request the physician refuses to discuss it any further, stating that, "We don't do palliative sedation here, never have never will! Ain't gonna happen." Linda says she does not wish to be admitted to hospital during her last days. She tells you, "It's ok, I know you tried to help me. I will just stop eating and drinking. It will be over soon." Over the next few days, Linda becomes semi-comatose and her husband insists on subcutaneous re-hydration. He will not accept that his wife is 'dying of thirst'. Linda dies slowly over the next two weeks with poor pain and symptom management and intermittent home nursing services.

Suggestions: What could have been done differently here? What could be changed for the next time you encounter a similar ethical issue in community health nursing practice?

Experiences of Moral Distress: Is this a situation where you might experience moral distress? If so, why? What might be some strategies that you would use to cope with the experience of moral distress?

CHN Meta-Narrative #9- Sanctimony And Stereotyping

Today you are training Kelly, a nurse from another part of your agency. You are a seasoned community health nurse visiting an immigrant family who has been on your caseload for the past twelve years. The parents have refused routine childhood vaccinations for all of their seven children on religious grounds. This family lives in poverty (i.e. often no hydro, depending on food bank hampers). The mother seems to be developing symptoms of depression over the past few months and is not looking after the kids like she used to (borderline neglect). Today, you identify that the two youngest children have head lice. Due to the language barrier it is hard to be certain if health teaching information comes across properly. You also have been wondering why the husband has not been at home lately. You ask the client where her husband is but she just says, 'he no here'. Even though the family has almost nothing, it is obvious that they are very close and love one another dearly. Kelly, the colleague you are orientating, is absolutely horrified to see the living conditions of this family. You explain that this family is doing the best that they can, all services that are available are in place, and that the mother is on the waiting list for counselling. Upon arrival back at the office, Kelly immediately makes a complaint against you to your supervisor and calls Children's Aid. Since her desk is not far from yours, you overhear her phone call to the child welfare office: "Well they are not from here, so what do you expect? Yes filthy, absolutely filthy, like dogs really. Having one baby after another on the taxpayers' dime. Seriously! Laziness really. That's all there is to it."

Solutions: What do you think the key ethical issues are here (i.e. autonomy, beneficence, non-maleficence, justice)? Can you identify ethical issues at macro (i.e. health care system, organizations/agencies, resources), meso (i.e. client, family, health care team), and/or micro (i.e. individual nurse) levels in this scenario? What are the nursing values that are at risk (i.e. trustworthiness; power, respect & dignity; choice, safety, & risk)?

What are (could be) some of the options?

Outcome: You are called to your supervisor's office first thing the next morning. Kelly is also there and she is crying. She states that she has never worked with such an incompetent nurse and that she feels traumatized by the living conditions that she witnessed. Your supervisor hands you a document to sign that indicates you have been advised to review the standards for nursing ethics and given a warning. "I don't think you need it, or it's fair really, but it's policy".

Suggestions: What could have been done differently here? What could be changed for the next time you encounter a similar ethical issue in community health nursing practice?

Experiences of Moral Distress: Is this a situation where you might experience moral distress? If so, why? What might be some strategies that you would use to cope with the experience of moral distress?

APPENDIX N:

SUMMARY OF PARTICIPANT EXAMPLES OF COPING WITH AND MITIGATING EXPERIENCES OF MORAL DISTRESS

Ann- use humour, explain what is legal and assure comfort measures, have important conversations early rather than later, put as many resources and supports in place as possible, "You have to learn what your limitations are and what your resources are so that you can make it through the day."

Dorsa- be welcoming, caring, helpful, make every effort so client and family feel that they are heard, working with feelings of impotence due to team dysfunction, coping: buying time away from situation, considered consequences of whistleblowing (I have to work here)

Vicky- need to adhere to best practice guidelines and timeframes, limited resources due to geography

Yvonne- need for proactive approach that is not happening on many levels- health care system, agencies, clients/families, individual members of health care teams including managers

Rachelle- frustrated by being told what can/can't say, no room to make judgement calls in clients best interest about what information is taught or how it is taught (i.e., one-to-one, large group)

Mary- "I walk the line," not too intrusive but helpful, some facts you just ignore, sometimes you have to get 'miserable'

Valerie- asking clients and families what they want (don't want) to know, how much, control flow, ask patient what they think is happening, 9/10 they know, no point in building a wall of silence

Kathleen- sometimes you have to say, 'you know what, you are at risk,' importance of assessments, documentation, talking to the team, reviewing supports, resources and looking at all options, sometimes need for advocacy

Christine (manager)- reflective supervision, 'what do you think you need to do,' 'if this, then what,' saying to them 'I will support your decision,' asking questions "so I was wondering... what if you tried this..." how does nurse cope if she doesn't act/say anything and something happens or client is gone?

Esther- "sometimes you just have to work with the system," change your approach to allow your supervisor to 'save face,' advocate for yourself (i.e., workload assessment tool), sick leave (although time limited and need to return to work before ready as main income earner), know the chain of command for challenging poor practices, "I'm still a cog"

Alisen-importance of speaking up about things that negatively impact nurse-client relationships, make suggestions, advocate for change, advocate for consistent messaging of health information across all sectors of care (i.e., importance of breast feeding)

Alison- challenged between committee work and clients who are very needy, our responses needs to be preventative not reactive, but the system is siloed and not set up for working together,

Josephine II- nurse can get caught up in the social role, the relational piece; nurses' role is to support, empower, give options because having one choice is not a choice

Elizabeth- nurse's support, allegiance, confidentiality is to the client first, sometimes "I have to be deceitful," need to get to the root of the problem for clients; "I often thought about that little person because my hands were tied"

Glen- finding the balance, risk management

Janet- need to be adaptable, have important (PC) conversations early in the relationship

Josephine I- when you don't feel supported with a really difficult case, you want to 'get off the case,' but then who will do it?

May- value of continuity, knowing 'face' of public health nurse, focusing on client safety, acknowledging feelings of loss when things "happen differently" than planned or intended, even when you do the 'right thing' can feel like a betrayal

Sarah- empowering staff to look at the big picture, problem solving with resources because you can't do it all, hardest part is deciding what 'not' to do

Tammy- try to respect culture and diversity, supporting a choice that is 'right' for them; sometimes you do end up saying "I wish this had worked out differently"

APPENDIX O:

SUMMARY OF PARTICIPANT IDENTIFIED ETHICS EDUCATION OPTIONS

Type of Education	Suggested Topics	Preferred Delivery Method	Participant Rationale	Researcher's Reflections
<p>Formal Education- Graduate and Undergraduate</p>	<p>Topics: Religion, environmental ethics, moral issues, biomedical ethics, problem solving, conflict management, ethical decision making tools and processes, prepare students for practice realities such as home care, palliative care, public health</p> <p>Course assignment-action plan for moral distress in practice</p> <p>Assigned course readings- College of Nurses papers on ethics</p> <p>Awareness for 'wounded healers' (individuals with emotional issues) with high marks, need for mentorship</p>	<p>Case-based learning (versus chalk n'talk)</p> <p>Interprofessional approach</p>	<p>"And, of course in nursing – really, I think most of us are 'spoon fed' ethical practice in nursing."- Yvonne, p.4</p> <p>"I don't think we hit ethics in the face hard enough."- Yvonne, p. 15</p>	<p>Lack of consistency among nursing programs on specific ethics, ethical decision making, moral distress content and courses</p> <p>Perhaps, the moral and ethical roots of why students go into nursing requires further exploration.</p>
<p>Continuing Education- External to Workplace</p> <p><i>Conferences, workshops, presentations</i></p>	<p>Presenters such as: Paddy Rodney, B. Jiwani, Mary Vachon, Claire Edmunds</p> <p>Topics such as: palliative care,</p>	<p>Regional versus travel to larger city centre</p> <p>Training together with other community</p>	<p>"...when they go to the conference, they're required to complete a conference template to</p>	<p>How to bring this information back to the team? How to bring the conference</p>

	<p>caregiver fatigue, trauma, vicarious trauma, post-traumatic stress disorder (PTSD), advanced care planning, compassion fatigue, burnout, grief and loss, guided imagery sessions, gerontology, geriatric assessment.</p> <p>Recommendations regarding professional training available which would help in coping with ethical issues: International Congress on Palliative Care, De Sousa Institute, Care for the Professional Caregiver at Sunnybrook Wellspring Centre, certification of nursing specialties, Community Health Nurses of Canada (CHNC) national conference, Registered Nurses Association of Ontario (RNAO) conferences, certificate in trauma counselling.</p>	<p>agencies and disciplines</p> <p>½-1 day workshops with case-based learning using real stories</p> <p>On-line courses</p>	<p>share that information with the rest of the division... have it on an electronic message board in a conference folder so that people can check back within two weeks after the conference, they can go and read about the conference and what they learned and what resources are available, manager selects and registers for concurrent sessions based on relevance to agency's work, so everything is relevant to almost everybody"- Josephine II, p. 10</p>	<p>energy back to the workplace?</p> <p>Time?</p> <p>Cost—one participant noted that if education is free it has no value, must cost (even minimal cost) something to be valued.</p>
<p>Continuing Education-Internal to Workplace</p> <p><i>In-house workshops, presentations, in-services,</i></p>	<p>Presenters such as: Mental health specialist, ethicist, supportive nurse manager, lawyer</p> <p>Topics such as: palliative care, ethical</p>	<p>Monthly education topic, journal club</p> <p>Round table, videoconference, teleconference, online webinar,</p>	<p>Morale is very management driven, management needs to hear and respond to employee distress- Esther,</p>	<p>Time. With increased workloads and staffing shortages, who has time for extra (education)?</p>

<p><i>education sessions, meetings.</i></p>	<p>issues and evidence-informed decision making, advanced care planning, stress management, dealing with difficult people, teambuilding, poverty, addictions, mental health, social determinants of health, multiple ways of knowing and nursing process, documentation and legal factors (i.e. inquest), support for management, team work and shared responsibility, available services and referral processes, narrative solution focus approach, emotional intelligence, nursing ethics standards, communication strategies and therapeutic relationships, mentorship, healthy workplace activities</p> <p>Recommendations:, weekly email about an ethical issue to ponder, Bridges Out of Poverty (book), guest speakers during nurses' week, opportunities for ethics consultation, mentoring pilot project using Blackberry/email, Storyteller Initiative</p>	<p>webcasts</p> <p>Online modules (15 min each) and access to articles</p> <p>Interdisciplinary rounds & training in teams</p> <p>Managers meeting (quarterly)</p> <p>Use of voicemail for information sharing</p> <p>Case-study/anonymous case review discussions (need to hear end of the story, outcomes)</p> <p>Put ethical issues on the meeting agenda- makes it important!</p> <p>Mandatory, paid training</p> <p>Timely debriefing of difficult ethical issues- open door policy with manager</p> <p>networking before meetings,</p> <p>Resource list: ethics education opportunities, resources and</p>	<p>Alisen</p> <p>Challenge of information overload and too many meetings- May</p> <p>Agency's ethical framework, no time for this, too much work- Vicky</p> <p>“Actually, I feel in the community we're sometimes more privileged, certainly where I am, than say hospital nurses. Because they have to take their own time and quite often pay for it themselves. At least that's my understanding from colleagues that work in hospitals. Where we have quite a fair bit of in-house training and we've always been able to go off to typically something every year, or something</p>	<p>Moral responsibility of care should be a shared responsibility- Mary</p> <p>How to engage staff to participate when already overworked? -optional, but paid (gives the education value, worth)</p>
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	<p>training.</p>	<p>supports, how to access</p> <p>requirement of certain number of education hours each year</p> <p>Buddy system (for coverage of case load and mentorship) , ethics committee, peer support, better organization of care rounds with team members</p> <p>New employee orientation</p> <p>Lunch ‘n Learn (short education session during lunch hour)</p> <p>Toolkit of brief scenarios and key discussion points, facilitated by local organizational champion</p> <p>safe private space to have these difficult (sensitive) discussions, policy that is responsive to individual client needs</p>	<p>comes into us.”- Mary (p.9)</p>	
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<p>Individual Education Options</p> <p><i>Self-directed professional development</i></p>	<p>Recommendations: reflect on your own values and beliefs, seek support from your team (choose people with similar values), know where to go for advice, support (EAP), and help, recognize your resource, limitations, work on managing your time effectively, reflect on acceptance and respect for client choice, improve your communication skills (respect, relationships), know your scope of practice and professional standards,</p>	<p>Ethics education and ethical decision-making tools from provincial college of nurses</p> <p>Webinars, online workshops (i.e. CATIE, Ministry of Health)</p> <p>Know your current community resources and how to access them (be aware of changes to services)</p> <p>Reading provincial nursing magazines</p>	<p>Adjust your thinking, ‘can you live with it?’ -Yvonne</p> <p>My mentor, my lifeline- Alison</p> <p>Give yourself permission to put boundaries around your work- Josephine II</p> <p>Take time to re-evaluate what is important and what isn’t, don’t take work home (in a bag or in your head), take your breaks, your lunch hour is sacred- Esther</p>	
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APPENDIX P: SUMMARY OF PARTICIPANT FEEDBACK ON E-MODULE

Questions on E-Module Evaluation Form	Participant Feedback (n=3)
1. Did the self-directed e-learning module meet its intended purpose?	YES
2. Did you find the professional meta-narratives to be generally representative of experiences in community nursing practice? Why or why not?	YES “The stories would be aspects of any nurses’ career activities. At least one of the stories directly related to personal experience.”
3. Was the self-directed e-learning module relevant to everyday ethical issues in your own nursing practice?	YES “Particularly the story of Joe, the vet who was not told of his diagnosis, bureaucracy re: being moved from vets waiting list to palliative care waiting list, mix ups re: waiting lists etc.” “Constantly trying to balance the desire to do more, to help more, and do it with less- less resources, less time, and sometimes less energy. It gets fatiguing to constantly try to squeeze water from the stone.”
4. Was the self-directed e-learning module relevant to experiences of moral distress in your nursing practice? How?	YES “Moral distress occurs daily, and some of it cannot be shared with or understood by non- nursing staff such as case managers, managers etc. None of whom have nursing backgrounds.” “Overwhelmingly complicated situations that are difficult to provide good care for, like the patient with poor cognitive abilities, happy in his bug infested rooming house, being taken advantage of by others, but not cognitively poor enough that can take away his right to make his own decisions, or the obese, diabetic woman who you can't provide education for to do her own diabetes self-management, and then she disappears. Lots of time and resources spent on both these situations with poor results.”
5. What was helpful about the self-directed e-learning module?	“Easy to use and makes sense.” “Some of the resources suggested”

	<p>“Challenges the learner to take time to consider everyday ethical practice issues, we sometimes don’t even realize we are facing. “</p>
<p>6. What would you suggest be changed about the self-directed e-learning module (things to add, omit, tweak)?</p>	<p>“More examples added.”</p> <p>“This looks great. As I reviewed through, and looked at this evaluation/feedback document, I found I had some difficulty completing as I thought perhaps I was missing some content in order to evaluate/complete? There were no speaking notes attached to these files, so I wondered what the “answers” or discussion surrounding the various “What Guides us Here?” slides? (17, 20, 23). I realize there are no set answers, and the purpose is to stimulate reflection, yet still I found myself looking for some answers or guidance surrounding responses to these questions or some guidance surrounding what these answers may possibly have been in each of the circumstances. I was certainly able to ponder my own thoughts surrounding these questions, which felt more like personal reflection/contemplation based on my current knowledge and understanding compared to learning how to critically appraise and answer or consider these questions and think of them or “answer” them in new or different ways. Some guidance around possible answers or considerations of the questions as they relate to each scenario may be useful/helpful/beneficial. Is there to be an accompanying text, or perhaps an audio narration that will go along with this module if online? Has there been consideration to what I have mentioned above already?”</p>
<p>7. Would you recommend this self-directed e-learning module to a colleague? Why?</p>	<p>YES</p> <p>“Give support and credence to what really happens in nurses’ lives.”</p> <p>“Good for getting discussions going, help support having peer support programs in place (I am working on that in my current setting right now).”</p> <p>“Because we don’t allow ourselves the time to “stop and smell the roses” in our day to day practice, so we certainly don’t take the time to “sniff” when things don’t “smell” very pleasing... We deserve and need to take the time to reflect on the ethical dilemmas we face in daily practice, to learn from those others have faced, appreciate their impact on us as professionals and compassionate human beings, and learn effective ways to navigate in the moral and ethical darkness we sometimes find ourselves in (and to be “ok” with the</p>

	outcomes at the end of the day, even when they are less than ideal).”
8. As a result of completing this self-directed e-learning module, how will your nursing practice change related to addressing everyday ethical issues if at all?	<p>“It likely won’t change, but it would assure me that I’m not alone and “knowing “adds support.”</p> <p>“Discuss more with others, do more reading, ensure have enough support.”</p> <p>“I already applied an ethical decision making framework in some complex situations... I will strive to do this with a greater consistency. I am more aware of the issues, the frequency and the endless variability that can surround ethical issues. No two are ever quite the same, and there are not always clean and pretty solutions to every problem we face...”</p>
9. As a result of completing this self-directed e-learning module, how will your nursing practice change related to addressing experiences of moral distress if at all?	<p>“It likely won’t change, but it would assure me that I’m not alone and “knowing “adds support.”</p> <p>“Documentation, discuss situations more with colleagues, ensure adequate self-care and peer support.”</p> <p>“I will personally continue to reflect on the potential for moral distress in my own practice, and the practice of those I support, and those I teach and educate.”</p>
10. Are there any other comments that you would like to share?	<p>“Great job, wonderful that you took this on.”</p> <p>“Well done, and thank you for the opportunity to participate. Thank you for having the courage to delve into the murky water.”</p>

APPENDIX Q: SUMMARY OF PHNs' EXAMPLES OF ROLES AND RESPONSIBILITIES

Diverse Specialty Areas of PHNs' Practice	Specific Examples of Roles & Responsibilities
Immunization/infectious disease care	<ul style="list-style-type: none"> • Immunizations and allergy shots • Safe handling of vaccines in doctors' offices • Presentations on travel health information • Telephone counselling • Facilitating decision-making for parents about immunizations
Prenatal and postnatal care	<ul style="list-style-type: none"> • High-risk mothers • Teaching breastfeeding courses • Newborn screening • Parenting teams • Breast-feeding teams • Healthy babies teams • Referrals to local resources: food access, counselling, women's services, welfare office
Falls and injury prevention	<ul style="list-style-type: none"> • Babies and children • Teens and adults • Older adults • High-risk frail elderly
Early childhood development	<ul style="list-style-type: none"> • Services to promote speech and achievement of developmental milestones • Early child health • Parenting teams

	<ul style="list-style-type: none"> • Referrals to local resources: food access, welfare office, counselling
Health of children/youth in school	<ul style="list-style-type: none"> • Teaching and supporting families in schools • Parenting teams • Engaging youth in committees where they design initiatives or choose what health topic they want to promote in schools • Referrals to local resources: food access, counselling, welfare office
Sexual health	<ul style="list-style-type: none"> • Testing for, treatment of, and counselling for sexually transmitted infections including HIV/AIDS • Birth control counselling (including the morning-after pill/emergency contraception) • Pregnancy testing and referrals • Counselling and support for sexuality and gender orientation issues • Referrals to local resources: counselling, women's services, welfare office, Salvation Army, methadone clinics
Harm Reduction/Addictions	<ul style="list-style-type: none"> • Needle exchange programs • Poverty reduction teams • Referrals to local resources: food access, counselling, women's services, legal clinics, welfare office, Salvation Army, methadone clinic
Other	<ul style="list-style-type: none"> • Developing specific initiatives (i.e. bed bug initiative) • Inter-agency group practitioners • Working on issue-based teams

PHN Roles	Examples of Activities & Responsibilities	Examples of Relationships with Clients & Colleagues
Educator/ Mentor	In-services Health teaching Counselling Discussing ways to empower clients to make informed health decisions	Individuals Families New staff, new nursing graduates Interprofessional teams Non-clinical staff Key community partners
Leader	Writing/implementing policies Upgrading paper binds to online formats Ensuring literacy of health education materials Participating in professional practice councils Initiating best practices campaigns	Communities Communities of practice Key community partners

APPENDIX R:
SUMMARY OF HOME CARE NURSES'
EXAMPLES OF ROLES AND RESPONSIBILITIES

Diverse Specialty Areas of Home Care Nurses' Practice	Specific Examples of Roles & Responsibilities
Palliative/end-of-life care	<ul style="list-style-type: none"> • Focusing on quality of life and symptom management • Telephone and virtual support • Educating clients, families, other nurses • Supporting and empowering clients and families to be as independent, involved in care, and able to make informed choices (as much as possible) • Managing complex health issues • Medication and pain management • Putting supports and resources in place (i.e. cognitive decline, lack of family support, financial issues)
Older adults	<ul style="list-style-type: none"> • Educating clients, families, other nurses about chronic, progressive illnesses from a holistic perspective • Supporting clients and families to be independent, involved in care, and able to make informed choices (as much as possible) • Managing complex health issues • Frail elderly and safety issues (prevention of repeated emergency visits) • Medication and pain management • Putting supports and resources in place (i.e. cognitive decline, lack of family support, financial issues) • Advocacy (i.e. reporting abuse)