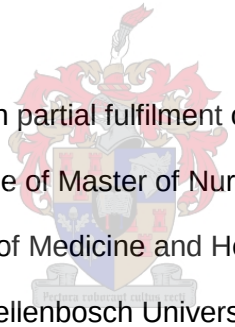
PROFESSIONAL NURSES' LIVED EXPERIENCES OF MORAL DISTRESS AT A DISTRICT HOSPITAL

URSULA VOGET



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DECLARATION

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ABSTRACT

Background

Nurses have the most contact with patients and are therefore confronted by situations of moral conflict. Since nurses are trained to provide care sustaining life, situations that impede their ability to provide quality care, pose a risk of causing moral distress. Ethical practices are guided by various nursing regulations as well as national and international guidelines.

The South African context adds unique stressors to the healthcare system. There is a demand for quality healthcare to be delivered with a budget shortfall of R600 million, coupled with challenges such as the burden of disease, excessive workloads, increased patient deaths, daily exposure to multidrug-resistant tuberculosis (MDR-TB) and a severe shortage of staff along all health professions.

The public health sector work environment is stressful and unsupportive with severely disproportionate nurse–patient ratios. Such conditions could sway ethical decision making and compromise the provision of quality nursing care and enhance moral distress. Due to the adversities, many nurses believe they are no longer providing proper health care and seek other job opportunities or leave the profession.

Methods

A descriptive phenomenological design was applied. One-on-one interviews were conducted with professional nurses permanently employed at a district hospital in the Cape Town Metro District Health Services, using a semi-structured interview guide. Thematic analysis of the data was performed.

Results

Seven interviews were conducted and results indicate that moral distress is experienced irrespective of age and work experience. Newly qualified and newly appointed professional nurses seem more at risk for experiences of moral distress due to challenges in their work environment. The major distressing factors relate to staffing (shortage as well as disrespect from colleagues), management, complaints, resources and doctors. Consequences as a result of moral distress include emotional, personality and behavioural aspects as well as the intent to leave their position. Different coping mechanisms were employed in an effort to cope with the daily challenges the professional nurses experienced.

Conclusion

Moral distress is experienced by professional nurses in medical and surgical wards. It can be elicited from different situations encountered in their daily work, which necessitates them to compromise their professional, moral and ethical standards.

Keywords

Moral distress, job satisfaction, turnover intention, violence in nursing, moral courage, ethical climate

OPSOMMING

Agtergrond

Verpleegsters het die meeste kontak met pasiënte en word dus deur situasies van morele spanning gekonfronteer. Siende verpleegsters opgelei word om lewe te onderhou, het situasies wat hulle beperk om kwaliteitsorg te lewer, die potensiaal om morele spanning te veroorsaak. Etiese praktyke word deur verskeie verpleeg-regulasies asook nasionale en internasionale riglyne gelei.

Die Suid-Afrikaanse konteks dra tot unieke uitdagings in die gesondheidsorg-stelsel by. Daar is ’n aanvraag na kwaliteit gesondheidsorg wat gelewer moet word te midde ‘n begrotingstekort van R600 miljoen, tesame met uitdagings soos siektelas, hoë werksladings, ‘n toename in pasiëntsterftes, daaglikse blootstelling aan multi-middelweerstandinge tuberkulose (MDR-TB) en ernstige personeeltekorte onder gesondheidswerkers.

Die werksomstandighede in die openbare gesondheidsektor is stresvol en nie ondersteunend nie, met buitensporige verpleeg-pasiënt ratio’s. Morele spanning vererger wanneer sulke omstandighede etiese besluitneming beïnvloed en die lewering van kwaliteit gesondheidsorg belemmer. As gevolg van die uitdagings glo baie verpleegsters dat hulle nie meer gehalte gesondheidsorg lewer nie, met die gevolg dat hulle van werk wil verander of die beroep wil verlaat.

Metode

’n Beskrywende fenomenologiese ontwerp met ‘n kwalitatiewe benadering was toegepas. ’n Semi-gestruktureerde onderhoudgids was gebruik om een-tot-een onderhoude met permanent aangestelde professionele verpleegkundiges by ‘n distrikshospitaal in die Kaapstad Metro Distriksgesondheidsdienste te voer. Tema-analise was gebruik om die data te analiseer.

Resultate

Sewe onderhoude was gevoer en die resultate het daarop gedui dat morele spanning ongeag ouderdom of werksondervinding ervaar word. As gevolg van uitdagings in die werksomgewing het dit geblyk dat nuut gekwalifiseerde en nuut aangestelde professionele verpleegkundiges ’n hoë risiko loop om morele spanning te ervaar. Die oorhoofse faktore wat tot morele krisisse aanleiding gee, is aan personeel (tekort, sowel as disrespek van kollegas), verpleegbestuur, klagtes, hulpbronne en dokters verwant. Morele spanning het emosionele, persoonlikheids- en gedragsveranderinge tot gevolg gehad asook die voorneme

van deelnemers om hul werk te verlaat. Professionele verpleegkundiges gebruik verskillende hanteringsmeganismes om die daaglike uitdagings wat hulle ervaar, te hanteer.

Slotsom

Professionele verpleegkundiges in mediese en chirurgiese sale ervaar morele spanning. Dit kan ontlok word deur verskeie situasies waarmee hulle in hul daaglikse werk te doen het, en hulle noodsaak om hul professionele, morele en etiese standaarde te skik.

Sleutelwoorde

Morele spanning, werkstevredenheid, omset voorneme, geweld in verpleging, morele moed, etiese klimaat

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ABBREVIATIONS

ANA	American Nurses Association
EN	enrolled nurse
ENA	enrolled nurse auxiliary
MDHS	Metro District Health Services
MDS	moral distress scale
PN	professional nurse
SANC	South African Nursing Council

CHAPTER 1:
FOUNDATION OF THE STUDY

1.1 INTRODUCTION

By virtue of their practice, nurses have the most contact with patients and are, therefore, confronted with intense situations leading to moral conflict. Since nurses are trained to provide care that sustains life, situations that impede their ability to provide proper patient care tend to cause moral distress (Arries, 2005: 64).

Pera and Van Tonder (2011: 3) stated that "the nursing profession develops its practitioners to become ethical agents who will advocate the well-being of patients and their families with compassion, commitment, confidence, competence and a deep sense of moral awareness". The curriculum of undergraduate education and training of professional nurses (as stipulated in Regulation 425 of April, 1988) makes explicit provision for ethical education and training, indicating that upon completion of the course the student "is able to maintain the ethical and moral codes of the profession and practice within the prescriptions of the relevant laws" (SANC,1988).

There is a multifaceted approach – ethical education and training, and curriculum, policies and legislations – that serves as guidance for ethical practice. Once nurses are registered with the South African Nursing Council (SANC – the legislative body that governs nursing practice in South Africa), ethical practice is underpinned by various regulations, and South African and international ethical guidelines such as:

- Regulation 767 of October 2014 – Regulations setting out the acts or omissions in respect of which the South African Nursing Council (SANC) may take disciplinary steps (SANC, 2014)
- Regulation 2598 – Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1978 (SANC, 1984)
- The Nurses Pledge (SANC, 2015)
- The Code of Ethics for nursing practitioners in South Africa (SANC, 2013)
- The International Council of Nurses' Code of Ethics for Nurses (ICN, 2012)
- The Metro District Health Services (MDHS) Nursing Ethical Code (Baartman, Ruiters & Brown, 2015)

Nurses are constantly faced with the challenge to reconcile their ethical practice (as dictated by the nursing regulations) and organisational constraints, which hinder their ability to

address challenges in the workplace (Parker, Lazenby & Brown, 2013). Examples include leaving a patient in labour alone because the only professional nurse on duty needs to also attend to two other patients in labour; and using linen savers in the absence of diapers. Other examples include leaving a ventilated patient unattended, no hospital gowns to dress patients in, so they are left naked, only covered with a sheet. Numerous more examples can be cited. Professional nurses are independent practitioners who are responsible and accountable for their acts and omissions, yet their ability to influence how things are done is greatly constrained (Humphries & Woods, 2015: 8). Accountability not only has implications for patient care, but also legal, economic and ethical implications as nurses are accountable to themselves, the patients and the public (Sorensen, Seebeck, Scherb, Specht & Loes, 2009: 874).

Research found that nurses' ability to process and resolve ethical dilemmas is dependent on the moral distress they experience through their relationship with patients and how ethical dilemmas are experienced in relation to the ethical climate of the healthcare organisation (Schluter, Winch, Holzhauzer & Henderson, 2008: 305). Lachman, Murray, Iseminger and Ganske (2012: 25) identified organisational culture as a barrier to moral courage, as it sets the tone for the way people in the organisation respond to unethical behaviour. The findings of their study confirm that nurses could be willing to compromise their moral standards if the organisation tolerates unethical behaviour. Through the study the researcher endeavoured to understand professional nurses' lived experiences of moral distress.

1.2 SIGNIFICANCE OF THE STUDY

Ample international literature is available on the presence of the phenomenon of moral distress experienced by nurses in various health care settings. It is uncertain if the phenomenon is also experienced by professional nurses at a district hospital in the Western Cape, South Africa. The findings of this study could assist in understanding professional nurses' lived experiences of moral distress at a district hospital in the Western Cape. An understanding of these experiences can be used in future to address related issues in an attempt to decrease moral distress and increase moral courage and job satisfaction.

1.3 RATIONALE AND BACKGROUND

In this section various concepts related to the phenomenon of moral distress is introduced in order to provide the reader with information and background of how organisational dynamics can be contributory to such experiences.

Moral distress – The concept of moral distress was first described by Jameton (1984: np). When nurses are unable to do what they believe is right, they experience moral distress (Corley, 2002: 636). Moral distress is a phenomenon specifically referring to stress associated with the ethical dimensions of health care (Pauly, Varcoe, Storch & Newton, 2009: 561). It is characterised by contraints, either personal (internal) or institutional (external) preventing a person (health professional) from taking actions that they consider to be morally right (Epstein & Hamric, 2009: 330).

Chambliss (1996: 91) found that ethical problems are not isolated incidences, but rather recurring events in predictable settings. The same problems are experienced in different settings, pointing to the fact that ethical problems does not relate to the individual nurse, but to the broader organisation. The ethical problems represent situations such as the decision to report an incompetent colleague or an adverse incident that occurred; not administering medication to a patient who cannot swallow, instead of consulting with the doctor for the insertion of a nasogastric tube; patients discharged prematurely in order to avail beds to others who needs it more.

Moral distress is not experienced only as a result of institutional contraints that prevent the healthcare provider from acting according to their moral convictions. It is also experienced in situations where healthcare staff are able to follow their moral decisions, but in doing so clash with legislative regulations, such as not charging patients for their hospital visits, treating patients even though they are not supposed to be treated at a certain facility, and giving patients medication without a prescription (Kälvemark, Höglund, Hansson, Westerholm & Arnetz, 2004: 1075; 1080).

Moral distress leads to frustration, burnout, resignations and nurses leaving the profession (Corley, 2002: 638) as well as interpersonal conflict, dissatisfaction and physical illness (Ulrich *et al.,* 2007: 1709). Research shows that moral distress is caused by providing poor quality care, unsuccessful patient advocacy, creating unrealistic hope to patients and their families, and that these conditions are exacerbated in the presence of a poor ethical climate (Shluter, Winch, Holzhauser & Henderson*,* 2008:313).

Moral courage – Lachman *et al*. (2012:24) defines moral courage as “the willingness to stand up for and act according to one’s ethical beliefs when moral principles are threatened…” It is the individual’s capacity to overcome fear and stand up for their convictions and a willingness to speak out and do what is right (Lachman, 2007: 131). Often it is fear that prevents nurses from acting ethically and doing the right thing (Gallagher, 2010). Organisational cultures supporting moral courage are characterised by open

communication on all levels, ethically supporting policies and procedures and empowerment of staff by management. Empowerment aids in creating positive working environments (Lachman *et al*., 2012: 26).

Organisational culture is viewed as the personality of an organisation. It is therefore valuable to gain an understanding of cultural issues underlying organisations and organisational behaviour (Olson, 1998: 346). Organisational culture creates a sense of belonging for those in the organisation as well as organisational loyalty. As it guides organisational behaviour, it can potentially do either great good or great harm (Lachman, 2007: 145).

Organisational culture – Professional nursing practice is often not supported by healthcare organisations (Corley, Minick, Elswick & Jacobs, 2005: 383). The work environment of public health facilities is found to be stressful and unsupportive (Hall, 2004: 34) and professional nurses' work environment is greatly affected by the culture and climate of their organisation (Hart, 2005: 174).

Gallagher (2010) refers to the work of Jameton, who in 1984 described that moral distress arise when a person (nurse) knows the right thing to do, but organisational barriers make it impossible to do what is right. One might be inclined to associate moral courage with no experiences of moral distress. However, even though sufficient moral courage would enable nurses to challenge practices and policies and speak out about them, organisations are not always supportive of such behaviour. Organisations rather act inappropriately and defensively, leaving even the most morally courageous staff member fearful to speak up (Gallagher, 2010).

Ethical climate of a hospital environment – Ethical climate is described as a way to "understand the influence of organisational practices and procedures on the ethical beliefs and behaviours of employees". Organisational ethical practices include perceptions of nurses' interactions with their peers, managers, doctors, patients and the hospital as their work environment (Olson, 1998: 348). The ethical climate of the environment is an important aspect of an ethical organisational culture and is needed to support professional nursing practices (Pauly *et al*., 2009: 563). Ethical climate can be perceived as an organisational variable and can be manipulated to improve the healthcare environment in order to improve ethical decision making (Schluter *et al*., 2008: 306). Parker *et al*. (2013) found that when nurses feel supported in a safe and ethical environment where their clinical judgement and reasoning are valued, job satisfaction increases due to the fact that moral distress decreases.

A study by Hart (2005: 176) showed strong evidence that the ethical climate was a significant factor in professional nurses' decisions to leave their positions, or even to leave the profession. In the researcher's experience, irrespective of staffing restrictions that impede the provision of quality nursing care, nurses are expected to provide quality nursing care at all times. Moral distress does not occur in a vacuum but can always be associated with a negative ethical climate (Humphries & Woods, 2015: 8).

Interdisciplinary relationships – Peers lacking moral courage and concern to take action against unethical working conditions pose a significant barrier to displaying moral courage (Lachman *et al*., 2012: 25). However, peer support has been identified to have significant influence on experiences of moral distress and improvement of environments conducive to correct ethical decision making (Schluter *et al*., 2008: 315). Nurses need to be provided with an environment where ethical dilemmas, professional relationship issues and other vast workplace challenges associated with a healthcare environment, can be acknowledged and addressed (Parker *et al*., 2013).

Research (Mokoka, Oosthuizen & Ehlers, 2010: 4) found that negative relationships in the workplace are characterised by a lack of respect and even verbal abuse from doctors, peers, managers, as well as patients and their families towards nurses. There is also evidence that nurses experience moral distress in the obligation they have to carry out a doctor's prescriptions, due to their differing values. The implication thereof is that besides conflict between the nurses' commitment to the patient and commitment to the organisation, there could also be conflict in values between different staff members (Kälvemark *et al.,* 2004: 1083). A collaborative approach based on rational discussion and sensitivity to moral decision making is required. Therefore, it is no longer realistic for doctors to assume a dominant position in moral decision making (Arries, 2005: 66).

Policies and procedures – The ethical climate is used as a way to understand how ethical beliefs and behaviours of nurses are perceived to be influenced by organisational procedures and practices (Olson, 1998: 348). Corley *et al.* (2005: 383) identified ethical conflict with hospital policy as a source of moral distress, specifically related to ineffective legal and policy structures. Standardised policies and guidelines, ethics education and ethical support are often lacking in organisations, despite the increasing demand for sound ethical judgements (Kälvemark *et al*., 2004: 1076).

Patient care – Patient safety and quality patient care, together with patient and family satisfaction with care, depend greatly on nurses as they help patients with every aspect of basic needs through their most difficult life circumstances (Ulrich *et al*., 2007: 1708). The

Patient's Rights Charter allows patients and their family members the right to participate in decision making on matters affecting healthcare (Department of Health, 1999: n.p). This includes moral and ethical decisions and therefore, patients and families are increasingly demanding to be empowered in this regard (Arries, 2005: 65).

Providing nursing care is intellectually challenging and physically demanding; delivered in a context which is increasingly complex and filled with ethical questions and dilemmas (Schluter *et al*., 2008: 304). Kälvemark *et al*. (2004: 1077) describe moral dilemmas as arising when two or more values are in conflict. There are good reasons to support either course of action as more than one principle applies to the situation. However, a loss of value is unavoidable as a decision must be taken. Nurses face morally distressing situations every day in their work environment that requires them to act with courage (Gallagher, 2010), but they also experience adversity in their daily practice, which affects the quality of patient care negatively. Links have been made between workplace adversity and an increase in moral distress, burnout, increased staff turnover and poor patient care (Vanderheide, Moss & Lee, 2013: 101).

Managers should ensure that nurses are functioning in an ethical environment – a trusting environment where ethical concerns are acknowledged and can be discussed (Parker *et al*., 2013). Fostering an ethical work environment that could decrease moral distress whilst improving quality patient care, is but one consideration for maintaining a stable nurse workforce (Takase, Kershaw & Burt, 2001: 825).

Cape Town Metro District – The highest proportion of the province's population is in the Cape Town Metro District, where the high population density is exacerbated by in-migration, which significantly impacts on planning and contributes to higher infrastructure costs and lack of services (Western Cape Government: Health, 2016(a): 16). Increased service pressures are experienced due to changing patient profiles. Although district hospitals have increased their beds, the number of days that patients spend in hospital increases due to patients being much sicker and more complex with poorer prognosis. High patient loads and long waiting times due to congested primary health care facilities as well as very high bed occupancy in metro district hospitals is evident of the increased service pressures (Western Cape Government: Health, 2016(a): 19–20). The researcher has observed that the increased patient totals lead to higher workloads for the short-staffed nursing corps. To the researchers' viewpoint, the severe service pressures coupled with increased patient acuity contributes to circumstances that compromise ethical decision making and the provision of quality nursing care, ultimately giving rise to moral distress.

1.4 PROBLEM STATEMENT

The ethical climate of an organisation influences the way in which ethical dilemmas are managed and influences ethical or unethical behaviour. Literature proposes that the ethical climate of a hospital environment is related to nurses' level of moral distress (Corley *et al*., 2005: 387; Olson, 1998: 345; Schulter *et al.,* 2008:306; Gallagher, 2010; Corley, 2002: 640; Pauly *et al*., 2009: 563; Hall, 2004: 34).

The provision of health services in the MDHS is influenced by high patient loads accompanied by staff shortages (Western Cape Government: Health, 2016(a): 19–20) – circumstances that could sway ethical decision making and the provision of quality nursing care, and therefore, give rise to moral distress. In the researcher's experience, the expectation of professional nurses to do the right thing remains high, irrespective of the working conditions under which they are expected to perform.

No previous studies could be found on moral distress experienced by professional nurses in the public health sector of the MDHS.

1.5 RESEARCH QUESTION

The study was guided by the following question: What are the professional nurses' (PN's) lived experiences of moral distress at a district hospital?

1.6 RESEARCH AIM

The aim of the study was to understand professional nurses' lived experiences of moral distress at a district hospital.

1.7 RESEARCH OBJECTIVES

The research objectives are to describe professional nurses, practicing at a district hospital in Cape Town Metro District's:

- lived experiences of moral distress
- influences that moral distress have on their lives
- what the causes of moral distress experiences are

1.8 RESEARCH METHODOLOGY

A comprehensive description of the research methodology used in this study is provided in chapter three. Therefore, only a brief overview of the applied methodology is provided in the current chapter.

1.8.1 Research design

A descriptive phenomenological design was applied to describe professional nurses' lived experiences of moral distress.

The design is based on phenomenological philosophy as proposed by Husserl, meaning a focus on epistemology, thus describing the experiences of the participant in an untainted manner (Watson, McKenna, Cowman & Keady, 2008: 233–234). Subsequently, the researcher bracketed her own experiences on moral distress and focussed on describing the experiences of the participant objectively, as proposed by Watson *et al.* (2008, 233–234).

1.8.2 Study setting

A natural setting for data collection was used, namely a district hospital in the MDHS in Cape Town.

1.8.3 Population and sampling

The population for the study consisted of all professional nurses at a selected district hospital in the Metro District Health Services, Western Cape. The hospital and participants were selected by means of purposive sampling. Seven in-depth interviews were conducted with professional nurses from the hospital.

1.8.3.1 Inclusion criteria

The inclusion criteria for participants were that they were professional nurses in non-managerial positions, employed full time in the hospital, and practicing in general medical and surgical wards. The inclusion criteria, therefore, refer specifically to professional nurses with a four-year diploma or degree (R425), or who have completed the bridging course (R683).

1.8.3.2 Exclusion criteria

The exclusion criteria were professional nurses practicing in general wards who were on leave at the time of the study.

1.8.4 Pilot interview

One pilot interview was conducted at the same hospital where data was collected from a participant who met the inclusion criteria for the study. The pilot study revealed no pitfalls and the data was included in the data set.

1.8.5 Data gathering method

Data was collected through individual interviews which were personally conducted by the researcher, using a semi-structured interview guide.

1.8.6 Trustworthiness

Trustworthiness was established by applying Lincoln and Guba's (1985) principles of credibility, dependability, transferability and confirmability.

1.8.7 Data collection

The researcher personally conducted in-depth one-on-one interviews at the hospital in a suitable venue as determined by the participants.

1.8.8 Data analysis

Colaizzi's method of data analysis (Edward & Welch, 2011: 164) was applied. The interviews were transcribed where after a search for themes was undertaken.

1.9 ETHICAL CONSIDERATIONS

The proposal was reviewed by the Health Research Ethics Committee of Stellenbosch University (Ethics reference number: S16/03/055) for approval to conduct the study, where after permission was obtained from the Department of Health as well as institutional permission of the hospital involved in the study.

Right to self-determination – Selected participants were offered the opportunity to practice their right to self-determination by being informed that their participation was voluntary and that they could withdraw at any time during the research process without repercussions. Information leaflets on the study were provided during the recruitment process. Voluntary, informed consent was obtained from each participant on the day of the interviews.

Right to confidentiality and anonymity – Individual interviews were conducted in a private room in order to ensure privacy to participants. Written, informed consent was personally obtained from all those willing to participate. Once each interview was concluded participants were awarded a number in order to protect their personal identity. Only the researcher knew what number was awarded to which participant. In the event that a participant wanted to withdraw after the interview process was completed, the researcher would be able to delete the specific audio recording and destroy the transcript of the specific interview. Confidentiality was maintained by not identifying the participating hospital by name. Informed consent was kept separate from the collected data. Audio data of the interviews were downloaded onto a laptop after each interview and deleted from the recorder. All transcripts are kept in a locked filing system and stored for five years. Computers, on which data was stored, was password protected and only accessible to the researcher and her supervisor.

Right to protection from discomfort and harm (beneficence) – A written explanation of the purpose and procedure for participating in the research was provided to all potential participants, including any risks and/or benefits of participation. Due to the nature of the topic there was a possibility that it might elicit uncomfortable emotions in some participants. Therefore, the Independent Counselling and Advisory Service (ICAS), used by the Western Cape Provincial Government to address employee wellness and provide employee assistance, were offered for referral of participants for the necessary emotional and psychological support.

1.10 OPERATIONAL DEFINITIONS

Professional nurse: "Professional nurse" means a person registered as such in terms of section 31 of the Nursing Act, No 33 of 2005. A professional nurse is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (Chapter 2, Section 30 (1) of the Nursing Act, No 33 of 2005)

Community service: "A person who is a citizen of South Africa intending to register for the first time to practice a profession in a prescribed category must perform remunerated community service for a period of one year at a public health facility (Section 40(1) of the Nursing Act, No 33 of 2005)

Community service professional nurse: According to regulation 8(a) of the regulations relating to the performance of community service "these regulations are applicable to any person who seeks registration on completing and meeting the requirements prescribed in the regulations relating to the Approval of and the minimum requirements for the education and training of a nurse (general, psychiatric and community) and midwife leading to registration published in Government Notice No R425 of 22 February 1985, or any subsequent regulation made to replace it."

Ethical climate: A way to perceive and understand the influence of organisational practices and procedures on the ethical belief and behaviours of employees (Olson, 1998: 348).

Moral distress: Painful feelings and/or the psychological disequilibrium that occurs when nurses cannot carry out morally appropriate actions that a situation requires due to institutionalised obstacles (Jameton, 1984).

Moral courage: The willingness to stand up for and act according to one's ethical beliefs when moral principles are threatened (Lachman *et al*., 2012: 24)

Lateral or horizontal violence: the terms used to describe physical, emotional and verbal abuse; referred to as inter-group conflict or “nurse-on-nurse aggression” (between nurses of the same rank) (Farrell, 1997:502)

Vertical violence: describes the abuse of power relationships between staff of all levels (Khalil, 2009: 208)

Bullying: for the purpose of the study, term “bullying” was used interchangeably when referring to horizontal or vertical violence or aggression

1.11 DURATION OF THE STUDY

Ethical approval was obtained from the Health Research Ethics Committee 1 on 18 May 2016 for the period of one year. Recruitment was done on 23 and 25 June 2016 for the day and night shifts. The pilot interview was conducted on 27 June 2016 and the final interview on 20 August 2016. Data analysis was conducted during September 2016 and the final thesis was submitted for examination on 1 December 2016.

1.12 CHAPTER OUTLINE

Chapter 1: Foundation of the study

Chapter 1 serves as scientific foundation for the study, which portrays the background and motivation for the study. It included a brief overview of the literature, research question, study aim and objectives, research methodology, ethical considerations, definition of terms, and study layout.

Chapter 2: Literature review

Chapter 2 represents a literature review related to the study topic.

Chapter 3: Research methodology

Chapter 3 contains a detailed description of the research methodology that was applied in the study.

Chapter 4: Results

Chapter 4 presents the findings of the study.

Chapter 5: Discussion, conclusions and recommendations

In chapter 5 the findings of the study are discussed according to the various objectives, conclusions are drawn and recommendations are proposed.

1.13 SUMMARY

Moral distress originates from various situations in the workplace where professional nurses are prohibited from acting according to their moral and ethical convictions, causing them intense psychological discomfort and suffering.

The aim of the study was to understand professional nurses' lived experiences of moral distress. A descriptive, phenomenological design was followed and in-depth one-on-one interviews were conducted. Colaizzi's method of data analysis was followed.

In order to establish trustworthiness the credibility, dependability, transferability and confirmability of the research study was instituted. The ethical considerations of beneficence, autonomy and confidentiality and anonymity were applied throughout the study.

According to the initial timeframe, the submission of the thesis was aimed for October 2016; however, it was extended to December 2016. The estimated budget was R12 532, but the final total amounted to R11 132.

Chapter 2 will present a literature review providing an in-depth understanding of professional nurses' lived experiences of moral distress.

CHAPTER 2:
LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 2 contains a presentation of the literature findings that add value and provide a better understanding of the topic under discussion: moral distress. The purpose of a literature review is to "develop a strong knowledge base" in order to conduct the research study. By critically reviewing evidence-based literature, information is exposed which adds to the "development, implementation and results of a research study" (LoBiondo-Wood & Haber, 2010: 79). The literature review aims to describe moral distress as experienced by professional nurses.

2.2 SELECTING AND REVIEWING THE LITERATURE

The literature review was conducted over a period of 18 months. It commenced prior to writing the study proposal and was adapted on completion of data collection and analysis to enhance alignment with the findings of the study. The Stellenbosch University Library and Information Services' electronic databases, Worldcat and Worldcat.org were utilised, that included search engines CINAHL, Medline and PubMed for a selection of journals and peer-reviewed articles. Ongoing support was provided by the librarian in order to access articles and books. The Google search-engine was also utilised using key words including moral distress; moral distress nursing; moral distress South Africa; job satisfaction; organisational culture; turnover intentions; moral courage; moral distress healthcare; and violence in nursing. Limited published research was found nationally compared to multiple international studies that were done. However, research on the topic remains restricted and material selected includes seminal studies and articles older than 10 years, as well as more recent research.

2.3 FINDINGS FROM THE LITERATURE REVIEW

The findings from the literature review are described under the following headings:

- The South African public sector
- The phenomenon of moral distress
- Causes identified from quantitative studies
- Findings from qualitative studies
- Effects of moral distress

2.4 THE SOUTH AFRICAN PUBLIC SECTOR

Public Health Care in the Western Cape – The purpose of district health services is to deliver facility-based and community-based services to the residents of the Western Cape. Facility based services are rendered at clinics, community health centres and district hospitals (Western Cape Government: Health, 2016: 53). District hospitals are categorised as small, medium or large based on the number of beds. These hospitals support primary health care (clinics and community health centres) and provide 24-hour services. General specialists based at regional hospitals provide outreach and support to district hospitals. District hospitals may only provide paediatric, obstetrics and gynaecology, general surgery, internal medicine and family physician as specialist services (Republic of South Africa, 2012: 4).

In 2006, over 80% of South Africans did not have medical aid; therefore, their only choice was to seek treatment at government healthcare facilities (Cullinan, 2006). In her speech during the Western Cape Health Provincial Vote 2016 budget debate, the Member of the Executive Council (MEC) of Health in the Western Cape, Dr Nomafrench Mbombo, identified the tension between the available resources and the demand for quality health care as the budget shortfall for the 2016/2017 financial year amounts to R600 million (Western Cape Government: Health, 2016(b)). Despite steps taken since 1994 to improve healthcare for all, the healthcare system in South Arica remains inequitable (Pillay, 2015: 277). Public health services are relying on the commitment of nurses and doctors to render the services (Cullinan, 2006). What can be achieved in the public health sector is adversely affected by the gross insufficiency of trained health workers (Jobson, 2015: 6).

The estimated population of the Western Cape (WC) was 6.2 million in 2015 and the province has 16 701 registered professional nurses. The WC therefore has a registered professional nurse-to-patient ratio of 371:1 (SANC, 2016: 1). According to the competencies for critical care nurse specialist, SANC has indicated the desired nurse–patient ratio in critical care units as 1:1 and 1:3 or 1:4 in high care units provided relevantly experienced critical care staff is available (SANC, 2014: 1–2). However, none such precise ratios are available for general medical or surgical wards. Different ratios of staff are required for the different health care environments in South Africa. International research about nurse-to-patient ratios is available (American Nurses Association (ANA), 2015 (a)) as these ratios are legislation in countries such as the USA. However, it was identified that the ratio's did not consider competency levels or an appropriate skills mix compared to patient acuity and the availability of support staff in hospitals (Uys & Klopper, 2013: 1–2). Some health institutions in South Africa were operational with less than half the staff complement than what is

required, with a third of health posts vacant (Cullinan, 2006). With a 1:18 nurse-to-patient ratio, a nurse has three minutes an hour to attend to each patient, perform routine duties and deal with emergencies (Bateman, 2009: 565).

There is evidence that an increase in the number of registered nurses is associated with a decrease in adverse incidents. The *Registered Nurse Staffing Act* became federal regulation in the USA and is supported by die American Nurses Association (ANA). The Act ensures that there is appropriate flexible nursing staffing plans according to changing patient needs in each unit (ANA, 2015(a)). In South Africa's public healthcare sector nurse–patient ratio's are considered severely disproportionate, even more so in the absence of clearly defined staffing norms (Denosa, 2012).

Many nurses believe they are no longer providing proper health care due to the stressful and unsupportive nature of the public health sector work environment. The main causes are factors beyond their control such as staff shortages, increased patient numbers as well as the prevalence of HIV/AIDS. Consequently, nurses seek other career options, which could include leaving the profession (Hall, 2004: 34).

The public health sector's main challenges have been related to the burden of disease as well as ineffective planning to meet the country's health needs (Jobson, 2015: 5). The burden of HIV-related patients has caused increased, complicated patient loads as well as overwhelmed nursing staff having to treat these patients. Many nurses are also HIV positive or work in fear of getting infected at work (Cullinan, 2006). As a result of the HIV pandemic, the need for healthcare workers has increased dramatically (Jobson, 2015: 5). Public hospital staff is also under stress from huge workloads, increased patient deaths and daily exposure to multidrug-resistant TB due to poor infection control practices (Cullinan, 2006). Due to bed pressures, patients are often discharged prematurely, which could result in re-admissions. The referral system between clinics and district-, regional- or tertiary hospitals pose many challenges, leaving seriously ill patients at inappropriate facilities, affecting their chances of survival (Cullinan, 2006).

The subtle presence of racism– the initial literature review did not include a discussion on race. However, during the interviews racial tension surfaced – the Black respondents working in a predominantly Coloured hospital environment were seemingly treated with less respect by Coloured colleagues. Subsequently the researcher deemed it appropriate to include literature pertaining to racism in the context of the Western Cape.

The South African healthcare system merits further exploration as it is likely that the South African context would add unique stressors (Langley, Kisorio & Schmollgruber, 2015: 36). In

the South African context, pre- and post-apartheid events influenced interaction between Coloured and Black people in such a way that their relationship is based on apparent lack of similarity between the groups, but also an increased awareness of differences (Brown, 2000: 201). The national mid-year population estimate of 2016 indicated that the black African population accounts for 80,7% of the total population, Coloured 8,8% and White 8,1% (Statistics South Africa, 2016: 2). In the City of Cape Town, the majority of the total of the population is Coloured (42,4%) with black African, 38,6% and White, 15,7% (Statistics South Africa, 2011). The interaction between coloured people and the black majority in South Africa dates back to how race classifications were done and the manner in which racial groups relate to those in other groups. Coloured people have historically been an intermediary group between White and Black people. As some Coloured people were allowed to pass as White, they thereby received a perceived higher status than Black groups, although the intermediary position resulted in Coloured people becoming a buffer between white and black groups in times of crises and caused further division (Brown, 2000: 198–199). Despite the end of apartheid, subtle, unspoken racial and cultural tension amongst groups is still present in Cape Town (Khalil, 2009: 207).

The nursing staff at the hospital is predominantly Coloured (49%) with a growing black African (40%) nursing staff (George, 2016). Steinman (2003: 30) found a steep increase in experiences of racial harassment amongst members of a minority group in workplace-specific healthcare environments (such as a certain hospital). Although the majority of the population is black Africans, within the Western Cape as well as in the hospital where the study was conducted, this is the minority group compared to the Coloured population. The findings revealed the presence of subtle racism amongst nursing staff, specifically from Coloured nursing staff towards black African colleagues.

2.5 MORAL DISTRESS

2.5.1 Definitions of moral distress

Pauly, Varcoe and Storch (2012: 2-3) found that moral distress is defined differently in various studies. They also suggested that a more critical stance towards moral distress is required in relation to ethical dimensions of practice, and that the concept should be reconsidered to include examination of philosophical perspectives guiding moral decision making, as well as the emotional responses triggered. The definition has been adapted by various researchers who have studied the phenomenon. The various definitions are displayed in Table 2.1.

Table 2.1: Definition of moral distress by different researchers

The concept of moral distress was first described by Andrew Jameton (1984: n.p.) as	"…arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action".
Corley, 2002: 636	When nurses are unable to do what they believe is right, they experience moral distress
Pauly, Varcoe, Storch & Newton, 2009: 561	Moral distress is a phenomenon specifically referring to stress associated with ethical dimensions of health care
Epstein & Hamric, 2009: 330	It is characterised by contraints, either personal (internal) or institutional (external) preventing a person (health professional) from taking actions that they consider to be morally right
Austin, 2012: 28	"the name increasingly used by health professionals to refer to experiences of frustration and failure arising from struggles to fulfill their moral obligations to patients, families and the public"
Varcoe, Pauly, Webster & Storch, 2012: 59	"The experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural contexts of the workplace environment."
ANA 2015(b): 44	"The condition of knowing the morally right thing to do, but institutional, procedural or social constraints make doing the right thing nearly impossible; threatens core values and moral integrity."
Langley *et al*. 2015: 37	"A conflict which arises in certain circumstances to do with patient care which occurs when one knows or believes what the correct thing would be to do but can't pursue this option OR when either of two responses might be appropriate to a situation, both of which are not considered ideal."
Woods, Rodgers, Towers & La Grow, 2015: 120	"…occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints."

Jameton's definition has been understood by researchers as if health care providers do not pursue the right course of action. However, the attempts of health care workers to pursue and act right are often not heard or silenced, and their actions dismissed (Varcoe *et al*., 2012: 58). The institutional constraints mentioned by Jameton (see Table 1) include challenges such as time constraints, lack of supervision, organisational policies and power stucture, or legal considerations (Corley, Elswick, Gorman & Clor, 2001: 251). This definition emphasises the impact of external and institutional constraints on nurses' ability to practice ethically, indicating that the moral agency of nurses are beyond individual control and located in the structures that governs nurses' practice (Pauly *et al*., 2012: 3-4).

A further refinement of the concept was suggested by Varcoe *et al*. (2012: 59) to also account for social, political and contextual factors limiting health care providers' ability to endorse their educational and professional standards, despite repeated attempts. These inclusions relate to an inability to perform in accordance with the professional standards expected, as a consequence of the context (institutional and broader socio-political) and not merely failing or avoiding responsibility. In such situations, healthcare providers may withdraw, leave or continue to voice their concerns.

2.5.2 Moral residue and the crescendo effect

Jameton (1984: n.p.) identified two parts to moral distress, namely initial distress and reactive distress. The initial distress is seen as the acute phase that occurs in the moment and is referred to as moral distress. It is resultant of situations where moral judgments cannot be acted upon and various options are considered as solutions. Solutions may range from informing the patient, confronting the physician or informing a senior, to resigning, screaming or simply doing nothing at all. However, after the situation causing moral distress has passed, reactive distress remains and is referred to as residual distress (Epstein & Hamric, 2009: 330). Irrespective of the choice, the outcomes remain unpredictable and possibly unpleasant. Moral distress and subsequent moral residue could lead to desensitisation and disengagement. In turn, this can lead to moral silence, deafness and blindness – people being morally mute (Varcoe *et al.,* 2012: 58).

Moral residue is the term used to describe the lingering feelings after experiencing a morally problematic situation. The cresendo effect describes the interactions between an increase in moral distress and an increase in moral residue. As repeated cresendos of moral distress are experienced over time, moral residue gradually increases, leading to a second cresendo. Moral residue can therefore create increasingly higher cresendos and new situations can evoke stronger reactions as the healthcare professional is reminded of earlier distressing situations (Epstein & Hamric, 2009: 332–333). Moral residue builds up over time in organisations where moral distress is not addressed. These crescendos can erode healthcare providers' moral integrity, leading to desensitisation to moral aspects, and in turn, lead to withdrawel from difficult cases, conscious objection or leaving a position or the profession (Hamric, 2012: 42).

2.5.3 Identifying moral distress

The experience of moral distress is different from experiencing moral outrage, as distress requires that people have a responsibility towards taking action and the outcome of the action (Fry, Harvey, Hurley & Foley, 2002: 376). As example, a nurse may be emotionally

distressed when restraining a patient, but will only become morally distressed if believing that restraining a patient is morally wrong (De Veer, Francke, Stuijs, & Willems, 2013: 101).

Although it is accepted that nurses bring values of moral practice into their work, it is not clear if they are able to always identify ethical problems in the work environment. The identification of moral distress relates especially to their ability to evaluate the extent of moral distress caused by the problems. For example, a nurse of 17 years was unable to recognise her perceived "burnout" as moral distress until learning about moral distress and recognising her own experience (Austin, Lemermeyer, Goldberg, Bergum & Johnson, 2005: 38). However, what may cause moral distress in one nurse may not cause moral distress in another. Therefore, irrespective of environmental challenges and ample opportunities for situations of moral distress to arise, experiencing moral distress should not be considered predetermined in any moral situation (Austin *et al*., 2005: 35).

Uncomfortable feelings that are experienced when barriers to a desired moral response is felt, is familiar to the majority of practicing nurses. Uncomfortable feelings can range from a nagging unease and escalate to fear, anger and guilt. These emotions, together with physical (sweating, shaking, headaches, crying, diarrhoea), cognitive (decreased coping, frustration, decreased self-esteem) and behavioral (loss of the ability to provide good patient care) symptoms, consitute moral distress (Austin *et al.*, 2005: 34–35).

In nursing, moral distress has been attributed to three key domains, that being: clinical situations, internal constraints and external constraints (Johnstone, 2013: 25). Austin *et al*. (2005: 34) found that it is often not that nurses find it difficult to determine what the right thing to do is – the greatest difficulty arise when the "right" choice is clear, but the implementation of the morally acceptable action is compromised. The chosen action could be prohibited by internal (such as fear or doubt) or external constraints (such as hospital policy or staff shortage). When nurses participate in moral wrongdoing they are violating their expected role of trusted caregiver and patient advocate (Austin *et al*., 2005: 34).

A study by Wilson, Goettemoeller, Bevan & McCord (2013: 1459), using a moral distress tool developed by the authors, amongst staff nurses and registered nurses in critical care and transitional care units, found the overall moral distress rating as "none to slight" according to the scale. However, findings of the two open-ended questions contained in the tool reflected the presence of moral distress amongst the participants; that they struggled with the provision of futile care, the workload and support that they received, amongst others. The inability of the tool (Likert-scale questions) to efficiently identify the presence of moral

distress compared to the findings of the open-ended questions suggested the possibility that qualitative studies could possibly better identify moral distress.

2.6 CAUSES OF MORAL DISTRESS

This section presents several causes and contributing factors to experiences of moral distress that have been identified in literature through quantitative (using specifically developed tools) and qualitative studies.

2.6.1 Causes identified through the Moral Distress Scale

Corley *et al.* (2001: 250–153) developed a tool – the Moral Distress Scale (MDS). This scale is underpinned by Jameton's definition of moral distress, which focuses on individual perceptions of clinical situations and emphasises organisational constraints. The moral distress scale identifies factors that contribute to nurses' experiences of moral distress related to intensity as well as frequency, with items related to each factor constituting root causes. Efforts have been made to revise the Moral Distress Scale and improve the scale's ability to detect a variety of root causes and the authors developed a shortened form more suitable to multivariate research in clinical areas. The Moral Distress Scale-Revised (MDS-R) was developed, which reflect more causes and broadens the scale's applicability. The majority of the quantitative studies surveyed utilised this instrument. In 2011, the author, Corley, stopped recommending the use of the MDS-R as the Moral Distress Thermometer was developed as an appropriate replacement (Hamric, 2012:45). However, the MDS and MDS-R are still used in more recent quantitative studies on the topic (Woods *et al*., 2015; Trotochaud, Coleman, Krawiecki & McCracken, 2015; Parker *et al.*, 2013).

Practicing with unsafe staffing levels – Adequate staffing levels with competent registered professional nurses are key in ensuring safe patient care and addressing moral distress (Langley *et al.,* 2015: 38). Aiken, Clarke, Sloane & Silber (2002: 1990-1991) found that increasing professional nurse staffing would significantly decrease mortality rates. There was a 8,4% death rate amongst patients (categorised as medical and surgical) with complications and a 4:1 patient-nurse ratio. It was determined by the same researchers that a patient–nurse ratio of 6:1 would cause a 14% increase in mortality rate, and 8:1 an increase of 31%. Safe staffing is an ethical issue and nurses need the moral courage and organisational support to ensure the clinical work environment is conducive for ethical practice and quality patient care. Safe staffing entails the right amount of nurses with the right kinds of skills, at the right times, for the right patients, in the right environment. If, according to a nurses' judgement, there is not enough staff to provide safe care, they tend to feel ethically compromised (Asher, 2006:20).

Practicing with staffing levels perceived as unsafe was identified as triggers for high levels of moral distress intensity and frequency in various studies (De Veer *et al.,* 2013: 106; Corley *et al.* 2005: 386; Zuzelo, 2007: 351; Vaziri, Merghati-Khoei, & Tabatabaei, 2015: 34; Pauly *et al.,* 2009: 567; Langley *et al*., 2015: 37).

In qualitative studies (Choe, Kany & Park, 2015: 1689; Kälvemark *et al*., 2004: 1078; Maluwa, Andre, Ndebele & Chilemba, 2012: 199) staff shortage was identified as a cause of moral distress. Langley *et al*. (2015: 38) found that due to staff shortage, agency nurses are used in provincial hospital intensive care units in an attempt to ensure minimal staffing levels. In some cases, there was only one permanent staff member on duty for the shift, causing anxiety, anger and a sense of abuse due to the overwhelming responsibility experienced by the permanent staff member. These agency nurses often rely on the permanent staff's expertise as they seldom have the necessary competencies to work in an intensive care unit.

Aiken *et al.* (2002: 1990) found, in a cross-sectional analysis amongst nurses in various healthcare settings, that the nurse-to-patient ratio significantly and negatively impacted the nurses' job satisfaction and caused higher emotional exhaustion. The findings revealed that where there was a 1:8 nurse-patient ratio, nurses were more than twice as likely to experience high levels of moral exhaustion than if the ratio is 1:4. Emotional and moral exhaustion could contribute to experiences of moral distress.

Without proper staffing, nurses tend to experience limitations to their ability to meet the professional standard demands (MacDonald, 2002: 199). Shortage of human resources was found to place increasing demands on the time required for nursing care. Subsequently, nurses worked more consecutive days and often without taking a break during their shift. As working conditions deteriorate, healthcare professionals find themselves unable to maintain patient care standards. Notably, lack of resources for training and mentorship left new appointees in a position where they were expected to perform beyond their capabilities, without the necessary support (Austin, 2012: 31) such as in-service education, on-the-spot training interventions, orientation and induction (Hall, 2004: 32).

The daily tasks of healthcare providers do not only relate to clinical patient care. Professional nurses also experience a heavy administrative workload, leaving them unable to live up to their own patient care standards. Shortage of staff exacerbates this situation and the awareness of the consequences of the lack of staff, to the extent that staff find it difficult to report sick due to the strain it will place on their colleagues (Kälvemark *et al.,* 2004: 1079). A study by Mokoka *et al.* (2010: 4) on the retention of South African nurses, found that

nursing shortages, heavy workloads, mandatory overtime, inflexible hours, lack of basic resources and equipment, as well as high demands by management, patients and visitors caused disillusionment. Even though nurses may enjoy the nature of their work, challenges such as work overload, lack of support, staff shortages and lack of equipment could cause some to leave their job (Hall, 2004: 32).

Findings from qualitative and quantitative studies suggest that adequate staffing norms will positively impact on professional nurses' ability to perform their duties to the required service standards. Study results are indicative that increasing the number of professional nurses will not only improve patient care, but also decrease patient mortality. Safe staffing levels will allow for adequate education and training interventions and orientation of new staff members. It is evident from the literature that practicing with unsafe staffing levels causes moral distress and is a reason why nurses leave, or intend to leave, their employment or the profession.

Ignoring patient wishes and end-of-life care issues – Various studies (Zuzelo, 2007: 351; De Veer *et al*., 2013: 104; Langley *et al.,* 2015: 39; Allen*,* Judkins-Cohn, deVelasco, Forges, Lee, Clark & Procunier, 2013: 113; Wilson *et al*., 2013:1462; Choe *et al*., 2015: 1687) found that nurses experience moral distress when they are confronted with situations where they need to ignore the patients' wishes and follow the family's wishes to continue life support, abide by the doctor's prescriptions for unnecessary tests and treatments and maintain futile care.

Study findings indicated that end-of-life care is a cause of moral distress, especially related to ignoring patients' wishes, dealing with the family after the patient's demise, and the management of end-of-life decisions by doctors. Prolonging pain and suffering through unnecessary tests and treatments for patients with poor potential outcomes, or alternatively, withdrawing care for patients with potentially good chances of survival are some of the situations professional nurses must endure. They often find themselves excluded from such decision-making processes, especially in intensive care units.

Langley *et al*. (2015: 38) further reported that intensive care nurses found it challenging to deal with the family after a patient's death, to the extent that they would "hide" to avoid the distress instead of communicating with the family members. The participants in Langley's study also experienced that their input was ignored and they felt excluded from decision making regarding patient care. Distress was experienced in cases where nurses had limited autonomy or decision-making power when they did not agree with the doctor or family's choice of treatment plan (Choe *et al*., 2015: 1688).

Policy – A study among New Zealand registered nurses (Woods *et al*., 2015: 123) highlighted the presence of moral distress related to cost reduction measures pertaining to patient care. The nurses in the study were expected to provide less than optimal care in an effort to reduce healthcare expenditure. This finding is indicative of registered nurses' lack of autonomy as their practice is restricted by organisational regulations not in the patient's best interest, and they are left powerless to act according to their moral judgement.

In a phenomenological study in Korea (Choe *et al.,* 2015: 1689) "conflicts with institutional policy" was identified as a theme, referring to policies perceived as ethically misguided such as prioritising cost above patient care (patients discharged prematurely without regard for their condition). In focus group interviews it was identified that nurses found it impossible to act according to the guidelines at times. Nurses found themselves in situations where they voluntarily broke the rules when experiencing conflict between rules and regulations and what was in the patient's best interest, and were willing to justify their actions. The nursing participants reported that they were sometimes forced to act according to regulations due to organisational structures preventing them from breaking the rules (Kälvemark *et al.,* 2004: 1080). Similarly, nurses in a Malawian qualitative study also identified that violating regulations in order to protect the patients lead to moral distress, especially when junior physicians undermined more experienced nurses, or when hospital regulations were in conflict with their duties (Maluwa *et al*., 2012: 199).

Competence – Increased competence is required of all categories of nurses as competent practice is expected throughout society (Jormsri, Kunaviktikul, Ketefian & Chaowalit, 2005: 582). Findings by Rice, Rady, Hamrick, Verheijde & Pendergast (2008: 362), Pauly *et al*. (2009: 567), Langley *et al.* (2015: 37), Woods *et al*. (2015: 123), and Johnstone (2013: 25) indicated that moral distress was experienced by nurses when they did not feel professionally competent to perform prescriptions or worked with incompetent colleagues.

New nurse graduates seemed particularly prone to experiences that could lead to moral distress. In open-ended interviews conducted with newly-graduated nurses employed in acute care settings in Canada (Ellerton & Gregor, 2003: 103–107) most of the nurses identified lacking the capacity to communicate with patients and families in a helpful manner. The new nurse gradudates reported that they struggled to complete their duties due to the time spent on locating equipment and resources as well as consulting with others for help. In some instances, new graduates in the study admitted feeling overwhelmed and frustrated by the complexity of the work and their own lack of knowledge and skill to manage clinical situations independently and with the necessary competence and confidence. From the

study findings it was clear that three months after graduation, the nurses were greatly dependent on the support of more experienced nurses while developing into their roles.

2.6.2 Factors related to causes

Clinical settings – Hamric and Blackhall (2007: 428) and Whitehead, Herbertson, Hamric, Epstein, & Fisher (2015: 120) found that registered nurses in the clinical setting tend to experience more moral distress than doctors. Hamric and Blackhall (2007: 428) further reported that registered nurses perceived their ethical environment more negatively and were less satisfied with the quality of care provided than the doctors.

Allen *et al*. (2013: 115), reported that health care providers in adult settings experienced higher levels of moral distress than their colleagues in paediatric settings as well as those in intensive care unit (ICU) environments (largely due to items related to futile care and the lack of decision making to withdraw care), compared to those in non-ICU environment (related to pressure to reduce cost). Vaziri *et al.* (2015: 34) similarly found that moral distress was higher in high intensity areas such as emergency departments, ICU and neonatal ICU, than in low-intensity areas. Irrespective of the clinical setting, research shows that registered nurses tend to have higher levels of moral distress than other health care personnel (Hamric & Blackhall, 2007: 428) as the professional responsibility of providing direct patient care may make them more vulnerable to experience moral distress (Whitehead *et al*., 2015: 122).

Relationship between ethical climate and job satisfaction –The importance of context and the clinical environment in moral distress experiences has clearly been identified in reseach findings (Hamric, 2012: 42). Nurses daily encounter situations where they are unable to follow ethically appropriate steps due to factors in the clinical environment, such as time constraints, legal consideration, institutional policy, supervisory reluctance, and deterring medical power structure (Corley *et al*., 2001: 250). Parker *et al*. (2013), using the MDS and Hospital Ethical Climate Survey (HECS), found that moral distress decreased as the ethical climate of a hospital environment increased. Increased job satisfaction was also related to an increased ethical climate. Whitehead *et al*. (2015: 121) similarly found that higher perceptions of ethical climate were related to lower moral distress scores. Atabay, Cangarli & Penbek (2015: 110) found that the stronger the ethical basis of an organisation, the lower the experiences of moral distress.

Different ethical climates also impact differently on moral distress, such as when organisational interest is the focus – protecting the organisation's interests becomes the priority combined with loyalty towards to organisation above all else. When the ethical climate is dominated by rules, moral distress increases. Rules are usually determined from

the top down. The nurses are then expected to follow the rules, which may be in conflict with their own convictions, limiting their freedom and autonomy (Atabay *et al.,* 2015: 113).

Intent to leave – Allen *et al*. (2013: 116), Trotochaud *et al*. (2015: 910) and Whitehead *et al*. (2015: 121) found a direct relationship between high moral distress scores and respondents who have considered leaving or have left previous employment. The impact of moral distress on turnover intention is considered moderated by the ethical climate, especially the effects related to concerns about poor care and the financial influence on patient care (Fogel, 2007).

The effects of unresolved moral distress include job dissatisfaction, burnout and staff turnover, which all have grave implications for a healthcare environment already plagued by poor resources and staff shortages (Langley *et al*., 2015: 40). Fourty-three percent of nurses in a study by Aiken *et al.* (2002: 1990) reported job dissatisfaction and burnout and intended to leave their positions within a year. Of nurses who were not burned out and satisfied with their work, only 11% reported intention to leave. Contradictory to the studies mentioned, no negative impact, such as intent to leave, was identified in a study on moral distress in critical care nursing by Choe *et al*. (2015: 1692).

Little is known about what happens to nurses' moral distress levels when they considered leaving a position but ended up not to. They could possibly experience increasing moral distress and moral residue, culminating in the crescendo effect. An alternative response to continuous exposure to morally distressing situations is withdrawal and desensitisation from such patient care issues. Desensitisation could decrease moral distress and counteract the increased distress of those experiencing the crescendo effect. Moral distress could also be decreased as nurses empower themselves to act (Whitehead *et al*., 2015: 123).

Demographics – Woods *et al*. (2015: 123) and Corley *et al*. (2005: 386) found that age was negatively correlated with moral distress – younger nurses experience moral distress more than older nurses, possibly due to learning how to deal with ethical problems through years of experience in the profession. However, as this correlation was low, it could also indicate that experience might not always be what is required to deal with morally distressing situations (Corley *et al*., 2005: 386). Allen *et al*. (2013: 113) found that nurses with more years of experience did not experience higher levels of moral distress, while a study by Maluwa *et al*. (2012: 202) found a positive correlation between participants' ability to develop coping mechanisms and their years of work experience.

Corley *et al*. (2005: 386) found a low correlation between race and moral distress intensity. All the participants in the study were registered nurses. Since 21% of the participants were

of African American origin, the researchers were of the opinion that race was a potential contributing factor to consider in participants' seeming lack of power, as reflected in the score of the Ethical Environment Questionnaire used in the study. An unexpected finding by the researchers (Ulrich *et al*., 2007: 1716) was that Black nurses participating in a study in the United States were three times more likely to indicate their intent to leave their employment than their Caucasian colleagues, and reported more stress related to ethics.

Stereotyping of racial groups prevents members of the group to perform optimally as they are not focussing on the task at hand, but more on the stereotype about their respective group. This is referred to as stereotype threat – the risk of conforming to the stereotype. By implication, African-American participants in a study by Steele and Aronson (1995: 808–809), experienced the patronising stereotype related to their intellectual abilities to impair their performance. Participants in the study were working just as hard as their colleagues of other races. Yet they spend a lot of time to perform minimal tasks and made many mistakes. They were therefore considered to be motivated, but incompetent.

Considering the background and historical relationships between different racial groups in South Africa, stereotype threat is a reality that compromises working relationships and working practices. Black Africans could still feel oppressed in the workplace due to a perception that they hold a lower status than Coloured and White colleagues, making them potentially more prone to bullying in the workplace. Northway (1997: 738) found that due to the effect of unchallenged assumptions and norms within society, oppression could occur. Oppression is therefore not always a result of purposeful disadvantaging of groups of people.

2.6.3 Findings obtained through qualitative studies

Although some findings from qualitative studies could be related to the causes of moral distress as identified through the MDS (discussed in 2.6.1 and 2.6.2), it also revealed differing experiences pertaining to moral distress. These findings were grouped according to experiences and are presented under the headings of patient related, personal, effects and work related.

2.6.3.1 Patient related

Family participation – In a phenomenological study (Robinson & Stinson, 2016: 237) amongst emergency nurses, the absence of family members when patients present to the hospital, leads to moral distress. It is perceived that elderly patients who cannot speak for themselves receive different care in the absence of family, as the family members act as patient advocates.

2.6.3.2 Personal

Religion – Emergency nurses sometimes experience a need to ask God for forgiveness when experiencing regret for care they are forced to render, such as resuscitating a patient who is not to be resuscitated. They also experience a need to be forgiven when they feel guilty about their reactions towards certain patients, such as judgement and discrimination, when having to treat murderers and also their victims (Robinson & Stinson, 2016: 238). Nurses in a study by Maluwa *et al.* (2012: 202) relied on religion as coping mechanism – praying to God for help in order to deal with their distressing situations and seeking forgiveness for their actions.

Managing emotions – In dealing with moral distress, emergency nurses turned to shutting off their emotions and feelings through denial and blocking, which numbs them towards distressing situations (Robinson & Stinson, 2016:238). Nurses in a Malawian study similarly used ignoring of negative emotions and forgetting about distressing situations as coping strategies (Maluwa *et al*., 2012: 202). Ethical discussions in hospitals are intiated when nurses raise concerns regarding patient care, often leading to a sense of moral outrage experiened by the nurses (Rich & Ashby, 2013: 278). Research (Austin, Goble, Strang, Mitchell, Thompson *et al*., 2009: 372) found that nursing staff experienced intense negative feelings when unable to provide basic care, such as feeding or bathing. Nurses strongly agreed that the "little things" matter, however they often do not have time to attend to it (Austin, 2012: 30).

Internalising care – In a study amongst intensive care nurses (Wilson *et al*., 2013: 1461), caring for patients that reminded the nurses of family members was a cause of moral distress. The respondents of the study experienced signs of moral residue, such as thinking of the patients after work or long after the patients have been discharged.

2.6.3.3 Effects

Personal and professional effects – Experiences of moral distress affect personalities of emergency nurse negatively, changing who they are. The effects of moral distress desensitise them, which in turn affects patient care. Family and peer relationships also suffer under the strain and often nurses cope by making inappropriate jokes or abusing substances (Robinson & Stinson, 2016:238). Participants in a Malawian study (Maluwa *et al.,* 2012: 202) identified insomnia, anorexia, headaches sadness, irritation and anger as effects they experienced due to moral distress.

2.6.3.4 Work related

Lack of ethical sensitivity – Intensive care nurses in Korea (Choe *et al*., 2015: 1688) experienced distress when fellow nurses, or participants themselves, did not adhere to nursing care standards. Especially when observing colleagues who covered up unethical behaviour of fellow nurses (implicating others for mistakes made or being indifferent towards medication errors) or lacking sensitivity towards ethical care (seniors leaving their work for junior nurses or ignoring the junior's opinions; doctors indifferent towards professional ethics) led to moral distress of the participants. Intensive care nurses in an American study (Wilson *et al*., 2013: 1462) similarly identified that they were, at times, faced with situations where they took care of patients in a manner they felt was incorrect due to fear of legal action and was pressured to transfer patients to other units inappropriately.

Workload and support – It was found by Rathert, May & Chung (2016: 46) that nurses who felt supported by management were less likely to report moral distress. The support was perceived when management actively encouraged the use of ethics resources. In a study by Wilson *et al*. (2013: 1462), nurses identified that they do not work effectively and efficiently and has become less empathetic due to their excessive workloads and work demands. This led to experiences of moral distress and participants indicated that there was a lack of support for them in these situations.

Lack of support structures was identified by Swedish participants as a cause of moral distress (Kälvemark *et al*., 2004: 1082) as they did not experience any organised support related to ethical issues in their workplace. Rathert *et al.* (2016:47) found that ethics support and efficacy is related to moral distress, but can be mediated by voice. In turn, moral courage is also increased and those with moral courage are perceived to behave in ways that decreases moral conflicts and lowers moral distress. However, voice does not seem to be significant when organisational support is high. When external support is perceived as low, an individual draws on their own internal resources of voice and efficacy.

Malawian participants raised a strong desire for support systems. The sources of support included the regulatory professional bodies, managers who would avail ethics resources and act with fairness (no favouritism, regular staff appraisals, no false promises), as well as from fellow colleagues (the desire to experience team spirit amongst colleagues, a focus on patient care, information sharing, and support) (Maluwa *et al*., 2012: 201).

Subordinate role – Nurses experienced moral distress due to their subordinate role to doctors in the healthcare hierarchy (Zuzelo, 2007: 354; Kälvemark *et al.,* 2004: 1081; Wilson

et al., 2013: 1462) and at times experienced lateral violence when confronting doctors or when voicing a conflicting opinion (Zuzelo, 2007: 354).

Many teams are being led by doctors who believe that decision making is their role and responsibility alone, instead that all members are partners in the care of the patients through collaborative teamwork (Hamric, 2010: 9). Nurses in Malawi identified that they are often forced to accept disrespect and that they are unappreciated and mistreated by patients as well as colleagues and superiors (Maluwa *et al.,* 2012: 200). In a South African study (Langley *et al.,* 2015: 38) nurses admitted to feeling unable to confront doctors due to the hierarchical nurse–doctor relationship, even if the doctors' incompetence and inexperience was apparent. However, nursing is a licensed, self-regulating profession with its own professional standards, which imply a right and a wrong way of doing things. No clinician's order has sufficient weight to override what is considered right or wrong by nursing professionals (MacDonald, 2002: 196).

Nurses have the biggest responsibility towards the patients' well-being and could become morally distressed due to being inhibited to act (Dudzinski, 2016: 322) when the hierarchical structure of healthcare prevents them from even acting as advocates for patients and their families (Langley *et al*., 2015: 39).

Advocacy – Patient advocacy is considered a fundamental value in nursing care (Barlem & Ramos, 2015: 613). Remaining silent when a professional nurse should speak up about the patient's desire, compromises the professional integrity and the moral obligation of the nurse. It is this compromise that is the essence of the moral distress experience (Hamric, 2010: 7). Wagner (2015: 11) stated that nurses with a sense of empowerment are less likely to suffer from the ethical conflicts that lead to moral distress. Advocacy, as part of the nurses's role, is often not accepted or expected by doctors and in some institutional settings (Hamric, 2010: 9). The scope of practice of professional nurses in South Africa, Regulation 2598, chapter 2(s) specifically refers to the professional nurse's responsibility to provide effective patient advocacy (SANC, 1984). Chapter 2 of Regulation 767 (Regulation setting out the acts or ommissions in respect of which the council may take disciplinary steps) states that failure to carry out patient advocacy as per scope of practice is documented as a punishable offence (SANC, 2014: 4).

Autonomy - MacDonald (2002: 196) states that merely allowing health professionals the formal authority to make decisions regarding patient care, is not meaningful in terms of professional autonomy if the institutional culture does not support their capacity for independent practice. Professional autonomy allows individual nurses to make some

independent decisions not subject to authoritative review by those outside the profession. It remains the responsibility of the nursing professional to act in accordance with the shared standards of the profession, whether addressing pressure from institutional authorities, inappropriate patient or public demands, or disagreements with members of the multidisciplinary team (MacDonald, 2002: 196). Healthcare professionals should be allowed to have substantial control over their professional practice and exercise their judgement if their professional autonomy is to be respected (MacDonald, 2002: 196).

Behaviour of colleagues – The manner in which nursing colleagues behave was identified as a cause of moral distress (Maluwa *et al.,* 2012: 201) especially in situations where colleagues are late for duty and are shouting at fellow nurses in front of the patients. In sub-Saharan African countries, nurses tend to accept unprofessional behaviour from colleagues and try to justify it due to the impression engrained from childhood that elders and those in senior positions should be respected (Khalil, 2009: 209).

Bullying has become a common occurrence in nursing. Vertical violence describes the abuse of power relationships between staff of all levels (Khalil, 2009: 208). Lateral or horizontal violence refers to inter-group conflict or “nurse-on-nurse aggression” (Farrell, 1997:502) between nurses of the same rank in an organisation (Khalil, 2009: 208) and impacts on a healthy work environment and retention of staff (the term bullying is used interchangeably when referring to horizontal or vertical violence or aggression). In a study of healthcare personnel at a 35-unit in-patient medical centre in the USA, participants indicated that behaviour relating to lateral violence was a common, serious occurrence and a cause why some nurses left their positions. There is an impression that new nurses are “tested” to establish if they will survive their new environment (Stanley, Martin, Michel, Welton & Nemeth, 2007: 1252, 1256). In a Canadian study (Laschinger, Grau, Finegan & Wilk, 2010: 2738), a third of the new graduate nurses who participated, experienced being bullied. Registered nurses in their first year of practice in Australia are exposed to verbal abuse, inappropriate racial comments, and physical threats and reported being undervalued by other nurses and being given too much responsibility, without the necessary support (McKenna, Smith, Poole & Coverdale, 2003: 93). Nurses experiencing moral distress are more likely to act abusively towards new or less assertive co-workers, thereby increasing the risk for lateral violence (Blair, 2013: 75).

When professional nurses find themselves the victims of bullying (vertical or horizontal), their practice is compromised as the effect of bullying could leave them powerless to fulfil their role due to the disrespect and undermining of their authority. However, professional nurses have been identified as the main perpetrators of verbal abuse, discrimination, bullying,

gossiping and shouting in general public hospitals in Cape Town (Khalil, 2009: 211–214). Negative behaviour can also be justified by perpetrators as a result of circumstances which they do not have control over. It might therefore be difficult to objectively determine who is being abusive towards whom in a particular situation (Farrell, 2001: 29).

Mismanagement by superiors – Maluwa *et al.* (2012: 200–201) found in their interviews that favouritism by managers causes moral distress in nurses. Favouritism is displayed in off-duty scheduling, who is nominated for training opportunities and who gets promoted. Nurses who raised issues related to favouritism at meetings were rather labelled as troublemakers than to address the issues at hand, so they chose not to speak out. Participants in the study also experienced that often their supervisors tend to defend the patient's rights at the expense of the nurses, whereas the nurses treat patients with dignity at all times, respecting and advocating for their rights. Observing unsafe practices and poor care were found especially distressing when no one in managerial capacity seemed to take any action, leaving nurses reluctant to report or respond to such observations (Austin, 2012: 32).

Shortage of resources – In a Malawian study (Maluwa *et al.,* 2012: 200), lack of basic resources such as blood, basic equipment and medical supplies was identified as a cause of moral distress. In a Swedish study, the lack of beds caused moral distress. Nurses were unable to offer the care the patient required due to the pressure for beds – more patients were in need for a bed than beds were available, leaving them in a position to make the perceived unethical choice between patients (Kälvemark *et al.,* 2004: 1079). In a Turkish study the lack of adequate physical conditions and lack of resources characterising the healthcare system is a cause for moral distress. The Turkish healthcare system is a rule-based environment and the lack of resources will lead to an inability to follow the rules. Lack of resources will lead to lack of adequate care provision, hence effective solutions to decreasing moral distress in such environments will include improving physical conditions and expanding the healthcare budget (Atabay *et al*., 2015: 113).

2.7 CONSEQUENCES OF MORAL DISTRESS

Nurses will encounter situations in their day-to-day practice where they are required to make moral decisions. They may end up doing nothing, or doing what they believe is wrong due to the constraints they feel when acting against their moral judgement when wanting to do the right thing. This in turn gives rise to moral distress (Johnstone, 2013: 25). Participants of focus group interviews, amongst various health care professionals in Sweden, reported moral distress when having to make difficult choices between following their conscience or

following the rules. Even though they acted and made choices, distress related to ethical dimensions of practice was still experienced. They admitted to sometimes breaking the rules because it was inevitable or due to personal choice (Kälvemark *et al*., 2004: 1080).

The consequences of moral distress are discussed under the headings of nurse outcomes, patient outcomes and organisational outcomes.

2.7.1 Nurse outcomes

In many cases, the channels for nurses to express their concerns about patient care are non-existant. Therefore, much of the emotions accompaning the concerns are internalised, which has presumably large, unquantified negative impacts on their professional lives. Moral distress leads to frustration, burnout, resignations and nurses leaving the profession (Corley, 2002: 638; Rich & Ashby, 2013: 278) as well as interpersonal conflict, dissatisfaction, physical illness (Ulrich *et al.,* 2007: 1709), compassion exhaustion (Rich & Ashby, 2013: 278) and physical consequences such as insomnia, anorexia, heart palpitations and lack of energy. Spiritual and social consequences are also not uncommon (Van Waltsleven, 2014: 166).

Literature describes three patterns of response to ongoing situations of moral distress. Firstly is a numbing of moral sensitivity and withdrawal from involvement in ethically challenging situations. Secondly, nurses leave their positions, or even the profession itself. And in the third place, professional nurses resort to deliberate objection to advocate for their patients (Hamric, 2010: 9). Pillay (2015: 277) concurred that healthcare workers respond in different ways: some withdraw, some resign, others continue to advocate for their patients – behind the scenes or openly. Feelings of powerlessness, subordination and inefficiency characterise moral distress. These negative feelings also lead to passivity and blunted moral sensitivity, especially if it remains unresolved (De Veer *et al*., 2013: 106).

In a study of New Zealand nurses, it was found that younger nurses were more at risk to experience moral distress than older nurses. Even though they might be educationally better prepared, the numerous organisational constraints render them incapable to make sound choices when confronted by ethical issues (Woods *et al*., 2015: 127).

Nurses tend to see themselves as the victims of moral distress instead of active agents able to prevent, improve and learn from moral distress (Rodney, 2013: 314). There could be something valuable in a healthcare providers' ability to recognise their distress and reflect upon the situation that gave rise to it. Moral distress could give rise to a moral awakening where practitioners become aware of the ethical distress that surrounds the nature of their

decision-making and those effected by it (Austin *et al*., 2005: 39). Experiences of serious compromise and moral distress could clarify an individual's commitments and strenghten resolve. Or the experiences can diminish nurses on many levels until they become increasingly ethically desensitised. In either event, it is important to note that the experience of moral distress and compromise can significantly impact the individual as well as the work environment (Varcoe *et al*., 2012: 59).

2.7.2 Patient outcomes

Moral tension is inevitable as it is not always possible to provide care solely according to individual nures's own ideals. A degree of moral tension might even improve quality of care as it maintains the sensitivity to moral issues in daily practice. However, if moral tension becomes moral distress, care could be compromised (De Veer *et al.*, 2013: 106). As moral distress threatens the integrity of the nurses, it also threatens the quality of patient care (Johnstone, 2013: 25). Rich and Ashby (2013: 279) stated that it can be potentially detrimental to patient care when there is a failure to hear, resolve and act (where appropriate) on moral concerns of individuals or groups of nurses.

2.7.3 Organisational outcomes

It was found that nurses who were less satisfied with their job had high moral distress scores (De Veer *et al*., 2013: 105). Failure to identify and treat moral distress in the workspace could cause healthcare providers to have repeated, unresolved cases of moral distress, which could lead to moral residue and a crescendo effect (Trautmann, 2015: 288). Accumulation of unresolved moral distress can result in job dissatisfaction (De Veer *et al*., 2013: 106). A lack of a sense of being appreciated leads to poor care and hollowing out of the profession. This, in turn, leads to low self-respect, leading again to lack of appreciation, which contributes to staff shortages (De Veer *et al*., 2013: 107).

Health professionals resigning from practice due to moral distress could be indicative of a toxic healthcare environment (Austin, 2012: 28). The nurses most deeply concerned with their patient's well-being are precisely the ones who the profession cannot afford to lose (Hamric, 2010: 10) and given the role moral distress plays in nurse resignations and ethical practice, reducing moral distress becomes an important priority (Corley *et al*., 2001: 256). De Veer *et al.* (2013: 106) concurred that moral distress should be reduced as much as possible as professionals with high standards for patient care are more prone to moral distress, yet are the professionals most needed. Other organisational outcomes relate to poor workplace relationships due to ineffective communication among colleagues, absenteeism and insubordination (Van Waltsleven, 2014: 165).

2.8 SUMMARY

The concept of moral distress has evolved over the past 30 years, yet there has not been one definition considered conclusive in capturing the essence of what it entails. The same situation may not evoke the same level of response or distress amongst different nurses. This indicates that experiences of moral distress are caused by an interaction of various aspects related to the nurse, the patient, the direct work environment and also broader regulatory and societal factors. The effects of moral distress can be physical, emotional or behavioural. Many professional nurses do not even realise what they consider burn-out, moral tension or work stress, actually meets the criteria of being morally distressed. Although moral distress is generally perceived negatively, it also has the potential of encouraging and creating awareness amongst professional nurses to act in accordance with their regulatory and ethical guidelines.

CHAPTER 3:
RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapters contain a description of the background of the study and a comprehensive literature review on nurses' experiences of moral distress. The current chapter provides a description of the research methodology that was used to understand professional nurses' lived experiences of moral distress at a district hospital in the Western Cape.

Research methodology refers to wisely chosen techniques used by the researcher to collect data. It is the blueprint, consisting of assumptions, rules and methods used by the researcher to expose their work to replication, repetition, analysis and critique (Given, 2008: 516).

3.2 AIM AND OBJECTIVES

The aim of the study was to understand professional nurses' lived experiences of moral distress at a district hospital. The research objectives were to describe professional nurses, practicing at a district hospital in Cape Town Metro District's:

- lived experiences of moral distress
- influences that moral distress have on their lives
- what the causes of moral distress experiences are

3.3 STUDY SETTING

Setting refers to the location where the study was conducted (Burns & Grove, 2011: 40). A natural setting for data collection was used and the researcher did not manipulate or change the environment for the study in any way.

The study was conducted at a district hospital in Cape Town's MDHS. It is considered a medium sized district hospital as it has between 150-300 beds. A limited number level 2 services are provided and the package of service offered includes in-patient, paediatric and obstetric care, out-patient visits as well as trauma and emergency care. The hospital receives referrals from primary health care facilities and general practitioners and refers patients to regional or tertiary hospitals for specialised services (Republic of South Africa, 2012: 35). Other services include medical male circumcision, assessment, referral and rehabilitation for people with mental health problems, HIV counselling and testing and HIV

and TB-related treatment, care and support services, social work services, physiotherapy, dietetics, pharmacy services are some of the allied health services also provided.

There are three surgical and two medical wards at the hospital. The profiles of patients treated at the hospital are related to the quintuple burden of disease in South Africa, including: high levels of violence and injuries, non-communicable diseases (cardiovascular disease, diabetes, chronic respiratory conditions and cancer), HIV/AIDS, high maternal and child mortality, and TB (Yerramilli, 2015). The multi-morbidity of patients leads to increased complexity, requiring more sophisticated investigations in order to make a diagnosis, more expensive treatments and longer hospital stays (Western Cape Government: Health, 2016(a): 15).

3.4 RESEARCH DESIGN

The researcher's goal was to understand the professional nurses' lived experiences of moral distress. Phenomenology is a research methodology that enables a researcher to understand the lived experiences of people in a specific situation (Terre Blanche, Durheim & Painter, 2006: 47). By focussing on lived experiences ("events that individuals live through"), meaning is derived and understanding can be developed (Watson *et al*., 2008: 232). Although phenomenology provides rich data and an in-depth understanding on a phenomenon there are also some disadvantages to this design. In-depth data collection could be compromised if the participants had difficulty expressing themselves, the data produced are not generalizable and although attempts are made, it could be difficult to ensure bracketing and prevent researcher bias (Van Manen, 1990). There could also be a risk that participants are not fully truthful about their experiences and manipulate the information based on their own preconceived ideas on what the researcher wants or does not want to hear.

There are two types of phenomenology: descriptive and interpretive, which are distinctly different in terms of how they are used as research methods due to the differences in the philosophical foundations. Descriptive phenomenology (Husserlian Epistemology) focusses on a description and explanation with the aim to uncover meanings of experiences. Interpretive phenomenology (Heideggerian Ontology) adds deeper meaning and interpretation to experiences (Watson *et al.,* 2008: 233-234). Pre-understandings are integrated and become part of the research findings (Matua & Van Der Wal, 2015: 24).

A descriptive phenomenological design was followed, which allowed a process of learning and constructing meaning of human experiences to take place through intensive dialogue (LoBiondo-Wood & Haber, 2002: 144). The research focus on the first-hand experience -

"what it is like to undergo a particular experience" - in order to describe it as authentically as possible, irrespective of the context in which it is experienced and without creating theories or explanations for the experience. Bracketing is applied to ensure that the researcher's pre-existing knowledge does not influence the study findings. Through descriptive phenomenology the researcher was able to generate new knowledge of the phenomenon of moral distress which was not clearly understood (Matua & Van Der Wal, 2015: 24-26).

3.4.1 Paradigm

The founder of descriptive phenomenology was Edmund Husserl. He believed that phenomenology is based on the meaning of the individual's experience. He referred to intentionality (experience of perception, memory, thought, imagination, and emotion) as one's directed consciousness or awareness of an object or event (Reiners, 2012: 1).

Husserl advocated a pure, untainted view on the nature of reality as described by the participant. He therefore focused on epistemology, meaning that acceptable knowledge is knowledge untainted by the view of the researcher (Watson *et al.*, 2008: 233). Therefore, to answer his question: "What do we know as persons?" he developed descriptive phenomenology. In this approach every day conscious experiences were described while setting aside, or bracketing, preconceived ideas and opinions (Reiners, 2012: 1).

The process of bracketing was employed (a Husserlian prescript) in order to ensure the true, lived experiences are accurately captured by the researcher. This was done through identifying preconceived ideas and knowledge about the phenomenon under study, and consciously putting it aside when the research was carried out (Burns, Grove & Gray, 2013: 284). Subsequently, the researcher made a purposeful effort to identify personal preconceived ideas and knowledge about the phenomenon. The researcher's pre-conceived ideas originated from personal experience as professional nurse (PN) in an organisation where PNs were kept accountable and expected to be disciplined for adverse incidents, without the organisational factors contributing to the circumstances being considered or addressed. The researcher was of the opinion that PNs do not choose to deliver sub-optimal care or not to abide by protocols and procedures, but that they were often left with no other option. Preconceived ideas and the efforts made to address it are displayed in table 3.1.

Table 3.1 Preconceived ideas and efforts to address it

Preconceived ideas	Efforts made to address preconceived ideas
Phenomenon: • expectations on PNs remain high irrespective of challenges • breaking the rules has become norm • possible indifference towards challenges preventing ethical practices Organisation: • unethical organisational cultures • constraints of work environment not considered • punitive reaction to transgression without considering challenges	During recruitment • included all who met the inclusion criteria • not selective regarding professional experience • no assumptions about the presence/absence of moral distress of participants • made a list – conscious awareness to bracket During data collection • applied bracketing • added to the list of preconceived ideas During data analysis • Colaizzi's method: step 1 – have the list to be reminded of preconceived ideas already identified and add • Verbatim transcriptions in order not to distort participant's responses with preconceived assumptions • Member checking

3.5 POPULATION AND SAMPLING

A population includes the entire group of persons of interest to the researcher, and who meets the criteria of that which the researcher is interested to study. A sample is a part of the whole available group that is selected by the researcher (Brink, Van der Walt & Van Rensburg, 2012: 141).

The target population was professional nurses practicing in general medical and surgical wards. Due to their position in the nursing hierarchy, professional nurses are the category with the highest level of responsibility and accountability as guided by their scope of practice, Regulation 2598 (SANC, 1984: 2), and are the ones mostly confronted with ethical dilemmas related to patients as well as staff.

Professional nurses in management and non-clinical positions, such as operational managers, educators or clinical programme coordinators were not included. Professional nurses in these positions are not directly involved in daily patient care and may encounter dissimilar moral dilemmas as professional nurses on ward level who are actively involved in daily patient care.

Other groups of professional nurses who were not considered were those practicing in speciality areas (including ICU, high care, maternity, psychiatry, theatre, and emergency

units). The nature of ethical dilemmas and ethical decision making they are faced with in these areas differ significantly from those in general areas. Much of the available studies have been conducted in intensive care (Langley *et al.*, 2015; Wilson *et al*., 2013) or emergency units (Robinson & Stinson, 2016; Unruh, 2010).

A purposive sampling method was used to select participants. It is a process whereby the researcher intentionally selects research participants based on the fact that the individuals will be able to provide abundant information on the research topic (Burns, Grove & Gray, 2013: 365). It is considered one of the best methods to gain information and an in-depth understanding of a complex issue (Burns & Grove, 2011:313). The researcher included participants in the population who would allow an in-depth understanding of the phenomenon (Terre Blanche *et al*., 2006: 289–290). In line with the Husserlian paradigm, during the selection process the researcher focussed on the experiences of the participants and not on preconceived ideas about them as individuals. In order to prevent bias (considering the Husserlian prescript explained earlier) the study was conducted at a district hospital in the MDHS where the researcher has not worked and does not know any of the staff. According to Brink *et al*. (2012: 134), sampling bias is caused by the researcher when personal views obscure the data, such as the researcher selecting research subjects based on personal preference but does not represent the population.

The sample size was dependent on when data saturation was established. Data saturation occurs when participants do not provide any new information, but rather repetitive data (Burns *et al*., 2013: 371). The researcher intended to purposefully interview 6–10 professional nurses. According to Morse (1994: 225), a minimum of six participants are required in a phenomenological approach. However, to confirm that data saturation is truly achieved, a bigger number of participants are required.

A purposive sampling method was also used to select the hospital where the study was conducted. The researcher is a clinical nurse educator for the general nursing stream at another district hospital in the MDHS. As moral distress was potentially observed at the hospital where the researcher is employed, it was deemed appropriate to purposively select another district hospital within the same region with a similar setting, as the circumstances contributing to moral distress might be comparable.

3.5.1 Inclusion criteria

The inclusion criteria required that participants were professional nurses employed full time in the hospital, practicing in general medical and surgical wards. This refers specifically to nurses with a four-year nursing diploma or degree (R425), or who did a R683 bridging

course (an enrolled nurse who completed a two-year course to become a professional nurse).

3.5.2 Exclusion criteria

Professional nurses practicing in general wards but who were on leave at the time of the study.

3.6 DATA COLLECTION

Upon ethical clearance, provincial approval from the Department of Health for the study to be conducted, and institutional permission, the researcher liaised with the clinical nurse educator of the chosen hospital who assisted to facilitate the data collection process. Permission was requested to approach eligible candidates directly in order to recruit them for the study. During recruitment, the researcher walked from ward to ward, recruiting professional nurses on all shifts. The purpose of the study was explained to each individual candidate and they were provided with an information leaflet. Some indicated immediately that they were interested to participate and others were contacted telephonically after the initial recruitment process allowing them time to read the information leaflet and consider the invitation to participate. All the professional nurses who indicated that they were interested to participate were recruited for the study in order to allow for diverse information that each individual would contribute based on their unique experiences.

In order to ensure inclusivity of all potential participants, participants had the option for interviews to be conducted in one of the three main languages of the Western Cape (namely Afrikaans, English and isiXhosa), as preferred. The Afrikaans and English interviews were conducted by the researcher who is bilingual and competent in both languages. None of the participants preferred to have the interview conducted in isiXhosa, as all seven were comfortable with Afrikaans or English.

The participants identified the time that was suitable to them, which included their lunch breaks or off duty times, in order not to cause disruption to operational requirements and patient care activities. Venues were identified, which would allow for limited interruptions for the duration of the interviews in order to ensure privacy. Arrangements were also made with the clinical educator in order to inform the manager on call that the researcher would be coming to the institution. The researcher reported to the respective manager on call with each visit to the institution prior to meeting each participant.

The interviews were conducted between 27 June 2016 and 20 August 2016. Interviews were audio recorded and participants were not addressed on their name or surname, and the

name of the hospital not mentioned in order to protect their personal identity and ensure anonymity. Participants were awarded a number by which they were identified by the researcher only.

Opportunity was provided on the day of the interviews for participants to give voluntary written consent. The researcher personally conducted the one-on-one interviews using a semi-structured interview guide where participants were encouraged to share their experiences using their own words. The researcher intended to conduct an in-depth interview of at least 30–45 minutes with each participant; however, some of the interviews extended to an hour. The interviews were audio recorded in order for the researcher and supervisor to listen to the data numerous times and be able to identify themes emerging from the data.

Interviews are a method of data collection where responses are obtained verbally (through face-to-face, telephonic or other interaction) and prove to be the most direct method of gathering information. Data collection occurred through one-on-one interviews, using a self-compiled semi-structured interview guide. During semi-structured interviews there are some specific questions, but it also allows for additional probes to be posed through open and closed-ended questions (Brink *et al*., 2012:1 57–158).

During the interviews participants were not addressed by their full name, merely as “Sister”. They were awarded a number in order to protect their personal identity and ensure anonymity. The allocated number was used to identify the transcriptions and quotations of participants’ responses.

Interviews were conducted by using the technique of reflection explained by Carl Rogers (1945), which included summarising and reflecting the messages of the interviewee in order to show understanding of what was said. The researcher needed to be familiar with the technique, as proper reflection allowed the participants to reveal more meaningful information and share their experiences (Rogers, 1945: 279).

The researcher received training on the interview technique from the supervisor involved in the study who has vast experience in conducting interviews and read extensively on interviewing techniques including Britten (2006: 14–17), Rogers (1945: 279-283) and Pope and Mays (2006: 15–18) and also practiced these techniques by means of mock interviews.

The interview guide was related to definitions and descriptions of moral distress and based on the objectives of the study. Discussions were initiated by open-ended, non-threatening questions. An example of the questions include “tell me about challenges you experience as

a professional nurse" and "tell me about situations where you were unable to do the right thing as you know is expected of a PN." The semi-structured interview guide contained four open-ended questions concerning professional nurses' challenges in their work environment and the influence it had on them professionally and personally (see Appendix 4).

The researcher had to display unconditional positive regard towards the participants in order to create an atmosphere of trust, which allowed the participants to verbalise their experiences. Bracketing was applied to ensure that the researcher did not influence the participants' understanding of the topic. The researcher thereby did not explain or provide examples when the participants indicated that they are not familiar with the term "moral distress", allowing them the opportunity to express their own reality without judgement. The researcher attempted to actively listen to participants at all times and temporarily suspend preconceived ideas on the topic (Hamill & Sinclair, 2010: 17). A list of preconceived ideas was drafted to remind the researcher of opinions and beliefs about moral distress to put aside during data collection and analysis and only focus on the participants' responses and be guided by it.

Whenever discomfort on the part of the participants was identified, the support and assistance of ICAS (Independent Counselling and Advisory Service) was recommended, especially in situations where the participants seemed to have many overwhelming challenges in their work environment, which were impacting on them negatively. The researcher consulted with the study supervisor continuously throughout the period of data collection.

3.7 PILOT STUDY

The purpose of the pilot interview was to test the research methodology as well as the interview guide. A pilot interview was conducted at the same district hospital where data was collected in order to:

- determine whether participants understand the questions
- identify problems in gaining access to participants and how participants would react to the procedures and study conditions
- test the feasibility of the research design
- ascertain whether there are any unanticipated effects that may be of concern (Burns *et.al*., 2013: 343)
- establish the researcher's competencies with the interview technique

The data collected during the pilot interview was included in the findings of the study as no pitfalls were identified during the pilot interview that would necessitate any changes to the

interview guide and procedure. The supervisor was not present during the pilot interview. The researcher provided the supervisor with a copy of the pilot interview. After listening to the pilot interview, the supervisor expressed her satisfaction with the interview as she was satisfied that the researcher was able to create a conversation with the participant and managed to sufficiently summarise, reflect and probe where it was required, as advised by Boeree (2006).

3.8 TRUSTWORTHINESS

Lincoln and Guba (1985) established that trustworthiness is important to evaluate the worth of a research study. It involved establishing the following:

3.8.1 Credibility

Credibility was demonstrated when the investigation was carried out in such a way that the believability of the findings were enhanced (Jooste, 2009: 319). Throughout the interviews the researcher made use of bracketing in order to ensure credibility of the research findings. The researcher identified and set aside (bracketed) pre-existing ideas about the topic in order for the true lived experiences of the participants to be reflected in the findings through reflexivity.

The truthfulness of the data collected was further verified when the researcher returned to participants after the initial interviews (also referred to as member checking or participant debriefing (Lincoln & Guba, 1985: 314)) in order to confirm that the data collected was a true reflection of their lived experiences. Another activity applied to increase the credibility of the findings was through peer debriefing (Lincoln & Guba, 1985: 308) where the researcher presented the research to the study supervisor for constructive feedback. This allowed for exploration of aspects which would otherwise only have been understood by the researcher.

3.8.2 Transferability

Transferability or fittingness refers to the possibility of applying the findings outside the context of the study, or not (Ryan, Coughlan & Cronin, 2007: 743). When readers can apply the findings of the study to other contexts and their own experiences, the findings of the study would be deemed transferable. The researcher assisted to provide a detailed database and “thick descriptions” through adequate in-depth descriptions of the data that was collected in the specific study context (Brink *et al*., 2012: 173). In order to achieve this, the researcher persisted with data collection until no new information emerged, indicating that data saturation was achieved as described in LoBiondo-Wood & Haber (2010: 236). Achieving data saturation ensured that all the possible relevant information was obtained from the study participants.

3.8.3 Dependability

Dependability, or auditability, involved that the researcher supplied sufficient information in order for the reader to determine how dependable the researcher and the study was (Ryan *et al.* 2007: 743). This implies that a study will be dependable when the same study is performed by another researcher who can clearly follow the trail used in a similar context, and arrive at the same conclusions.

The researcher ensured dependability for the study by carefully documenting each step and activity in order to conduct each interview by following the same process. The same semi-structured interview guide was used for all participants and audio recordings were verified by the researcher and supervisor.

3.8.4 Confirmability

Confirmability required the researcher to indicate how conclusions and interpretations were reached, demonstrating that it was clearly derived from the data collected (Ryan, *et al*., 2007: 743). When the other three characteristics of trustworthiness are achieved, confirmability is established (Lincoln & Guba, 1985). The researcher ensured confirmability by verifying all transcripts and allowing the study supervisor to verify them, and providing evidence of how themes and sub-themes were derived.

3.10 DATA ANALYSIS

Data analysis is the process of making sense from the data collected. The data must be prepared and through different analysis techniques, the researchers peeled away the layers of each interview in order to develop a deeper understanding. Several generic processes can be used to analyse qualitative data (Cresswell, 2009: 183) to ensure that the researcher becomes engrossed in the data, a process also referred to as “dwelling” (Streubert & Carpenter, 1999: 28).

Interviews were conducted in English and Afrikaans based on the participants’ preference. Afrikaans transcriptions were translated into English by the researcher who is proficient in both languages. Translations were confirmed by the study supervisor and co-supervisor who are both skilled in English and Afrikaans.

Qualitative studies require interaction between the researcher and the data. Several processes for data analysis are available, depending on the chosen school of phenomenology. Several researchers have developed data analysis approaches, which include the concepts of bracketing, intuition and reflection (required for developing meaning). Colaizzi’s method of data analysis is one such example and was applied to analyse the data

collected for this study as the method supports descriptive research and is perceived as logical and credible for the "lived-experiences" approach of phenomenology (Holloway & Wheeler, 1996: 124-125).

Colaizzi's method included seven steps (Edward & Welch, 2011: 164):

Step 1: Transcribing of audio-recordings of participants' descriptions

Recorded interviews were transcribed verbatim. Verbatim quotes of participants prevent misinterpretations and remain true to the essence of participants' descriptions and untainted by the researcher (Hamill & Sinclair, 2010: 23).

The researcher also applied a proofing process. A proofing process takes place when the researcher compares the audio recordings with the written transcriptions. Even though the researcher personally conducted the interviews, information might be discovered for the first time during proofing. Proofing allows for primary data analysis as the researcher might also underline words or make notes in the margin while reading and listening (Burns & Grove, 2011: 93). The researcher applied the technique as described and highlighted, underlined and made notes on the transcripts while reading through and listening to the interviews. Additional pre-conceived ideas that the researcher became aware of were added to the existing list.

Step 2: Extracting and numbering significant statements relating directly to the experiences of each narrative, and entering it into a numerical list

In order to extract significance it is necessary for the researcher to become immersed in the data by extensively re-reading and re-listening until being fully invested in the data (Burns, Groves & Gray, 2013: 280). The researcher read the transcriptions repeatedly while listening to the audio recordings, thereby becoming aware of significant information and statements. Participants' statements that relate directly to the phenomenon being studied are considered to be significant information and was numbered and listed as guided by Edward & Welch (2011: 2). Codes underlie the themes that were extracted from the data (Burns & Grove, 2011: 93). When coding, text was broken down and the researcher gave each part of the text a label.

Step 3: Formulating more general re-statements or meanings from each significant statement

The process of data reduction was applied in an attempt to reduce the amount of data and enable the researcher to analyse the data that was collected more effectively. Meanings were formulated and attached to significant statements in an effort to classify similar

statements, as guided by Burns and Grove (2011: 94). The individual underlying meanings were coded into categories related to the representing exhaustive descriptions.

Step 4: Creating theme clusters based on the formulated meanings, then organising the meanings into groups of similar types

Clustering of similar data is what the actual process of data analysis consisted of. Clustered ideas are also referred to as themes, which are reported on once all the intended meanings have been extracted. It is presented in a meaningful way to the audience it is intended for (Streubert & Carpenter, 1999: 28) such as in a table format. Contradictions between grouped themes may appear, however researchers should refrain from excluding those themes which do not seem to fit (Holloway & Wheeler, 1996: 125). A section of the final theme map is presented in Table 3.2.

Table 3.2: Section of the final theme map

THEME 5:	**Not ticking all the boxes: things left undone**	**Being taken for granted: why do we try?**	**Life after work**	**Dwindling professionalism: the abused becoming the abuser**	**Catch 22: To leave, or not to leave**
Powerlessness and despair	• time constraints • unable to do everything • staff shortage and patient aquity	• not being appreciated • efforts not recognised • life-threatening exposure • patient care at any cost • desensitised • detachment	• still thinking of work at home • withdraw from family • remember things when at home	• confronting staff in front of patients • shout at staff • not completing tasks • not attend to patients needs • withdraw • not sharing information • almost made an accident • gained experience • grew professionally • not report challenges	• consider changing careers • doubt in choice of profession • disillusioned about realities of the profession • no other options • need for financial stability

Step 5: Developing a comprehensive description of the experiences as described by the participants through a combination of the themed clusters and associated formulated meanings derived in step 4

Themes derived from the lived experiences of the participants initiate the process of interpretation. Themes can be related to the larger context of the study. Through interpretation, the usefulness of the research findings was considered (Burns & Grove, 2011: 97). An exhaustive description of the phenomenon was created by integrating all the themes. The exhaustive description can also be validated with participants, which supports Colaizzi's suggestion of flexibility when applying the seven steps (Holloway & Wheeler, 1996: 125). During data analysis, meanings were further derived from the verbatim transcriptions through interpretation of experiences and developing meaning from the statements and identifying underlying emotions of participants. Sub-themes were merged and the essence of each experience expressed, as per theme identified. Information was considered useful when compared with the study objections to determine whether it will answer the research question. Validation of the exhaustive descriptions was confirmed with the study supervisor.

Step 6: Identifying the fundamental structure – the essence – of the phenomenon, which will be revealed through rigorous analysis of the exhaustive description

Repetitive and inappropriate descriptions were removed in order for findings to be concise and emphasise the overall research aim. Improvements were made to ensure themes clearly related to the sub-themes, supported by appropriate verbatim quotes of participant's.

Step 7: Returning to the participants for validation of the findings through follow-up sessions, allowing for alterations to be made according to the feedback received

The researcher contacted participants telephonically in order to verify the study findings. Once the verification process was completed the findings were discussed with the participants for further input. The participants who the researcher could contact were satisfied that the findings were accurately reflecting their lived experiences and emotions.

3.11 SUMMARY

In chapter 3 the research design, population and sampling, instrumentation, data collection and data analysis were described in detail, as well as the steps taken to ensure trustworthiness.

In chapter 4 the in-depth description of the research findings are presented.

CHAPTER 4:
FINDINGS

4.1 INTRODUCTION

The study findings are presented and discussed in Chapter 4. Data collected during the interviews was analysed in order to describe the professional nurses' lived experiences of moral distress.

The raw data was transcribed verbatim and analysed according to Colaizzi's method of data analysis, which was described in Chapter 3, section 3.10. Verbatim transcriptions promote bracketing (a Husserlian prescript) and enhance authenticity by staying true to the participants' responses and thereby not obscuring the findings.

Data is presented in two sections: Section A contains a discussion of the biographical data of participants; Section B confers the themes derived from the collected raw data. Participants were each allocated a number to ensure anonymity.

4.2 SECTION A: BIOGRAPHICAL DATA

4.2.1 Gender

All seven (n=7) of the participants were female. Upon recruitment, there were only female professional nurses present in the various wards. It is plausible that there are no male professional nurses practicing in the general wards of the hospital when considering SANC's breakdown of provincial distribution of nursing manpower versus the population of the RSA, as at 31 December 2015, where it is recorded that the Western Cape only has 1 193 male registered nurses, compared to 15 508 female registered professional nurses for the province (SANC, 2016: 1).

4.2.2 Demographics: Age, years of experience and years at current hospital

Ages ranged between 25 and 52 years. The length of registration as registered professional nurses ranged from 20 months to 28 years and the length of service at the current institution from three months to 20 years. Three (n=3) of the participants completed their year of community service at the same hospital, after which they were permanently employed: two (n=2) were employed immediately and one (n=1) after a year of completion of community service.

Table 4.1 represents demographical information of each participant: their age, years of experience as a professional nurse and length of time they have been practicing at the current hospital as a professional nurse.

Table 4.1: Demographics of each participant

Participant	Age	Years as PN	Period at hospital as PN
1	46 years	28 years	1 year 8 months
2	37 year	2 years	3 months
3	52 years	23 years	10 years
4	25 years	20 months	7 months
5	35 years	5 years	5 years
6	50 years	5 years	5 years
7	32 years	2 years	2 years

4.2.3 Highest nursing qualification

Three (n=3) participants obtained four year degrees in nursing and midwifery and four (n=4) obtained four year diplomas in nursing and midwifery. One (n=1) obtained their diploma through the R683 Bridging Programme for Enrolled Nurses. One (n=1) participant was in possession of a post-graduate diploma in a non-clinical qualification.

4.3 SECTION B: THEMES EMERGING FROM THE INTERVIEWS

Referring to Chapter 2, section 2.6.1, where various definitions of moral distress was discussed, the interviews aimed to gather data on challenges the participants experienced that affected their ability to do the right thing as prescribed by personal, institutional and regulatory prescripts. The term “moral distress” was not commonly used and on recruitment few potential participants were familiar with what was referred to. However, once it was described as “knowing what the right thing is to do as a professional nurse, but not being able to do it due to various challenges, and the consequent influence it has on PNs”, possible participants could immediately identify with the concept.

Seven themes emerged from the interviews and were related to staffing, management, resources, doctors, powerlessness and despair, fear and coping.

Sub-themes emerged from some of the major themes and are displayed in Table 4.2.

Table 4.2: Themes and sub-themes

Theme	Sub-theme
1. Staffing issues influencing the ability to do the right thing	• Too much work, too little staff • Disillusionment: workload and shortcuts • Discomfort, inter-collegial relationships signifying need for change • Staffing pressures relieved by the presence of students • Community service professional nurses: Burden or support • Resistance to change
2. Managerial behaviour, support and vertical violence	• Authoritative leadership, elements of rudeness: inconsideration and irresponsibility • Threatened with disciplinary action • Inadequate orientation on ward level • Demands of patients versus managerial standards: unable to please either • Unreasonable expectations from relatives
3. Availability of resources	• Frustrations due to unavailability of stock: compromising patient care • Competition for beds
4. Relationships with doctors	• Meeting demands • Lack of attention to detail • Professional hierarchy: Feelings of inferiority
5. Powerlessness and despair	• Not ticking all the boxes: things left undone • No voice • Being taken for granted: why do we try? • Life after work • Dwindling professionalism: the abused becoming the abuser • Catch 22: To leave, or not to leave
6. Fear	• Unfinished tasks • Personal shortcomings: reluctance to commit • Avoiding confrontation • Breaking the rules
7. Coping strategies	• Talking about the challenges: sharing experiences

	• Rest and relaxation • Shifting the focus • Being assertive and staying positive • Releasing emotions • Pray: to make it through the day

4.3.1 Staffing issues influencing the ability to do the right thing

The theme of staffing comprises the opinions and experiences of professional nurses regarding staffing-related aspects influencing their ability to do the right thing, and the consequences thereof.

Too much work, too little time – All participants were of the opinion that the nurse–patient ratios were insufficient and considered their respective wards to be short-staffed for the workload and patient acuity in the 25-bedded medical and or surgical wards where they practiced. They often found themselves as the only PN on a shift (in exceptional cases there will be two PNs on a shift), practicing with one or two enrolled nurses (ENs) and two enrolled nursing assistants (ENAs). Norms generally range from 4–5 nursing staff members per shift. More than one of the participants was in the situation where they only had one ENA on duty with them on a shift.

> *"Short-staff. Almost every day. Because there's a lot of work. It's too much. You're always fatigued because you are working overtime… We have 25 patients. Now at night it's just me and one staff nurse and two nurses. Sometimes we have 12 bedridden patients, so they need to be turned. Everything needs to be done. So by the time we're finished we are really tired. We just need to sleep."* (Participant 5)

Shortage of staff was further exacerbated by patients who must be escorted to other institutions for further investigations, leaving the ward without the staff member who escorted the patient. As the staff member will not be replaced, the remaining staff have to cope without that staff member. Sometimes staff got shifted between wards, which was not perceived as an ideal solution as patient acuity and the needs of the wards were often not considered. This practice might have increased the physical number of staff in a given ward, however did not address patient acuity nor encourage appropriate skills mix of staff.

> *"Personeeltekort. Dit ruk hand uit, regtigwaar. Hierdie balansering van die een saal het vyf en die ander een drie, dan moet een van vyf oorgaan. Maar my behoeftes in my saal is anders as daai ene. En niemand verstaan wat jy sê nie. En meeste van die gevalle dan is jy alleen suster. Jy't een staff nurse*." (Participant 1)

> Translated response*: "Staff shortage. It's really getting out of hand. This balancing of the one ward has five and the other one three, then one of the five must go over. But the needs*

> *in my ward is different from the other ones'. And no one understands what you are saying. And in most cases you are the only sister. You have one staff nurse."* (Participant 1)

The experience of the participants was that staff does not get replaced when absent due to sick leave or annual leave. The ward then had to cope in the absence of the staff member. Only in exceptional cases would agency staff be used, or in some cases overtime awarded, depending on the available budget. Another practice some participants were exposed to was to cover two wards in the absence of a PN in the other ward.

> *"You are asked to help in other wards. So we work in the wards and then we go work in the other wards. That's how they do it. No money for OT* (over time). *No money for agency. So you do your work and then you go and do it in the other ward. Then you hand over in the morning. They expect everything to be done. … It's a big risk, but they don't do anything about it. They don't. …* (Participant 5)

Although it was not easy, another participant was able to assert herself against the night matron when requested to cover two wards.

> *"But I say me, I can't cope with two wards at the same time, it's really too much. But they say "but Sister, it's just for one night". And then it happen again. I say, "I can't, I'm sorry. You have to find somebody to work there." "But it's late at this time." But I say, "I really, I can't Sr." That was the night matron working that time. Because I was keep on "OK, it's fine I can cope" they won't replace mos."* (Participant 7)

Participants were under the impression that increased staffing was a solution to most of the challenges they were facing. Increasing staffing to two of each category, or at least two enrolled nurses and three ENAs were some of the suggestions made. Participants were of the opinion that increasing the number of PNs per shift would positively influence their role and enable them to perform tasks as required by their regulatory frameworks.

> *"… sometimes we don't do like the books. Because if you do things like the books… yhoo! Sometimes it's gonna make long – gonna take you long to finish. But ke, if you are two registered nurses, registered staff, you just then you are fine. You are able to do things by the books.* (Participant 7)

The perceived shortage of staff that participants were faced with causes moral distress. The lack of sufficient staff of all levels was not only physically and mentally exhausting, but also left them with feelings of frustration, hopelessness and despair. Some were exploited in order to compensate for poor staff planning and to sustain management's stance that staff will not be replaced, seemingly at any cost. The concerns participants raised were not heard, leaving them voiceless. The working conditions forced them to improvise, and thereby, compromised their ability to do the right thing.

Disillusionment: workload and shortcuts - From the responses it was evident that the PNs had considerable awareness of their roles and responsibilities as a PN, to the extent that the reality of being a PN was even disillusioning to some. Responsibilities referred to numerous clinical and administrative duties.

> *"I didn't know that nursing is like this."* (Participant 7)

There was an acute awareness of their roles and responsibilities, that it must be fulfilled according to legislative prescripts and that there would be consequences if duties were not performed to the expected standard. Participants experienced lingering feelings of unease and anxiety of potential consequences due to their awareness that their practice could jeopardise patient care.

> *"Dis goed wat by mens kan spook, wat jy dink: Wat as die pasiënt dit of dat oorgekom het en jy het dit nie gedoen soos jy geleer is om te doen nie? Hoe gaan jy jouself uit daai situasie bedink? Wat gaan jy sê? Want jy het nie die regte ding gedoen nie."* (Participant 6)
>
> Translated response: *"Its things that can haunt you, when you think: what if something happened to the patient and you didn't do it the way you were taught to do it? How are you going to get yourself out of the situation? What are you going to say? Because you didn't do the right thing."* (Participant 6)

Resuscitation of patients (referred to as "code blue" by participants) was mentioned by several participants as a stressful event. They realised their responsibility towards it and the presence of moral distress is displayed in their fear that circumstances – such as one PN covering two wards – could prevent them from fulfilling their expected duty and potentially saving a patient's life. During resuscitation the expectation is that the PN should be the main role-player, especially until the doctors arrive.

> *"Because sometimes there's a code blue there, there's a code blue there and then you can't divide yourself in two."* (Participant 7)

Participants were able to identify their own shortcomings with regards to their clinical skills. Insecurities seemed to be relieved in the presence of another, more experienced PN practicing on the same shift.

> *"I get nervous when it's a resus. I don't like a resus because I get confused… I've never been exposed to much, so when it's time for a resus I don't know what to do… so I think really I don't like it because I don't feel confident enough… If it's during the day then it's fine for me, because we're two sisters. But it's only fine if the other sister is competent so that I can watch… I don't want a patient to die because of me."* (Participant 4)

Performing electrocardiograms (ECGs) were mentioned by several participants as a contentious issue. It was expected by the doctors that it must be performed by the nurses on ward level; however PNs were of the opinion that it was not in their scope of practice and was time consuming. Reluctance to perform ECGs seemed to also be associated with participants' own perceived incompetence to perform and interpret it.

> *"Ons het lank gesukkel met die dokters om EKG's te doen… Ek gaan nie EKG's doen nie omdat ek alleen werk…"* (Participant 1)

> Translated response: *"We struggled for a long time for the doctor's to do the ECG's… I'm not going to do ECG's because I am working alone…"* (Participant 1)

A participant shared her experience of not only having to manage the ward, but being put in the situation of managing the hospital at night. Although it was seen as a learning experience, the participant was not oblivious to the potential risks involved in such a task. It appeared as if management took advantage of PNs to fulfil duties for which they are not experienced enough, and then failed to support them to perform it.

> *"Daar's eintlik baie druk… Ek is nie 'n operasionele bestuurder nie, maar hulle verwag van ons om 'n hospitaal te run met die risiko's verbonde… Vir my is dit vreesaanjaend."* (Participant 3)

> Translated response*: "Actually there's a lot of pressure… I'm not an operational manager, but they expect us to run the hospital with the risks involved… It's frightening to me."* (Participant 3)

It was apparent that the shortage of staff influenced the PN's ability to perform the duties expected of them. These expectations were not only required by the employer, but there was a personal and professional commitment and sense of responsibility towards fulfilling duties and delivering patient care to a desired standard.

> *"Wat ek nou ontdek het, as gevolg van die personeeltekort, wat nursing care betref is daar nogal baie agteruitgang. Jy kom nie by alles uit wat jy veronderstel is om te doen nie of wat jy moet doen nie."* (Participant 3)

> Translated response*: "What I discovered is that due to the staff shortage, there is a decline in nursing care. You don't get to everything that you are supposed to do or that you have to do."* (Participant 3)

Several participants referred to "splitting" themselves in order to ensure all duties were performed despite the shortage of staff. Role division, where they would take over some duties of the ENs, such as oral medication administration or wound care, became common

practice under such conditions. Despite their efforts they were, at times, unable to perform all expected tasks to the standard they would have wanted to.

> *"Even If we have one nurse off sick, the nurse must replace her because the nurse can't work alone turning and washing the patients, and then one of us must do the staff nurse's job and you must do the staff nurse's job alone. The other sister must do the whole sister's job… They're (management) expecting a lot from the nurses… That's why I must split myself. I don't know how. To help the other sister and help the staff nurse as well."* (Participant 4)

Participants' work day became task-orientated – completion of all tasks was paramount. They were left feeling helpless and powerless in an uncompromising environment.

> *"....I have a lot of IVs* (intravenous medication) *in the ward and I'm still busy and the patient rings the bell… 'Can I please have morphine?' Then you're just like 'Can I please finish my work?"* (Participant 5)

Role division was further complicated by patient acuity – bed-ridden, elderly, aggressive, confused patients that required greater nursing input – and the realisation that the PN would have to account for things not done.

> *"It makes the workload very heavy, and when it's like that you don't even go for tea time… With our surgical patients most of them are amputated. If she or he wants to go to the toilet he needs assistance, and the medical patients… it's elderly patients. Some of them are confused. You're busy with this patient, the other one is jumping out of the bed. You need to run there, because if he or she falls then something else is a case….* (Participant 4)

Although participants verbalised that they were doing what was required to be done for the shift to the best of their abilities, some duties were not always seen as priority tasks. Most referred to "small things" – mouth care, catheter care, patient education about medication on discharge, passing a nasogastric tube, ordering blood as prescribed, intake and output monitoring, leaving gaps in the drug books, performing ECGs – that they were not able to perform or sometimes were left undone. Tasks mentioned as "small" seem not to be considered as significant, yet tasks that warrant being considered as critical were given the same label. There was a realisation that the consequences of incomplete tasks could be grave and participants experienced feelings of guilt as a result.

> *"…if you didn't give (morphine) the same time the patient asked, if you were busy with something else like putting in a drip or something… when you finally arrive you can see the patient is really in pain. You're feeling so guilty because you wish you could have come earlier… It's going to come back to you. You're a human being; you know how the pain is…" (Participant 5)*

Shortcuts seemed to also be a result of shortage of staff. Duties not done "by the book" were mostly schedule drug management and blood administration. Participants were fully aware that shortcuts are not allowed, but chose to do it in the best interest of the patient and to meet patient needs.

> *"Soos die drug kas. Jy kan nie alleen daar ingaan nie. Maar as 'n pasiënt nou 'n fit kry, dokter sê "Valium", dan sal ek dit gaan uithaal sonder 'n witness."* (Participant 3)
>
> Translated response*: "Like the drug cupboard. You can't go in there alone. But if the patient is having a fit now and the doctor says "Valium", then I will go and take it out without a witness."* (Participant 3)
>
> *"Jy gee die morfien alleen, en dan skryf jy in. Dan sal 'n nurse saam met jou teken. Of sê nou maar jy't 'n pasiënt wat aggressief is en die pasiënt moet nou Ativan kry. Jy't alreeds die dokter gebel en dokter gesê gee die Ativan, maar nou vat jy net die Ativan… Maar jy doen dit sodat die pasiënt uitgesorteer kan word."* (Participant 1)
>
> Translated response*: "You give the morphine alone, and then write it in. Then the nurse will sign with you. Or let's say you have a patient who is aggressive and the patient must get Ativan. You already phoned the doctor and the doctor said to give Ativan, but now you just take the Ativan… But you do it in order to sort out the patient."* (Participant 1)

To the benefit of the patients, the participant's with more than five years of experience in the profession, found themselves practicing outside of their scope of practice at times, or wanting to practice as a proactive, independent practitioner. However, the realisation that they do not have the autonomy to at times address patients' needs without a doctor's prescription left them frustrated and powerless to act in the patients' best interest.

> *"Hulle dwing vir jou om dom te act en om dom besluite te maak en so. Ek is 'n registered nurse, laat ek my eie besluite maak dan dra ek die gevolge daarvan … Daar is baie goed wat ek kan doen wat dokter kan doen. Wat ek aan die einde van die dag gaan doen, want ek doen dit vir die pasiënt. Dan is dit net daai spesifieke dag wat iets gebeur met die pasiënt, dan is ek in die moeilikheid. Dit gaan vir my 'n vreeslike groot negatiewe ding wees." (Participant 1)*
>
> Translated response*: "They force you to act stupid and make stupid decisions and so on. I am a registered nurse, let me make my own decisions and I will take the consequences thereof… There are many things that I can do that the doctor can do. At the end of the day, what I do I do for the patient. Then it's just that specific day that something happens to the patient, then I am in trouble. It's going to be a very big negative experience to me."* (Participant 1)

The influence of shortage of staff on participants' roles and responsibilities and the consequent workload leads to despair and helplessness, leaving some disillusioned about the profession they have chosen. Responsibilities revolved mainly around the successful completion of tasks, causing anxiety at the notion that tasks might be left incomplete. When shortcuts were taken, it was done with full awareness of the difference between right and wrong in the situation; however, it was motivated by the premise of putting the needs of the patients first. Yet, not being able to perform duties according to the legislative and institutional frameworks contributed to participants' experiences of moral distress as they were acutely aware of the consequences of such transgressions. Participants with more years of experience appeared to have more self-confidence to act according to their own discretion, whereas those with two or less years of experience in nursing were left overwhelmed by the challenges, forcing them to take initiative in order to get the job done, which contributed to the causes of moral distress.

Discomfort, inter-collegial relationships signifying need for change - Especially the three newest employees (who were Black African) verbalised their experience of subordinate nurses (enrolled nurses – ENs and enrolled nursing auxiliaries – ENAs) who has been at the institution for many years (often of Coloured race) that did not acknowledge their role as a PN, were manipulative and openly disregarded or challenged their delegations in front of staff and patients, eliciting feelings of discomfort and disrespect. Participants experienced these staff members as resistant, lacking responsibility and were not open to be corrected by the PN.

> *"It's not like I'm sitting on the chair and saying go and do that. No, I'm not sitting in the chair. I'm busy with something else. The nurse will just tell you "Do it. You can do it". The other staff nurse told me "You can finish what you're doing then you can do what you must to". How do you respond to that?"* (Participant 5)

Such overt disregard gave rise to feelings of helplessness and due to their lack of experience and minimal exposure to other institutions and environments, these participants were left disempowered to address the staff and manage the insubordination.

The PN (Coloured), who obtained her qualification through the Bridging Course (R683), had similar experiences with sub-category nurses of the same race. This could be attributed to professional jealousy towards those who were granted study leave and promotional opportunities, or to the generalised tendency of disrespect that seemed present towards professional nurses.

Some participants were of the opinion that it is because they were younger than the sub-categories of nurses that they experience the resistance, or that it was the norm of how new employees were treated.

> *"There are different experiences with different wards. In other wards, when you get there, the first impression you get, you tell yourself "This is how I'm going to be treated for the rest of the period I'm going to work here. They look at your face. They look at the colour. They look at the age. Especially the old nurses. The twenty, thirty year experience people is not nice."* (Participant 5)

Participants were left powerless and seemed to accept that they will not be able to change the situation, as it was considered the norm at the institution. Their authoritative position was compromised and they were left exploited, affecting their confidence, to fulfil their role and adding additional stress to ensure duties were performed when staff refused to follow delegations. An undercurrent of racial tension seemed to be present amongst the Coloured sub-categories of nurses with many years' experience at the institution, towards the Black African professional nurses who were in a superior position to them. This situation signifies a need for change on the side of the Coloured nurses to accept leadership irrespective of race.

The researcher witnessed such disregard during one of the interviews with a newly employed Black African professional nurse during her lunch break, which was continually interrupted by a Coloured ENA. Eventually the interview was terminated due to the continuous interruption, calling the PN out of the office and proclaiming in the corridor that the PN is not allowed to do the interview.

> *"She said we're not allowed to do this…. It's the attitude of the old staff. I'm a sister, it's a nurse. She's in the ward. She's supposed to accept the patients. … I'm a senior, she's a nurse. And she wants to tell me do this, do these duties. I know I'm new and she's got many years here in this ward, but it's not allowed to do that..."* (Participant 2)

Although procedure was followed and permission was granted for the interview to be conducted, the participant was powerless against the explicit confrontation and disrespect of the ENA, suggestive of overt vertical violence towards her.

When newly appointed, some participants experienced a lack of support, or even bullying, from more senior professional nurses who had more years of experience in nursing, suggestive of horizontal violence.

> *"Dis 'n nuwe suster. Sy weet sy moenie premedikasie gee as daar nie toestemming is nie, maar toe word sy geboelie oor die telefoon deur die suster."* (Participant 1)

> Translated reponse*: "It's a new sister. She knows she mustn't give the premedication if there isn't consent, but then she got bullied over the phone by the sister."* (Participant 1)

New appointees were exposed to negative role-modelling by senior, more experienced PNs. Due to their lack of self-confidence and inexperience in their role, they were easily misled and made the scapegoats when complications arose.

> *"Because I used to follow anything that the old sister do… I'm counting with the sisters, no man, she's my supervisor… "Sister, there's something wrong, what are we going to do now?" "OK, we must just cover"… I just said what sister told me to do."* (Participant 4)

The disrespect from subordinate staff members lead to poor working relationships. Their lack of support influenced the workload of the participants and caused added pressure to their already limited capacity to ensure their own duties are completed. In an effort to relieve their distress and to ensure everything gets done – such as admission, discharges, making beds, and basic patient care – they would perform it themselves.

> *"Because everything is gonna come back to me! So I have to make sure they do what I told them to do…. At the end of the day they not being called, it's me who must answer… for them also."* (Participant 7)

> *"Die bed moet geskuif word. Ek gaan dit self doen. Niemand het ge-worry nie. … doen dit self en kry dit oor en verby. Dit gaan my net meer frustreer Mense het dit mos nou nie gedoen nie, so doen dit mos nou self."* (Participant 6)

> Translated response*: "The bed must be moved. I'm going to do it myself. No-one bothered… do it yourself and get it over and done with. It's just going to frustrate me more. People didn't do it, so just do it yourself."* (Participant 6)

There seemed to be an element of sabotage present, where sub-categories denied responsibility as they were aware that the PN will be expected to account for acts and omissions. This was also behaviour suggestive of vertical violence. Participants were left anxious due to the possibility of incomplete tasks and the consequences they would have to endure because of it.

> *"Others just leave things undone because they will not be asked. It will come back to you… Why wasn't the intake and output done? They won't understand. They come to you. There are people who don't do things because they know."* (Participant 5)

It was evident that disrespect from subordinates left participants feeling disempowered, undermined and with self-doubt about their own capabilities. Participants were reluctant to

accept promotional opportunities due to the fear of being undermined and the negative impression that would be created about their ability to be an effective and efficient PN.

> *"Dan wonder jy hoekom luister die mense nie vir jou nie. Hoekom het hulle nie die regte ding gedoen nie?... Die manager sê vir my ek moet oorvat, maar ek sien nie kans daarvoor nie. Ek sal nie dit wat ek wil hê by die nurses kry nie. Dit voel vir my as ek dit nie kan bereik nie, dan laat iemand anders liewerster dit doen. Miskien gaan daai ander persoon dan beter wees, ek weet nie."* (Participant 6)

> Translated response*: "Then you wonder why the people don't listen to you. Why didn't they do the right thing?... The manager told me to take over, but I don't feel up to it. I won't get what I want from the nurses. It feels like if I can't achieve it let someone else rather do it. Maybe that person will be better than me, I don't know."* (Participant 6)

Teamwork between shifts was identified as a way of ensuring continuity of care. At times, some of the participants experienced reluctance from the next shift to carry out activities that they were not able to complete. For some participants the implication was that they missed their transport home as they were forced to follow up on a matter, which the next shift did not want to take over.

> *"Sometimes you hand over to the nursing staff, they say "No, it's your job… They don't want you to hand over. If you hand over the things that happened in the day they don't want to do the follow-up."* (Participant 2)

In an attempt to minimise the moral distress of incomplete tasks and confrontation from the next shift, participants were willing to sacrifice their time after their shift has ended to personally ensure duties were completed. Due to inexperience and undermining of their role by sub-categories, their ability to hand over incomplete tasks was further compromised. Despite the fact that nursing is a 24-hour service and continuity of care by different shifts were implied, lack of co-operation was commonly experienced.

Participants identified relationships with staff from other departments, such as the Emergency Centre (EC), from where most patients were admitted, as an important factor in continuity of care, workload of the receiving ward and even averting and managing complaints from patients and family members.

> *"Ons kry pasiënte van EC af. Dan is hulle admission HB* (Haemoglobin) *5 of 6. Hulle moes dit daar opgetel het. Ons het 'n paar gevalle gehad waar die HB so laag is dat die pasiënte nou nie teater toe kan gaan nie… Die ding van EC is, die dokter is daar. Maak klaar."* (Participant 1)

> Translated response: *"We get patients from EC. Then their HB (haemoglobin) on admission is 5 or 6. They should have picked it up. We had a few cases where the HB was so low that the patient couldn't go to theatre… The thing about EC is the doctor is there. Finish what was started."* (Participant 1)

Incomplete tasks on admission to the wards added to the pressure on the PN to ensure all duties were performed and that doctor's prescriptions were implemented timeously. Incomplete tasks in a task-orientated environment contribute to experiences of moral distress.

Inter-collegial relationships did not include members of the multi-disciplinary team, but focussed on the relationship between participants and their peers or subordinates. There was evidence of the presence of horizontal as well as vertical violence, which could be exacerbated by racial tension and contribute to experiences of moral distress. Participants experienced feelings of disempowerment and disrespect and patient care was compromised by reluctance to take over incomplete tasks and ensure continuity of patient care. Self-doubt was prevalent amongst participants as they questioned their own competence, capabilities and authority as a PN when receiving ample resistance from subordinates and not being supported by peers.

Staffing pressures relieved by the presence of students - Student nurses were placed in clinical facilities in order to achieve learning outcomes as directed by their education and training institution and in order to meet the clinical hour's requirement, as prescribed by SANC, and adhere to professional registration standards. From the participants' responses, the role of students seemed to be as workforce and having students in the wards brought relief to staffing pressures.

> *"Op die oomblik het ons studente wat geplaas is hierso, wat 'n groot help is… Hy werk om die afdeling te dek… Dit bring bietjie verligting, want daar is studente…. Audits van lêers wat gedoen moet word – dit kan ek nog doen op die oomblik omdat daar is nog iemand om te help."* (Participant 3)

> Translated response: *"At the moment we have students placed here, which are a big help… He works to cover the unit… It brings a bit of relief, because there are students… File audits that must be done – I can still do it at the moment because there is someone to help."* (Participant 3)

> *"Een ('n verpleegster) was gister op verlof. Gelukkig was daar studente. Maar wat as daar nie studente is nie? Dan sit jy met daai handjievol personeel en ons moet na 25 pasiënte kyk."* (Participant 6)

> Translated response: *"One (a nurse) was on leave yesterday. Luckily there were students. But what if there aren't students? Then you sit with a handful of staff and we must take care of 25 patients."* (Participant 6)

Community service professional nurses: Burden or support - The presence of community service professional nurses was not always experienced as a benefit by the participants. The fact that they were inexperienced and in many ways incompetent, had limited autonomy and had to practice under supervision, placed an additional burden on the participants. At times, the pressure on the participants of having a community service professional nurse in the ward outweighed them being considered as help.

> *"Selfs die comm serves (community service professional nurses) kom aan en weet nie wat aangaan nie. Hulle is net drie maande in 'n afdeling en lyk my teen die derde maand weet hulle soms ook nog nie wat aangaan nie. Ek meen, jy kan nie heeldag polisieman speel nie. Wanneer gaan die werk gedoen word?"* (Participant 6)

> Translated response: *"Even the comm serves (community service professional nurses) get here and don't know what's going on. They are in a department for three months and it seems at the end of the third month they sometimes still don't know what's going on. I mean, you can't play policeman all day. When will the work get done?"* (Participant 6)

> *"You are working alone. And then sometimes they give you a comm serve. With a comm serve, yes you have help, but it's not someone you can rely on."* (Participant 5)

Some of the participants, who completed their community service, commonly abbreviated comm serve on hospital level, at the same institution, recalled their experiences. There seem to be a fine balance between the acknowledged risks involved in managing a ward alone as a community service professional nurse, and being forced to adopt, often prematurely, the role of PN due to being placed in the position.

> *" I worked with a sister for two days. It was my first time to be alone. So she just told me "You know sister, I'm not gonna be able to work with you for two months… I didn't take it seriously … I work alone. Comm serve alone in that ward. Yho yho yho yho it was tough! It's where I learn to stand on my own. And I say, OK! This is nursing!... And mos normally you can't work alone as a comm serve. You have to work with somebody close to you. But not here. … Even the comm serve now they work alone. So you must be responsible."* (Participant 7)

Another participant shared the following about her experience:

> *"As a comm serve… on my first month I gave a patient the medication and I didn't explain to the patient… I decided that day, and realised after that, I'm wrong. I'm so wrong… What if*

> *he died? Then I was going to be responsible for whatever was going to happen to him."* (Participant 4)

The reality of the role, responsibility and expectation of professional nurses became apparent to some participants during their community service placement. The realisation came when they registered the implications of their actions on patient care. The risks and consequences involved when not adhering to prescribed institutional or legislative procedures contributed to a lack of quality nursing care that was provided. Participants realised that patients' lives were at stake, and unlike student status, as the PN they will be kept accountable.

Resistance to change – Participants commented on the apparent resistance to change from fellow staff members, and also from nursing management. Staff did not appear to be open to input from new employees wishing to share their experiences gained at tertiary institutions, with a desire to upskill and inform staff of new developments.

> *"Ek kom van 'n plek af waar almal moes alles geweet het. Ek is so gewoond aan, soos suster verduidelik nou vir my, as ek omdraai en daar staan iemand agter my dan sê ek "Kom gou hier, ons maak so en so." Maar ek kry kyke hier. Dit is uit gewoonte uit. Dis hoe ons moet wees met nursing, maar hulle hou nie daarvan nie. Hulle hou nie van verandering nie."* (Participant 1)

> Translated response: *"I come from a place where everyone had to know. I am so used to, as sister explains to me, when I turn around and someone is behind me then I say "Come here quickly, we do this and that." But here I get looks. It's out of habit. It's how we should be in nursing, but they don't like it. They don't like change."* (Participant 1)

Participants experienced frustration with staff that was reluctant to do what was requested and continued to perform duties the way they had become accustomed to. Participants also experienced that they were expected to conform to the way things were done as the organisational culture seemingly did not encourage innovative ideas that could improve systems and outcomes.

> *"They are very comfortable in the way that they are doing. That's why they don't want to change. And sometimes change is good… But, yho, you explain and explain to the old nurses. It's really, they are very resistance to change. But they have to change because things are changing…"* (Participant 7)

It was perceived that systems and processes were outdated, such as ordering stock, and there was ignorance towards provincial guidelines and prescripts that were not being implemented (such as National Core Standards). It created a sense of frustration and

powerlessness as participants were restricted from taking initiative or suggesting alternative ways of doing things. One participant, with many years' experience in nursing and exposure to various environments, found this aspect especially challenging.

> *"Die kontrole van bloed… Nou dit is mos nou amper 15 jaar oud daai gedeelte. Hulle weet nie dit nie. Hoe kan julle sê julle weet dit nie? Dis iets wat van die Department (van Gesondheid) af gekom het… Goed wat hulle moet weet, weet hulle nie. Die checklists van National Core Standards is nog nie in plek hierso nie… Maar hulle glo ons doen nog al die jare so, en ons hou hom so."* (Participant 1)

> Translated response: *"The control of blood… Now that part is almost 15 years old. They didn't know it. How could they say they didn't know? It's something that came from the Department (of Health). Things they should know, they don't. The checklists for National Core Standards are not implemented here yet… But they believe we've been doing it like this for years, and we keep it that way."* (Participant 1)

Based on the findings, staffing is a complex issue influencing the participants' ability to do the right thing. Staffing challenges entailed more than just the shortage of staff. The attitude of the existing permanent staff members negatively influenced team cohesion and added pressure to the professional nurses' workload and ability to fulfil their responsibilities. It created feelings of frustration, powerlessness, hopelessness and caused self-doubt and disillusionment. Findings suggested that students and community service professional nurses were utilised as workforce in an attempt to compensate for the staff shortages. An organisational culture of resistance to change seemed to be present where innovation was not encouraged and structures were seemingly inflexible.

4.3.2 Managerial behaviour, support and vertical violence

Authoritative leadership, elements of rudeness: inconsideration and irresponsibility - The majority of participants experienced negativity towards nursing management – whether on ward level or collectively. Only one participant experienced her manager as supportive, fair and maintaining an open door policy. Although the participant would try and resolve issues on ward level herself, she would only involve the manager when necessary. Some of the participants would also approach their managers for support, with varying results.

The majority of participants' impression was that managers were arrogant, incompetent, inexperienced, unprofessional, rude, lacked objectivity and were not positive role-models.

> *"There's a manager who came the other day and shouted at me… There was other people in the passage, and then she left. After that I was so furious. On my way home I nearly caused an accident…"* (Participant 5)

> *"Management is die grootste probleem. Hulle is baie arrogant en onprofessioneel… Sy (area bestuurder) kom daar in en sy begin op ons te gil en skree. Ek staan en kyk die vrou so aan, nou dink ek, "Wow!" Die manier en die woorde wat gebruik was. Julle (management) praat dan soos skollies… Dis amper soos," Ek het die pos, daar's niks wat jy aan my kan maak nie."* (Participant 1)

> Translated response: *"Management is the biggest problem. They are very arrogant and unprofessional… She (area manager) came in and started shouting and screaming at us. I stood there and looked at her, thinking, "Wow!" The manner and the language that was used. You (management) are talking like skollies… It's almost like, "I have the job, there's nothing you can do to me."* (Participant 1)

Rudeness and shouting by managers were indicative of overt vertical violence and the managers abusing their positions of power in the nursing hierarchy, which contributed to experiences of moral distress. The psychological consequences of being treated in such a manner had negative influences on participants' behaviour and affected their respect of superiors.

There was a perceived lack of support from management towards the challenges the participants experienced on ward level. Managers were seen as being mostly in the office and out of touch with clinical practice, and disinterested in what was happening in the ward.

> *"En mos most of the times they are in the office. They are not around you, you see. So, that's how hard it is." (Participant 7)*

> *"Omdat hulle nie rerigwaar in sale eers gewerk het nie. Daai ondervinding om te bestuur is nie daar nie. Hulle is baie meer betrokke met, jy weet, kantoor duties as wat hulle betrokke is by die pasiënte se sorg" (Participant 1)*

> Translated response: *"Because they didn't really work in the wards first. That experience to manage is not there. They are much more involved with, you know, office duties than what they are involved with patients' care." (Participant 1)*

Participants experienced reluctance from managers to get involved on ward level or to assist when there was only one professional nurse on duty; whether to assist during a code blue, or to keep the drug key when the only PN on the shift was going on lunch. Participants were left helpless and had no choice but to accept their situation.

> *"Our manager she's always in the office. Even if you are one registered nurse who's working… You have to deal with that code blue and I must go there and you see they don't even come and help. So it's really, it's too much. Sometimes you need to go to lunch… Then you give her the keys, she says, "No, no, no, don't give it to me." Who must I give it? "Give it*

> *to sister in (another ward).”… Because she doesn’t want to take responsibility.” (Participant 7)*

There was a perceived lack of action from managers to address the challenges reported to them, especially the challenges related to shortage of staff. This created a sense of hopelessness and desperation.

> *“When I started it (shortage of staff) was a big problem. It was a huge problem. Everyone was talking about it in the meetings. Instead of things getting better I think things are really getting worse.” (Participant 4)*

Some participants felt that management did not care for the nurses. Management seemed to place high demands on the limited nursing staff, not expecting any complaints, especially related to patient care, irrespective of the challenging working conditions. Very rarely did participants experience appreciation from management.

> *“With management, you know, they expect so much from people… we do give the care to i-patient, we do try our best. But it seems as if they don’t understand really what is happening here in the wards. Even if we, we talk with what’s going on, but still they are so hard. They are so hard on us… That’s the condition that we work here. They really don’t care about i-nurses anymore…”* (Participant 7)

Participants were not always able to confront their managers, and felt they had no voice and they were left unsupported, especially when there were complaints or adverse events.

> *“Would they understand? No! With the management that you have that is not supportive at all. It would be nice if I’m in trouble my managers sit with me down, “What happened?... You don’t have time to say “Can I explain myself?” I don’t bother anymore. I don’t.”* (Participant 5)

Some participants refrained from expressing their concerns to their managers for support due to their perception of possible racism or favouritism experienced.

> *“… I didn’t bother myself to report it or to talk about it. Because we once laid a complaint about the manager, that she’s a racist. It depends who is wrong. It depends, is it a white staff member or not.”* (Participant 5)

> *“But she is supportive, but she’s got her favourites… She doesn’t hide it. But she is supportive in her way.”* (Participant 7)

There was the impression amongst participants that managers were reluctant to raise their concerns to senior management.

> *"…they are so scared our operational managers, to talk to this lady that is our boss. They are so scared. Even sometimes, "Can you call her we want to tell her A, B, C." But you can see that she's shaking in her boots."* (Participant 5)

> *"Ons gevoel in die saal is ons bestuurders… neem nie standpunt in nie. Hulle praat nie hard genoeg vir ons nie. Want dis is nie hulle wat besluit hulle gaan nie ekstra mense kry nie, dit kom mos van hulle seniors af."* (Participant 1)

> Translated response: *"Our feeling in the ward is that our managers… are not taking a stand. They don't speak loud enough for us. Because it's not them who make the decision not to get extra people, it comes from their seniors." (Participant 1)*

Managers were experienced as unprofessional, incompetent and unsupportive. Participants desired support when dealing with complaints or clinically, to assist with patient care. Evidence of vertical violence – racism, favouritism, rudeness and shouting – was present and contributed to experiences of moral distress. Findings suggested strict hierarchical structures, with managers possibly restricted from acting without the approval of senior management.

Threatened with disciplinary action - Many of the participants identified that disciplinary action was the consequence they experienced (or got threatened with) when they were unable to complete duties as expected, or complaints were received due to operational challenges they experienced.

> *"The only thing they say at in the meetings in the mornings, they don't say, "OK sister, I understand the workload is too much, I'll ask the senior management to get us another nurse. I will ask the management to do this and that." (They say) "Sister, you will be disciplined!" That's the only thing what we hear from them."* (Participant 5)

> *"And you know, my manager sometimes it is, sometimes it threatens you that, I'm gonna discipline you, I'm gonna discipline you!" Every time you hear the word discipline, discipline… and I say yhooo! Nursing!.. It's really, it's hard."* (Participant 7)

There seemed to be different reactions towards the threat of being disciplined. To some participants it became an empty threat, and did not seem to have any influence on them.

> *"We were saying the language of the hospital is disciplinary. You don't mind anymore when you see someone is going to discipline you."* (Participant 5)

In some instances, the reality of a disciplinary action was experienced as a wake-up call and had encouraged a participant to perform their duties correctly and with more concern. It

assisted them to recognise their responsibility as PN and that they will have to give account, irrespective of the circumstances.

> *"But when I was a comm serve… maybe it's because I learned in a hard way. I made lots of mistakes and I even got a warning, which is how it all started. I got a wake-up call. Because I used to follow anything that the old sisters do."* (Participant 4)

As participants realised their roles and responsibilities towards patient care, they understood that some situations warranted being disciplined.

> *"..as a new sister, when things get bad, they're shifting the blame to you. But I wasn't afraid to take the consequences. If I was part of the whatever happened, I said, "It's OK, I'll sign the warning, because I believe when I did it, it was wrong."* (Participant 4)

The constant threat of being disciplined can cause anxiety in participants, especially as they do not get any support from their managers and are acutely aware of the consequences they will have to face when complaints and adverse events arise. Contradictory to the desired effect of disciplinary action, which is to improve practice, it was experienced by some as an empty threat and did not have any apparent influence on their actions.

Inadequate orientation on ward level - Lack of orientation of new staff members was experienced by several participants, leaving them insecure and it took them longer to grasp the expectations and ward routine.

> *"…I got stressed because I work with the other sister. The other sister is going to leave, I work alone. In the meantime I don't know nothing about this ward. I've got stress."* (Participant 2)

Contradictory to the experiences of disrespect from some lower category nurses, when newly employed, participants also received more support from lower category nurses, or non-nursing staff, than they did from their peers or managers. This seemed to be how all new employees were treated, irrespective of years of experience in the profession.

> *"… die mense wat vir my gewys het wat gedoen moet word was die nurses. My bestuurder van daai saal was nie by gewees nie." (Participant 1)*
>
> Translated response: *"the people who showed me what to do were the nurses. My manager of that ward was not present."* (Participant 1)
>
> *"But there's a lot of information at the clerk at this ward. If there's something we don't know and the clerk don't know, he run away to ask the nurse. He give the most support and he explains everything if you don't understand."* (Participant 2)

Lack of orientation for newly appointed employees contributed to experiences of moral distress as participants felt disorientated and ill-equipped to fulfil their role and functions and meet expectations placed upon a PN, at times taking shortcuts and breaking the rules in an effort to complete their duties. Contradictory, lack of orientation could also contribute towards ignorance regarding the role and the expectations placed upon them, leading to indifference and not finding it morally distressing. Participants relied on lower category staff or even non-nursing staff for support and ward orientation when newly appointed.

Demands of patients versus managerial standards: unable to please either - Dealing with complaints was mentioned by several participants as a challenge. All attempts were made by participants to avoid complaints as far as possible, as they had to account for what went wrong and perceived it as a bad reflection on them as leaders. Complaints were experienced as an incident that could potentially lead to disciplinary action. It increased the pressure placed on the participants to perform their duties within the legal frameworks of the profession, yet without consideration for the working conditions they are exposed to.

> *"And then they (management) expect you to give 100% care and they don't want any complaints from the patients, from families. If there is a complaint that the nursing care was poor you are really in trouble. That shift is really in trouble… we are trying to give what we can do… but still they complain."* (Participant 7)

> *If you always getting complaints it's saying something else about your shift and it's saying something about you as a leader… then it means there's something that you don't do. There's something that you're not doing right. There's something that we're doing and it's wrong."* (Participant 4)

From the experiences narrated by participants it seemed as if patients had high demands that could not always be fulfilled, often due to the consequence of staff shortage. Although most complaints had merit, there seemed to also be instances where patient demands tended to be unreasonable.

> *"I-patient complain a lot of things. That you didn't smile to them, you didn't greet them… it's things like that… it's just small things."* (Participant 7)

Some participants experienced little support from management when it came to managing patient complaints, causing frustration and a sense of powerlessness.

> *"I-patient is always right. They complain about what every they complain. But they (management) don't want to listen to your side of the story. They just listen to the patient side and that's it… even if you want to explain what happen or went wrong, they don't want to listen to you. You are guilty.* (Participant 7)

The nature of complaints was often patient care related, leaving participants feeling helpless and demotivated as they were making all efforts to perform their duties to the expected standards, yet it was not good enough.

> *"…most of the complaints is about the care that we give to the patient. Sometimes they not satisfied with the care that we give…some of them they don't appreciate of what we are doing."* (Participant 7)

Unreasonable expectations from relatives - According to participants, more complaints were received from family members than from patients themselves. From the experiences it seems as if family members also had high demands that could not always be fulfilled. Families' expectations could be as a result of lack of information, leaving the PN in the predicament of answering patient-related questions that should be discussed with the family by the doctor. During visiting times especially, the participants found themselves in situations to answer family queries of events that might have happened when they were off duty. At times participants had to endure verbal abuse and threats of law suits from rude visitors, while maintaining their professionalism in such situations. Complaints caused feelings of demoralisation and being unappreciated.

> *"As gevolg van die tekort kom daar ook baie klagtes uit van, ek sou nie sê pasiënte nie, maar familielede. Daar is so baie klagtes dat dit eintlik 'n negatiewe uitwerking het op die staff.* (Participant 3)

> Translated response*: "Due to the shortage there are many complaints from, I won't say from the patients, but from the family members. There are so many complaints that it actually has a negative effect on the staff.* (Participant 3)

> *"If I get so difficult family members who don't appreciate anything that you do, all they want to do is sue you…"* (Participant 7)

Dealing with complaints also helped participants to grow professionally and gain confidence in their role.

> *"If it's preventable, you prevent it rather than be sorry. I think with the complaint part it comes from there, but since then I think along the way I learned how to deal with family members. I learned how to deal with patients. I learned how to smile. I think you must have a strategy. You must just have a plan for how to deal with people's attitudes…"* (Participant 4)

Findings indicated that participants were not supported by management when patients or family members complained about poor nursing care. Staff was not awarded an opportunity to explain their side of the story and management did not consider the contributing factors.

Demands from management, patients and family members remained high, irrespective of the challenging working conditions, causing participants to feel demotivated, demoralised and unappreciated.

4.3.3 Availability of resources

Frustrations due to unavailability of stock: compromising patient care - Shortage of stock caused frustration and time wastage, and seemed to be linked with out-dated ordering systems and mismanagement of supply chain processes. At times, essential items such as plaster and hand towels were out of stock in the stores and the staff in the wards needed to find alternatives to compensate. The alternatives may not have been in the best interest of the patient or be able to fully meet the patients' needs, yet participants had no other choice. Compromising patient care can lead to experiences of moral distress.

> *"Ons kan nie ons werk ordentlik doen nie, want daar is 'n tekort aan voorraad, daar's 'n tekort aan personeel.. Dit vat langer voor jy die regte ding kan doen want jy moet nou eers gaan soek vir dit. Dit vat langer, of jy sit opgeskeep met 'n produk wat jy nie veronderstel is om te gebruik daar nie."* (Participant 1)

Competition for beds - The shortage of beds posed tangible problems. Participants were confronted with working conditions where they had to admit patients into reserved beds or admit inappropriate patients from EC as an instruction from seniors.

> *"Die ander challenge is jy moet beddens soek vir die pasiënte… Of dit nou mediese pasiënte of chirurgiese pasiënte is, dit maak nie saak nie. Hulle sê die hospitaal is vol en jy moet die beddens gee."* (Participant 6)

> Translated response: *The other challenge is that you have to look for beds for patients… Whether it's medical patients or surgery patients, it doesn't matter. They say the hospital is full and you have to give beds.* (Participant 6)

> *"They don't say this patient is on TB treatment or the patient has TB not on treatment. And then you tell them you have a bed, but in a four bedroom, and then you mix that patient there. So if you go to nurse the patient, how are you going to wear a mask while the other three patients are there? So you must go then without protection. Sometimes it's an MDR patient."* (Participant 5)

Unavailability of resources affected patient care and required additional time to devise alternatives. When patient care is compromised, experiences of moral distress can result. Findings were indicative of feelings of moral distress arising due to bed pressures and participants being instructed by managers to admit inappropriate patients. Such practices pose a serious risk to the health of the nurses and other patients. These instructions

reinforced the perception that management did not care about the nurses and that participants were powerless against unreasonable and unsafe practices that did not conform to the required quality healthcare and infection control standards.

4.3.4 Relationships with doctors

Meeting demands - Challenges related to meeting the doctor's demands and performing tasks considered to be the doctor's responsibility. ECGs (mentioned in 4.3.1) were considered by some participants as a time-consuming activity and they were of the opinion that it was not within their scope of practice. The instruction to perform it added to participants' workload and was considered a source of additional pressure to their already extensive list of duties to be completed, and a potential cause of conflict between the disciplines when not done.

> *"Ek kan nie sê ek kom nie goed oor die weg met die dokters nie… hulle wil hê jy moet EKG's doen, maar ek gaan nie die EKG's doen as my werk nie klaar gedoen is nie… Dit is nie eintlik ons werk om dit te doen nie… Dis klein goedjies maar dit kan vir jou 'n challenge raak, want jy stress die heeltyd."* (Participant 6)
>
> Translated response: *"I can't say I don't get along well with the doctors… they want you to do ECGs, but I am not going to do ECGs if my work is not done… it's not actually our job to do it.. it's small things but it can become a challenge, because you stress all the time."* (Participant 6)

Lack of attention to detail - Other challenges were caused by doctors' lack of attention to detail that had consequences for patient care and the risk of incidents or complaints that the participants had to deal with, which could add to experiences of moral distress as the PN will be held equally accountable for not identifying and correcting the mistake.

> *"A doctor can put a wrong sticker for someone else's consent form. If you didn't see that it's a big problem… We must re-do the consent forms."* (Participant 4)
>
> *"Toestemmingsprobleme en toestemming vir die operasie self. Daar is nie getuies nie."* (Participant 1)
>
> Translated response: *"Problems with consent and consent for the surgery itself. There aren't witnesses."* (Participant 1)

Professional hierarchy: Feelings of inferiority - The negative professional relationship between doctors and nurses and historical hierarchy between these two disciplines were also experienced by some participants, giving rise to feelings of inferiority.

> *"En die verhouding met die dokters is baie swak. Die dokters sien nie vir ons as hulle kollega's nie. Hulle kyk neer op ons en hulle verwag, hulle gee baie keer hulle verantwoordelikhede vir ons."* (Participant 1)

> Translated response: *"And the relationships with the doctor are very bad. The doctors don't see us as their colleagues. They look down on us and expect, they often shift their responsibilities on us."* (Participant 1)

Findings suggested that relationships between doctors and nurses were strained, and participants felt inferior and not valued as a member of the multidisciplinary team. Nursing staff experienced doctors as demanding and not fulfilling their responsibilities, thereby placing additional pressure on the professional nurses, possibly adding to experiences of moral distress. The lack of acknowledgment and appreciation from doctors could add to PNs' resistance to perform duties they consider out of their scope of practice.

4.3.5 Powerlessness and despair

Throughout the interviews there was a distinct sense of powerlessness and despair that participants experienced. These feelings were especially prominent when participants shared their experiences of failed attempts to fulfil their roles according to the required standards and experiencing resistance – from subordinates to follow delegations and managers to address their concerns. The reality of their work environment seemed to be disempowering, expecting them to follow blindly as they had no choice but to accept the situation and find ways to improvise and ensure the work got done. Subordinates, management as well as the work environment rendered them hopeless and helpless.

> *Are they seeing these challenges we are facing? Are they really seeing them?"* (Participant 5)

Not ticking all the boxes: things left undone - A sense of despair and helplessness were present when participants were unable to perform all the duties expected, and all the tasks required of them due to circumstances beyond their control, such as staff shortage, patient acuity and other challenges as discussed under theme 1. These emotions were more prominent amongst the participants with two or less years' work experience.

> *"…as you see I'm alone. I work hard. It's time for my lunch now, then they give me the discharges, they talk about the wounds. As I'm a junior sister in this hospital… it's hard to manage this ward alone." (Participant 2)*

No voice - Participants experienced feelings of disappointment, futility and despair as their concerns were not addressed and they were left exposed to function in an environment where their professional practice was compromised. They experienced powerlessness to

address challenges or bring about change in their capacity at the institution. Participants were desperate for interventions, but seemed to have lost hope that it would materialise.

> *"It's a big risk but they don't do anything about it. They don't. Are they seeing these challenges that we are facing? Are they really seeing them?" (Participant 5)*

Being taken for granted: why do we try? – Participants did not feel appreciated, valued or treasured as employees. Due to their efforts not being recognised, some became demotivated and disillusioned. Participants doubted if the nursing management even cared for them, or recognised their efforts at all as they exposed themselves to potential life-threatening situations in an attempt to uphold patient care. They therefore also experienced feelings of despair, which could contribute to desensitisation and detachment and have negative consequences on patient care.

> *"They are not looking at the staff. Do they have enough staff? Do they have enough equipment? Sometimes there's not even those masks to go to that MDR patient. What are they thinking about us? What about us? What are we here for? Are we here to help or are we here to also die? We risk our lives. Then we're dead and we can put a candle with a cross and a picture."* (Participant 5)

A sense of despair existed as participants were left disempowered and risked becoming indifferent towards their challenges and the consequences it had on them. Frustration, demotivation, powerlessness, guilt and discouragement added to feelings of being emotionally drained, reluctant to go to work in the morning and despondent to fulfil their duties.

> *"Ek voel partykeer moedeloos, niks meer lus om dit te doen nie."* (Participant 1)
>
> Translated response: *"Sometimes I feel discouraged, not in the mood to do it anymore."* (Participant 1)
>
> *"When you wake up in the morning you don't feel like coming to work, especially if you're working alone…"* (Participant 5)

The psychological impact of the work experiences was so severe that one participant feared being admitted in a psychiatric ward due to the effects it had on her.

> *"…Because if I can keep focusing on what is happening there I will go mad. Seriously. I will admitted there in psych… They will admit me in psych the way things are in those wards."* (Participant 7)

Life after work – The feelings of despair that participants experienced during their work day were often still present when they were at home. Participants shared their experiences of the consequences that the working conditions had on their personal lives and relationships with their family members. At times they found it difficult to spend quality time with loved ones, as their thoughts were still with work, and found themselves withdrawing from family and friends.

> *"So when we work, or you work as if there's no tomorrow. You work as if you don't have a family to look after when you get home. When you get home you just sleep. You are just so, so tired."* (Participant 5)

Dwindling professionalism: the abused becoming the abuser - Participants experienced that their own professionalism was challenged by the consequences of the adversities in the work environment. Despair and demotivation seemed to have contributed to deterioration of participants' professionalism and positive role-modelling. Consequently they were guilty of confronting staff in front of others and being rude towards nursing managers. Due to the circumstances they became the perpetrators of vertical violence and displayed similar behaviour to others as their managers and subordinates inflicted on them. The contradictory role of being the victim and also the perpetrator could contribute to experiences of moral distress.

> *"Maar ek was so kwaad dat ek haar sommer net daar voor die pasiënt… ek weet dit was verkeerd… En dit was nie reg nie, mar ek was nou rerig baie baie kwaad."* (Participant 6)

> Translated response*: "But I was so angry that in front of the patient … I know it was wrong… And it wasn't right, but I was really very very angry."* (Participant 6)

> *"…when you're asking someone to do something and they don't. Maybe ending up shouting at the person, which you're not supposed to. Afterwards you calm down and you say, "I was wrong by doing that."* (Participant 5)

Catch 22: To leave, or not to leave - Due to the challenges they experienced, some participants doubted that they made the right career choice.

> *"It's really, really, unfair towards us. It makes you think: Did I choose the right career? Am I sure I still want to be a nurse? Because if it's so challenging, if it's so life threatening, do I still want to be here?"* (Participant 5)

Although none of the participants intended to leave the profession, some intended to leave their current employment. Some of the participants viewed that leaving their employment was the only solution as no other attempts have proved successful to bring resolve to the

challenges they are faced with. Reasons for leaving their position related to the restrictive and unsupportive working environment that they were exposed to and the conditions under which they were expected to perform their role without compromise.

> *"Ek is besig om 'n ander werk te soek… Dat ek net hier uit… Ek kan nie langer bly nie..."* (Participant 1)

> *Translated response: "I'm busy looking for another job… So that I can just get out of here… I can't stay any longer."* (Participant 1)

Despite their intent to leave, some participants felt compelled to stay for financial reasons. If external motivation was their only reason for going to work, they might be withdrawn, desensitised or detached from patient care, merely going through the motions of completing their shift. By implication, some participants will accept (although reluctantly) the working conditions as the norm that cannot be changed and risk becoming morally mute, giving up their voice for change and doing what is right, completely.

> *"But if I can get any opportunity, any way out. But for now it's, I'm getting a salary at the end of the month. Life goes on."* (Participant 5)

4.3.6 Fear

Various situations elicited a sense of fear amongst participants due to the possible consequences involved.

Unfinished tasks - There was a sense of fear amongst participants when sharing their experiences of incomplete tasks and "doing something wrong" or "what might go wrong". There seemed to be underlying tension throughout the shift as participants anticipated and feared potential adverse events. They were constantly aware of their responsibilities and desperate to prevent it from occurring, even if it meant sacrificing their break times in order to ensure all the work gets done.

> *But if you are one, no! It's impossible especially in medical ward. It's impossible!"* (Participant 7)

Personal shortcomings: reluctance to commit - The added responsibility and fear of the consequences of inaccurate interpretation of ECGs was a distressing situation some would rather avoid. Similarly participants seemed reluctant to accept tasks and duties due to a fear of what might go wrong, such as being in charge of the hospital at night. The potential consequences of their own shortcomings seemed to be a deterring factor to act due to fear

of not being able to perform to the expected standards (as with a code blue mentioned) and the resultant consequences.

> *"Dit kom toe ook nou daarop neer dat as jy dit gedoen het en daar makeer iets dan moet jy die dokter laat weet daar's 'n probleem. No ways!"* (Participant 1)

> Translated response*: "Then it came down to it that if you did it and something is missing, then you must let the doctor know there's a problem. No ways!"* (Participant 1)

Avoiding confrontation - There was even a reluctance to address insubordinate staff members, due to the clear lack of respect towards them and fear of the repercussions of the reactions they were likely to receive.

> *"But there is someone I'll never ever in my life talk to, because when I get home I'll be crying. She will tell me something that will sit on my mind for the rest of my life, so I better not. You avoid people like…rude people. You better avoid them."* (Participant 5)

Breaking the rules - Several of the participants mentioned intrusive thoughts about work that they experienced when they were off duty. Often the thoughts were related to their own concern for not completing all their duties or not completing tasks to the expected standard. Their inability to do what they considered to be the right thing could contribute to feeling morally distressed.

> *"Dis nogal iets wat mens kan onderkry, want jy lê by die huis, dan dink jy: jy het dan geweet jy moes die ding so gedoen het, hoekom het jy dan nou nie so gedoen nie?"* (Participant 6)

> Translated response: *"That's something that can get you down, because you are lying at home, then you think: you knew you should have done something in a certain way, then why didn't you?"* (Participant 6)

> *"But at night when you get to bed it all comes back. You think, why didn't do, what did I do wrong…"* (Participant 5)

Due to lack of support from managers and a culture of disciplining, a sense of fear seemed to be prevalent at the notion that anything went wrong, or anyone did something wrong. Participants were improvising and breaking the rules to ensure all the duties were performed. They feared the consequences of incomplete tasks, but equally feared the consequences of their shortcuts.

4.3.7 Coping strategies

Participants expressed various ways in which they coped, or even "survived" their challenges and profession. Some participants relied on their years of experience in nursing

to help them deal with situations more effectively, or even on the experience they gained during their time of employment at the institution. The experiences gained at other institutions have also equipped some of the participants with adequate coping mechanisms.

> *"Jy raak seker maar ouer en jy weet dan hoe om 'n situasie te hanteer en om kalm te bly. Dit het ek aangeleer, om kalm te bly."* (Participant 3)

> Translated response: *"You probably get older and you know how to manage situations better and how to stay calm. I've learned it, to day stay calm."* (Participant 3)

Talking about the challenges: sharing experiences - Informally talking to colleagues or family members about challenges experienced was mentioned as a coping strategy by the majority of participants.

> *"We talk like, maybe as colleagues. We just talk about it generally. We don't say "It happened to me." We just talk about it generally, sometimes it help to just discuss about it."* (Participant 5)

Some participants made use of the bimonthly in-service training sessions to discuss challenges with their colleagues in the absence of management.

> *"We talk about those challenges there because we are free there. There is no management. That's where I get to talk about work experience."* (Participant 5)

Rest and relaxation - Various ways of relaxing were mentioned, ranging from listening to loud music, participating in social activities outside of work and having "me-time".

> *"Sometimes I play music so hard. Gospel music. It also makes me to relax."* (Participant 7)

> *"Wat ek ook probeer doen is om af te skakel as ek by die huis kom… Ontspan in 'n bad of net 'n movie kyk…"* (Participant 3)

> Translated response: *"What I also try to do is to shut down when I get home… Relax in a bath or just watch a movie…"* (Participant 3)

Shifting the focus - Some participants coped by focussing on patients and their relationship with staff members, and rather removing themselves from negativism.

> *"Ek dink ek kom deur al hierdie "dit" omdat ek my in die personeel se verhouding ingooi en die pasiënte se verhouding."* (Participant 1)

> Translated response: *"I think I get through all of "this" because I focus on my relationship with the staff and patients."* (Participant 1)

> *"Ek sal net by die pasiënte gaan staan, 'n stukkie te vertel of te lag."* (Participant 3)

Translated response: *"I will just go stand with the patients, tell a joke or have a laugh."* (Participant 3)

Being assertive and staying positive - Being assertive and having a positive attitude was how some of the participants were able to deal with the challenges they encountered.

"Dit is belangrik dat jy maar jou sê, sê. Jy moet op die man af wees met hulle. (Participant 6)

Translated response*: "It's important to say what you want to say. You must be upfront with them."* (Participant 6)

"Challenges mos do happen everywhere, so just kick and go and move on, because this things will happen and you can't run away from them. You just need to have coping mechanisms, that's all." (Participant 7)

Releasing emotions - Many of the participants found that crying helped to give them an outlet to bottled up emotions of frustration and helplessness. It enabled them move on and to face another day at work.

"Sometimes I do cry in my room and say yho! How can I handle this? This is really difficult, but I have to move on…." (Participant 7)

"…dan sal ek in die badkamer sit en huil. Ek voel beter agterna…" (Participant 3)

Translated response*: "…then I will sit in the bathroom and cry. Afterwards I feel better…"* (Participant 3)

Pray: to make it through the day – In order to cope with the challenges at work, one participant particularly prayed for no complications during her shift – specifically no code blue, adverse incidents or complaints that she would have to deal with.

"It's difficult really. But we see how the day goes and we just pray. When I come to work I just pray." (Participant 4)

In some cases where participants acknowledged to a manager that they were unable to cope with the expectations, they were accused of having an "attitude". No resolve was offered. This further demonstrated the management's indifference towards the challenges and consequences the participants had to endure.

"If you say here you can't cope with whatever, they (management) say you've got attitude. If you refuse to do things they say you've got attitude." (Participant 7)

Findings indicated that participants had created and implemented their own coping mechanisms, only aiding them to deal with the consequences of the challenges experienced and providing short-term relief. Years of experience seemed to positively contribute to implementing healthy coping mechanisms. No formal interventions were initiated by nursing management that added to disappointment and hopelessness the participants experienced. They had no choice but to develop their own coping mechanisms if they wanted to survive in their work environment.

4.4 SUMMARY

This chapter discussed the findings. The biographical details of participants were presented as well as seven themes with sub-themes that emerged from the interviews.

It is deduced that moral distress is present and experienced by participants in varying degrees. Findings were indicative of participants experiencing personal and professional consequences of morally distressing situations such as shouting at colleagues in front of patients and withdrawing from family and friends. Due to the working conditions, one of the participants feared being admitted to the psychiatric ward, a clear indication of the distressing and unhealthy environment they are subjected to and that must be endured.

From the findings it appeared that experiences of moral distress were strongly associated with situations that compromised participants' ability to perform their duties according to the desired personal, professional and legislative standards. These situations were more often experienced when associated with various staffing, management and resource challenges and an undercurrent of a task-orientated, uncompromising, change resistant, autocratic organisational culture. Managing complaints and relationships with doctors were also indicative of contributors to experiences of moral distress, but to a lesser degree. Participants managed to develop their own coping strategies. Their powerlessness, despair, fear, indifference, desensitisation and intent to leave confirmed that moral distress was experienced.

The relationship between the themes seemed to revolve around the emerging autocratic and detached nursing management. The organisational culture did not seem to promote ethical practice and PNs found themselves in a no-win situation – they were "damned if they do, damned if they don't" – as they were confronted daily with the decision to compromise their professional integrity in an attempt to satisfy legislative, patient and management's demands and expectations at a price that only they will have to pay.

In chapter 5, a concise overview of the key findings of the study will be presented, which will demonstrate the realisation of the study objectives. Based on the findings, chapter 5 will contain appropriate recommendations, a description of limitations, as well as the final study conclusion.

CHAPTER 5:
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In chapter 5, conclusions are drawn regarding professional nurses' lived experiences of moral distress. Based on the study findings, the conclusions will be discussed in terms of the study objectives, thereby also demonstrating whether it was achieved. Recommendations will be made regarding interventions to alleviate situations contributing to experiences of moral distress. The study limitations will be discussed and recommendations for future research made.

5.2 DISCUSSION

The aim of the study was to understand professional nurses' lived experiences of moral distress at a district hospital. A discussion of the study findings associated with each study objective is provided. Study findings interlink between the three study objectives.

5.2.1 Objective 1: Describe professional nurses' lived experiences of moral distress

Prior to the study, the participants were not acquainted with the term moral distress, but the findings of this study indicated that moral distress was experienced by professional nurses practicing in the general medical and surgical wards. In a Malawian study (Maluwa *et al,* 2013: 203) the participants were also not familiar with "moral distress" prior to the study, and Rice *et al.* (2008: 368) found that moral distress was commonly experienced among nurses practicing in medical and surgical wards.

The findings of this study demonstrate an understanding that moral distress is experienced when participants are confronted with situations that prevent them from performing their duties to the required professional standard. These situations relate to staff shortages and lack of resources, which necessitate them to improvise in order to deliver patient care, often not to their personal or professional desired and required standards. Improvisation also included, at times, acting against prescribed policies and procedures. The current study revealed situations that arose where professional nurses' actions were in conflict with legal frameworks when following their own moral decisions. An example is where participants had to issue scheduled drugs without a witness. The latter is confirmed in a Swedish study completed by Kälvemark *et al*. (2004: 1083). The resultant consequence could have disciplinary implications from their institution or regulating body (SANC) as it is contravening

the regulations of their practice. The findings revealed that participants were aware of the possible consequences.

Experiences of moral distress were further exacerbated after making the decision to break the rules. They experienced fear, self-doubt and regret about their chosen actions, often when they were already off duty and plagued by intrusive thoughts about what happened at work and were burdened about the possible consequences of their actions. Similar findings were revealed in international studies by Wilson *et al*. (2013: 1461) and Maluwa *et al*. (2012: 204). Cullinan (2006) also confirmed that the implications of staff shortages were increased workload and high expectations of those who remain in the public health sector. In their study it led to demoralisation, absenteeism and burn-out of the already limited manpower.

One particular factor causing distress in the current study was when complaints were raised by patients or family that could possibly result in disciplinary action against the professional nurses on duty thereby questioning their integrity and competence without considering the challenges in the work environment. Participants of the current study were often mistreated by relatives of patients and Farrell (1999: 538) confirmed that negative behaviour towards nurses from patients or their relatives were found to significantly contribute to experiences of moral distress. It was found in the current study that the nursing management seemed to have a zero-tolerance stance towards complaints. However, they failed to support the professional nurses' plight regarding staff shortage and other challenges experienced in the clinical environment. The failure of management structures in public hospitals was found by Cullinan (2006) to be one of the contributing factors why conditions in public hospitals in South Africa have become increasingly stressful.

Moral distress has become a major problem in the nursing profession and is common in situations of staff shortage, lack of competent staff and restricting nurses' autonomy to meet the need of patients and their families (Corley, 2002: 636). Moral distress destroys the integrity of the healthcare providers and compromises their core values, with the lasting effects leaving them morally desensitised and with intent to leave their profession (Hamric, 2012: 47). The findings of Hamric (2012: 47) and Corley (2002: 636) are aligned with those of the current study (see section 4.3.5).

In the current study it was found that relationships between nursing staff of all levels and categories contribute to experiences of moral distress as participants were exposed to horizontal and vertical violence and poor role-modelling in the workplace which rendered them powerless, helpless and disillusioned about the profession and their role. Expression of disregard and disrespect was displayed towards some participants in front of other staff

members and patients. Considering the abuse participants of this study endured from colleagues and patients' relatives, Khalil's (2009:216) findings confirmed that when nurses publically display disrespect towards other nurses, it encouraged patients and members of the public to display similar behaviour towards nurses.

Relationships between doctors and nurses were strained due to the doctor–nurse hierarchy that left PNs feeling inferior. There was a perception that the PNs were expected to perform the doctors' duties and adopt some of their responsibilities. However, professional nurses were already overwhelmed with nursing tasks and did not react well to additional duties. With the doctor-nurse relationship already strained in an environment at risk for causing moral distress, Rushton, Caldwell & Kurtz (2016: 43) also confirmed that the presence of moral distress amongst different healthcare professionals could further contribute to a breakdown in multidisciplinary teamwork and communication.

Participants developed their own coping mechanisms to deal with their experiences of moral distress in the absence of acknowledgement and interventions from nursing managers or the broader organisation to provide any form of support. Findings of a study by Rushton *et al.* (2016: 40) concurred that nurses have a responsibility to address their own distress even though their primary obligation is towards patient care. Through daily exposure to situations where moral distress is not acknowledged or addressed, the influence is evident in the crescendo effect discussed in Chapter 2, section 2.5.2. As Epstein and Hamric (2009: 11) stated: "It is not appropriate to expect highly skilled, dedicated and caring healthcare professionals to be repeatedly exposed to morally distressing situations when they have little power to change the system and little acknowledgment of these experiences as personally damaging or career compromising" (see section 2.7.3).

The consequences of moral distress on participants of the current study were noteworthy. This concurred with findings of a study by Pauly *et al.* (2009: 569) indicating that moral distress might not occur frequently; however it had significant consequences when it was experienced. As moral distress is associated with burnout and nurses' intent to leave their position or profession, it is important that it must be identified correctly (see section 2.5.3). When mislabelled as an ethical dilemma or compassion fatigue, the interventions to attempt to resolve it will differ (Trautmann, 2015: 288). It is vital that experiences of moral distress are acknowledged in the organisation in order for appropriate interventions to be implemented to address the root causes effectively.

5.2.2 Objective 2: Describe the influences that moral distress have on the lives of professional nurses

Objective 1 aimed to understand professional nurses' lived experiences of moral distress. In a quest to understand the lived experiences, the influences of moral distress, objective 2, was partly addressed and therefore, some overlapping of information is presented.

Moral distress has emotional, mental and psychological influences on the PNs in the current study, as well as implications for their personal lives and professional behaviour (see section 4.3.5 and 4.3.6). Experiences of moral distress caused to some participants to become disillusioned and desensitised, and they even avoided difficult patients or intended to resign from their job. Such behaviour influenced the quality of patient care. These findings were aligned with the findings of Maluwa *et al*. (2012: 204) who similarly established that due to moral distress, nurses failed to deliver adequate physical care because they avoided patient contact and lost their capacity to care due to the physical and psychological consequences they suffered.

Participants of the current study experienced frustration, powerlessness and despair, especially due to staff shortage and the excessive workload pressures they had to cope with whilst not being adequately supported by managers or subordinates to deal with these challenges. Similarly, findings of a study by Maluwa *et al*. (2012: 204) identified frustration, hopelessness, powerlessness, anger and insomnia resulting from experiences of moral distress. Current study findings indicated that managers were indifferent and detached when participants reported challenges related to staff shortage to them. Humphries and Woods (2015: 10) confirmed in their study findings that staff shortages, high patient volumes and managers' reactions when staff shortages and patient care issues were reported to them, were inter-related influences resulting in moral distress. Participants of the current study further also experienced feelings of disempowerment and consequent lack of confidence and self-doubt due to the disrespect that subcategory staff displayed towards them as PNs.

Participants in a study by Rushton *et al*. (2016: 42) compromised their moral integrity, however it was not always justifiable (such as in an emergency) and the findings of the current study confirmed this. For participants in the current study these compromises became the norm of their daily practice due to the working conditions that required them to improvise to any extent, as long as the work got done. They were also desperate to make any effort in order to avoid negative consequences due to incomplete tasks. Similarly to participants in a study by Humphries & Woods (2015: 1; 10) the PNs of the current study also had no choice but to compromise in an uncompromising environment due to the constraints they were faced with.

Some participants in the current study experienced the lingering effects of moral distress when they were at home, having intrusive and obsessive thoughts about how they managed situations at work and the possible consequences if things went wrong due to them not following policies and procedures, or innocently forgetting to complete a task. One participant remarked: “Jy lê by die huis dan dink jy: jy het dan geweet jy moes die ding so gedoen het, hoekom het jy dit dan nou nie so gedoen nie? (Translated response: “You lie at home thinking: you knew how you were supposed to do something, why didn’t you do it like that?”). A study by Hwang and Park (2014: 38) confirmed that nurses experiencing moral distress were more likely to make medical errors when performing their duties. Consequently, participants in the current study withdrew from their family, indicating that moral distress had a negative impact on their personal and family lives, “when (they) get home (they) just sleep” which is what Maluwa *et al*. (2012: 204) also found.

For participants in the current study, being the victims of bullying in the workplace contributed to experiences of moral distress. This finding is supported by a study by Rushton *et al*. (2016: 44) which found that discrimination and inequities within health care was associated with experiences of moral distress and led to feelings of helplessness and an inability to act morally. Perversely, participants in the current study also became the perpetrators of bullying, which equally caused them to feel morally distressed, as they “end up shouting at the other person, which you’re not supposed to do” (see section 4.3.5). This finding confirms the findings of Farrell (2001: 29) that aggression can breed aggression and when members are exposed to it as the norm in the work environment they might copy the negative behaviour.

The accumulation of various aspects of the work environment leading to moral distress resulted in an overall feeling of despair to the extent that some participants dreaded going to work in the morning or feared being admitted in a psychiatric ward. Such reactions are also indicative of the crescendo effect as discussed in section 2.5.2, and in Objective 1.

Although not a study aim of the current study, the negative impact that moral distress has on patient care is indisputable (see section 2.7.2). Findings of the current study indicated that often, only required patient tasks are performed due to excessive patient loads or staff shortages. Participants experienced moral distress and guilt when they were unable to perform basic care and by implication, holistic patient care was neglected. The delivery of quality patient care was compromised. Due to the overwhelming working conditions, critical tasks were demoted to “small things”, which might not be performed at all, to the required standard or with the necessary attention. The findings were similar to that of De Veer *et al*. (2013), who found that moral distress arose when nurses felt that they did not have enough

time to provide the quality of patient care they desired. As one participant stated, “aan die einde van die dag kon jy nogsteeds nie alles bereik wat jy wil graag gedoen het nie” (Translated response: “at the end of the day you still could not achieve everything that you wanted to do”) (see section 4.3.1).

Nurses in a study by Schluter *et al.* (2008: 316) denied that their experiences of moral distress impacted on patient care and participants in a study by Maluwa *et al*. (2013: 204) were of the opinion that they *were* able to provide effective patient care. Yet, in working conditions where moral distress was experienced, the likelihood that provision of quality patient care will be compromised is high. Decreased communication, lack of co-operation between staff, inability to be familiar with all the patients in order to address all their needs and provide emotional support (Maluwa *et al.*, 2013: 204), fewer experienced staff, and challenges with prioritising patient care (Woods *et al*., 2015: 128), are all associated with moral distress caused by staff shortages that was also evident in the current study’s findings.

Due to experiences of moral distress, there was an indication that some participants in the current study would leave their job. This reaction was related to the collective challenges they experienced, such as the consequences that staff shortage and disrespect had on them as PNs, but also personally; like high demands and lack of support; no opportunities for professional growth due to an organisation’s resistance to implement updated practices and failure to show appreciation and concern for their nursing staff. These situations rendered them powerless and helpless, filled with despair and frustration. The only options available were to either accept their working conditions (which also caused moral distress) or learn to deal with the situations they cannot change, or to leave. Previous studies (Hart, 2005: 177; Schluter *et al*., 2008: 319; Hwang & Park, 2014:36) emphasised the importance of the hospital ethical climate and organisational culture (Jacobs & Roodt, 2008: 73) in nurses’ decision to leave their positions or the profession (see sections 2.6.2 and 2.7.3). These findings provided insight into the possible reasons why three of the participants in the current study indicated their intention to leave their current job (see section 4.3.5).

Years of service in the profession and the institution could prove to be mitigating factors in experiences of moral distress (see sections 2.6.2 and 2.7.1). Filipova (2011: 60) found that nurses practicing at facilities for one to two years expressed higher intent to leave than those with more than 10 years of employment at a hospital. Findings of the current study related to demographics of participants differed from literature, as half of the participants employed at the hospital for 5 years or less (n=5) expressed their intent to leave, irrespective of years of experience in the profession.

According to Maluwa *et al. (*2013: 205) older nurses appeared more resilient than younger nurses to situations causing moral distress, likely due to their life experience. The older PNs in the current study, with vast years of experience as professional nurses, neither conveyed the same feelings of despair as the younger participants, nor declared that they experienced bullying from subordinate staff. They also seemed to have better developed coping skills, likely due to life and professional experience as Maluwa *et al.* (2013:205) alluded to. However, the intention to leave was still present amongst them. With younger nurses more susceptible to moral distress than older nurses (Woods *et al*., 2015: 127) and leaving the profession due to the stressful working environment, as what was found in the current study, nursing shortages will continue, and retaining nurses becomes essential (Mokoka *et al*., 2010: 8).

5.2.3 Objective 3: Describe the causes of moral distress experiences

In an effort to understand experiences and influences of moral distress, the third objective (exploring the causes) was also addressed and therefore overlapping of information is present. Causes of moral distress for participants in the study were mainly contributed to external factors, especially insufficient staffing, rendering them powerless to change their situation. The root causes extend beyond the institutional constraints as in Jameton's original definition of the concept (Hamric, 2012: 41).

Situations that lead to moral distress placed emphasis on the need for professional nurses to act as patient advocates (Barlem & Ramos, 2015: 613) as required by Regulation 767 of the Nursing Act (33 of 2005) (SANC, 2014). Causes of moral distress were identified in previous quantitative and qualitative studies and included factors internal to the caregiver (powerlessness and lack of knowledge), external factors related to the situation (shortage of staff, no administrative support, incompetent healthcare workers and clinical situations) (Hamric, 2012: 41), which was confirmed by the findings of the current study. External causes identified by Woods (2015: 128) included insufficient resources, poor leadership, recruitment and retention difficulties, indifferent and unsupportive organisational cultures, and lack of organisational support, which once again aligns with the findings of the current study. The root causes of participant's experiences of moral distress are discussed below.

Bullying in the workplace (see section 2.6.3.4) – Whether participants experienced horizontal or vertical violence, the influence it had on them was severe and morally distressing. Bullying by subordinates influenced their ability to act with confidence and authority as professional nurses; bullying from superiors hampered their opportunities for professional growth. Although one might be of the opinion that professional nurses would have empathy for each other as they are exposed to similar challenges, evidence of

horizontal violence is present in situations where a scapegoat is needed. Therefore there was very little support from any level in the organisation and participants had no ideal ways to cope with the situation themselves.

Similar to a Malawian study, nurses in the current study also experienced moral distress due to disrespect from all levels – peers, managers, patients and doctors. Professional nurses' expectation to be respected in their role was not met. Such disregard influences their ability to treat patients with the necessary dignity and respect (Maluwa *et al*., 2013: 204). Findings by Ulrich *et al*. (2007: 1716) confirmed that lack of respect in the workplace was associated with negative attitudes and psychological effects as experienced by participants of the current study.

Findings of the current study was aligned with Farrell (2001: 31) who identified that conflict within nursing could be related to generational and hierarchical influences, but is exacerbated by poor role models and ineffective management of conflict amongst staff. Such conditions enabled the conflict to continue and resulted in a toxic work environment, which was unsafe for patient care (Sousa, 2012: 30) as was also found in the current study.

Managers should act like role-models (Maluwa *et al*., 2012: 205) which were also the sentiment of participants in the current study. Poor role-modelling by nursing mangers was discussed in Chapter 2 (see section 2.7.3.4) and was described by participants with comments like: "…kom daar in en sy begin op ons te gil en skree (Translated response: "…came in there and she started screaming and shouting at us" – see section 4.3.2).

The consequences that bullying had on participants who were newly graduated and newly employed at the institution, were particularly noteworthy and concurred with Sousa's (2012:29) findings that new graduates or employees are often the targets as they are still insecure in their roles and have not developed collegial support systems within their work environment. New staff and younger nurses in the current study were particularly prone to incidence of lateral violence by existing staff that undermined their integration into the new environment. When rudeness is common practice in a department, it is easily adopted by the staff practicing in the area (Stanley *et al.,* 2007: 1259) as was evident in the current study findings.

When subgroups prevent meaningful interaction with the rest of the group, it can also be referred to as a clique, who gains control and resist change (Farrell, 2001: 29). The experience of disrespect and disempowerment of three of the African participants related to other categories of nurses' acceptance of their role, could be attributed of cliques within their

wards, which were racially motivated (see section 2.4). Discrimination in the public health sector in Cape Town is still a challenge despite racial tolerance that has been promoted in the country by democratically elected governments (Khalil, 2009: 2015). When nurses share similarities, subgroups (cliques) could form. Cliques of nurses on ward level can act as a tool to disregard "those who are perceived as different or who are seen as a threat" and can instigate interpersonal difficulties between colleagues (Farrell, 2001: 29) as is evident in the current study findings. The possibility exists that cliques were present in the wards where participants in the current study worked, which disregarded the authority of newly qualified and appointed professional nurses. Professional nurses directly supervise subordinate nurses (ENs ad ENAs) and are responsible for the acts and omissions of those they supervise (Geyer, 2015: 36). If their credibility was compromised through cliques, they would be unable to effectively fulfil their supervisory role and would not be able to hold subordinates accountable for their own acts and omissions. Such conditions added to the workload of the PN, resulting once again in them compromising their own practice to ensure all duties were performed and tasks completed.

Restricted work practices – Some participants in the current study became so task-focused that addressing patient needs were neglected and patient requests dismissed if it did not relate directly to the task they were busy performing. They experienced moral distress when their tasks were interrupted and incomplete, but also when they were unable to address patients' needs timeously. Participants described not being able to always provide analgesia when requested "when you finally arrive you can see the patient is really in pain" and the feelings of guilt it evokes "then you just explain to the patient, "Please forgive me; I feel so guilty" (see section 4.3.1). This finding is supported by results from Schluter *et al.* (2008: 318) that indicated that nurses experienced frustration and guilt resulting from their inability to provide the care they wished.

A shift was viewed as over when all the nursing tasks for the day were completed, and if not, it was not received well by the shift taking over, even preventing them from handing over. As one participant stated, "if you hand over things that happened in the day, they don't want to follow (it) up" (see section 4.3.1). Nursing tasks are performed within strict rules, task and time guidelines (Farrell, 2001: 28) that becomes the ward routine. In the current study, inexperienced nurses structured their workload around time and tasks to the extent that patients are also seen as tasks to be completed, as indicated by responses like "I will finish my IV's, I will help the staff nurse to give oral medication" (see section 4.3.2). This was supported by Farrell (2001: 28) who found that nurses became caught up in the schedules,

tasks and routines, to the extent that if tasks are not completed, they are unable to go on their tea or lunch break, which are often inflexible timeslots.

By solely focussing on routine tasks, nurses missed the opportunity to act with innovative ideas (Olsson & Gullberg, 1991:32). Similarly to the current findings, Maluwa *et al*. (2012: 203) found that nurses experienced distress when they are unable to provide care resulting in the patients suffering due to incomplete tasks. Delayed responses, dismissiveness, medical errors and ignoring patient requests could also be an indication of nurses' absence of moral courage (Hawkins & Morse, 2014: 268) and presence of moral distress as evident in the current study results.

Resistance to change – Participants in the current study identified resistance to change in organisational processes as well as individual staff members (see section 4.3.1) as causes of moral distress. It became morally distressing for participants when staff resisted changing practices that could improve care and when they were forced to follow outdated guidelines, even though they knew better. Findings of the current study concur with Farrell (2001: 31) who identified that he nature of nursing work practices often hamper change and productive working relationships, leaving nurses feeling disempowered.

The legal requirement for a diverse work environment came as a culture shock for some employees in South Africa. Challenges resulting from interpersonal relationships in a diverse work environment include anger, apathy and hostility (Gwele, 2009: 7). It is important for employees to understand that diversity is not static (Jeffreys, 2008: 39) and does not only refer to ethnicity, but also to broader cultures within nursing – for example new graduates making the change from student to professional. Subgroups forming amongst nurses who share characteristics, could contribute to the resistance to change – fear of the unfamiliar and unknown – when the subgroup distantiate themselves from the larger group (Farrell, 2001: 29). The effects of cliques were discussed earlier as it is also associated with workplace bullying that was found in the current study.

Shortage of staff (see section 2.6.1) – An underlying cause of moral distress in the current study was participants' perception that there was a staff shortage which left them unable to deliver safe, comprehensive, quality patient care. Because of the staff shortage, participants experienced excessive workloads and had no alternative but to improvise in order to get all tasks completed. They were constantly confronted with the possibility of complaints about poor nursing care, the risk of litigation and being guilty of negligence. They were exposed to severe pressure to ensure everything got done without complications, yet without the necessary support from staff or nursing management. Considering the nursing

management's stance of no replacement of staff, one might consider that they did not agree that shortage of staff was present. The current study findings are aligned with those of Corley (2002: 638) and Woods (2015: 126) who found that situations creating moral distress are exacerbated by the growing shortage of nurses and incorrect staff skills mixes for specific units. Patients with complex, life-threatening and chronic conditions imposed higher demands on the staff members who were allocated to care for them (Allen *et al.,* 2013: 116) confirming what participants in the current study experienced. As the only professional nurse on a shift in a ward with 25 patients, participants only have 2,4 minutes per hour to address each patient's needs (see 2.4).

Staff shortages gave rise to medico-legal risks which threatened patient care (Mokoka *et al*., 2010: 8) and resulted in criminal acts as the system forced professional nurses in the current study to break the rules by taking shortcuts. Participants referred to their inability to manage schedule drugs according to legal prescripts, often due to staff shortages (see section 4.3.1). Study findings indicated that participants were aware when they were breaking the rules and accepted responsibility for their choice of actions to do so. Non-adherence to legal prescripts was motivated by the patients' best interest. Lachman (2007: 277) reported that in medical-surgical environments, nurses always found themselves with the choice to do the right thing even if it was more time-consuming and they lacked the confidence to voice their concerns, which was also the case for participants in the current study. Due to staff shortages, participants felt they had no alternative than to transgress. Similarly to findings by Sorensen *et al*. (2009:884), participants in the current study experienced frustration when held accountable, but no attention was given to the variables influencing their job satisfaction, such as recognition, rewards or opportunities for professional growth. In order to motivate staff and build their self-esteem, it is crucial for managers to acknowledge and appreciate the contributions that they make (Pietersen, 2007: 59), which was a clear desire from participants in the current study.

Accountability at the institution where the study was conducted was enforced by the threat and implementation of disciplinary action. Participants shared their experience of feeling unsupported and being disciplined or being threatened with disciplinary action from their managers when facing complaints or problems (see section 4.3.2). As Farrell (2001: 31) indicated, conflict amongst nursing staff is often resultant from misplaced frustration due to lack of autonomy in their own working conditions and attempts to implement change are unsuccessful and the fear of punishment a constant reality, such as the conditions that the participants of the current study were exposed to. Defensive, unsupportive and punishing organisational cultures prevent nurses from doing the right thing (Gallagher, 2010).

Lack of management competence and support (see section 2.6.3.4) – Findings of the current study indicated that nurse managers did not provide sufficient support for professional nurses to manage the challenges they were faced with in the clinical area, possibly due to their own lack of competence to fully perform their role. Such incompetence and lack of support contributed to experiences of moral distress as participants were expected to deal with challenges and consequences on their own, and the manager's intervention extended only to a punitive action without any recognition for what the participants must deal with. The lack of competence also translates into a lack of understanding of the intensity of the challenges and being indifferent to the predicaments the professional nurses were confronted with, hence resulting in a lack of reaction to address their concerns or provide physical support in the clinical area. These study findings were supported by the work of Vaziri *et al*. (2015: 36) who found that lack of support from management increased moral distress and decreased job satisfaction. The manager (and management) has a role and responsibility to fulfil in establishing and maintaining a productive and positive culture amongst staff practicing in the same unit (Stanley *et al*., 2007: 1262) and is obligated to create a healthy work environment where nurses will not be subjected to unprofessional behaviour such as intimidation, threats, shouting from peers, managers, patients or doctors (Maluwa *et al*., 2012: 204). Sadly, this was not the case for participants in the current study.

Evident in the current study and in literature (Farrell, 2001:30), it appeared that participants did not get the attention from their managers that they deserved – that managers were passive towards the welfare of their colleagues. The development of an efficient and effective health service is hampered by a lack of management capacity at every level of the health sector (Cullinan, 2006). Findings of the current study concurred with findings from Mokoka *et al*. (2010: 8) that nurse managers lacked the power, managerial and leadership skills required to manage a multigenerational nursing workforce. Such a diverse workforce required more knowledge to deal with situations influencing nurses to the extent that they wanted to leave their employment. Managers require effective interpersonal skills to address challenges amongst staff. However, in some cases in the current study, these skills were not developed due to managers being promoted prematurely, hence lacking skills to effectively fulfil their role. People management requires a vast number of complex skills, yet the requirement for nurse management positions in Australia, as in South Africa, does not require formal managerial skills as much as managerial experience (Farrell, 2001: 31) (see section 4.3.2).

Nursing managers' responses towards moral distress ranged from identifying it as a sign for organisational change, unavoidable in clinical practice and had to be accepted or dismissed (Pauly *et al.,* 2012: 7). However, findings of the current study suggest that the nursing management at the institution was indifferent and dismissive towards the professional nurses' challenges and the possible effects it had on them. In ethically difficult situations, managers and peers should be willing to advocate for each other (Schluter *et al.,* 2008: 318), a practice that was not present in the current study findings. Study participants experienced their managers as unsupportive and not awarding them the opportunity to explain themselves, nor do they advocate for them (see section 4.3.2; 4.3.5).

Lack of orientation – Newly appointed employees in the current study, whether new graduates or with years of experience in nursing, identified the lack of ward orientation as a challenge, which could contribute to experiences of moral distress (see section 4.3.2). Lack of orientation leaves them uncertain of internal policies and procedures and unable to effectively fulfil their role without clear guidelines as to what is considered right or wrong in the organisational context. Findings supported Wagner's (2015: 11) conclusion that especially nurses with less experience needed assistance from more experienced nurses to gain confidence (Wagner, 2015: 11). Development of basic professional knowledge and skill could be hindered by inconsistencies in the experience of transfer from student to professional, leading to a reality shock (Olsson & Gullberg, 1991: 32) which was also true in the current study (see Chapter 2, section 2.6.1).

A good mentorship programme could effectively reduce moral distress in new appointees (West, 2007: 7). Alternatively, nurses receiving good or bad orientation could similarly experience a lack of moral distress, but for varying reasons. Nurses with good education and training and receiving adequate orientation realise the implications of moral dilemmas on their pratice, whereas nurses with poor orientation becomes insensitive towards the implications of moral dilemmas, thereby not experiencing moral distress (Corley, 2002: 646).

Unethical organisational climate – Findings of the current study were suggestive that the ethical environment of the organisation was not conducive for ethical practice, which contributed to experiences of moral distress due to the restrictions that is placed on the participants' abilities to act ethically and within their legal frameworks. When considering the challenges and working conditions professional nurses were exposed to, such as staff shortages, (see Chapter 4, section 4.3.1); concerns raised to management not being addressed; and favouritism (see Chapter 4, section 4.3.2), it is evident that PNs were not provided with an environment supporting them to do the right thing, but merely to ensure that tasks are completed without repercussions.

An ethical work environment guides professional nursing care (Hwang & Park, 2014: 36) (see Chapter 2, section 2.7.2). A safe, ethical environment enables nurses to practice ethically and makes them feel safe, leading to decreased moral distress and increased job satisfaction (Parker *et al.,* 2013), which was desired by the participants of the current study.

5.3 LIMITATIONS OF THE STUDY

The term “moral distress” was unfamiliar to most of the participants. However, they could easily identify with experiences where they were unable to “do the right thing” due to certain limitations. Participants were therefore unable to identify what they were experiencing was defined as moral distress.

The study was conducted at a single site – one public district hospital in MDHS in the Western Cape – and excluded the wider population of the other health care facilities, public or private, in the service area.

As the target group was professional nurses, the experiences of other categories of nursing staff were excluded. Study findings are therefore only applicable to professional nurses at the specific hospital.

5.4 CONCLUSIONS

Findings of the study indicated that professional nurses experienced moral distress at the district hospital. It affected them on personal, professional and psychological dimensions and related to a variety of causes. The most prominent underlying cause seemed to be related to the perceived shortage of nursing staff of all categories and the resulting compromises that are made to ensure basic patient care is provided. Study findings indicated that the professional nurses involved knew what the right things was to do, yet in some instances they chose not to do the right thing for the benefit of the patient. Their intent to leave the profession or their current positions was contributed to a lack of moral courage and a negative organisational culture. The participants felt unsupported, unappreciated and disrespected in their role, creating a sense of despair, demotivation and desensitisation. All of these factors contributed to their experiences of moral distress.

5.5 RECOMMENDATIONS

Recommendations were made based on the causes associated with professional nurses’ experiences of moral distress.

5.5.1 Increasing staffing

As staff shortages were cited by participants as one of the main causes of their experiences of moral distress, increasing nursing staff of all categories per shift should alleviate such experiences. More staff will lower the workload pressures per nurse and enable nursing staff to take initiative and provide holistic nursing care compared to merely being task orientated. The SANC can play a significant role to address power imbalances related to workload (Mathibe-Neke, 2015: 78) such as legislating sufficient nurse-patient ratios and suitable, flexible nursing skills mix prescripts based on patient acuity in a specific ward or unit, in order to render safe, quality nursing care.

The image of nursing as well as the quality of healthcare will be restored through regulated staffing norms (Denosa, 2012). Unless it is enforced through legislation, adequate staffing levels may not be implemented. Different levels of health care require different nursing ratios (Uys & Klopper, 2013:2). An increase in professional nurses per shift will allow for ethical and legal practices as they will not be forced to compromise care by taking shortcuts and breaking the rules, which will also result in a decrease in adverse incidence and complaints and increased quality of patient care provided. To ease workload pressures, more professional nurses should be employed (Mbangula, 2015:51). Investing in higher numbers of professional nurses will lower the risk of adverse incidents and patients dying in hospital and ensure positive outcomes (Uys & Klopper, 2013: 2; Aiken *et al.,* 2002: 1992).

In light of the healthcare budget limitations (see Chapter 2, section 2.4), it might not seem feasible to propose an increase in staffing levels as a recommendation, as by implication there is no money to employ more staff. However, a review in healthcare budget is required when considering the advantages of increased staffing on existing staff as well as patient care and the overall improvement in healthcare delivery it will impose.

5.5.2 Improving management competence and support

As leaders in nursing, managers play a crucial role in establishing workplace cultures and setting the tone for acceptable and unacceptable organisational practices. In order for nurses to feel safe and secure in their positions they require a manager they can look up to and rely on. Competent managers will be able to contribute to the development of a competent nursing workforce, supporting staff to act within their boundaries determined by their scope of practice and within the legal frameworks of their profession.

In order to establish a positive culture and tone in a nursing unit, the manager of the unit has a critical role to play (Stanley, *et al.,* 2007: 1260). Instead of punitive threats, a supportive manager will take cognisance of contributing factors and implement measures that will

prevent re-occurrence of negative incidents and create a learning culture where staff can learn from the mistakes made without fearing disciplinary actions, blame or litigation. Nurses should be encouraged to seek help without the fear of being judged because they can not cope (Hall, 2004: 34). Competent managers will acknowledge their own shortcomings and actively seek interventions for professional development. Workshops, courses and development programmes should be implemented to address the managerial and leadership shortcomings of nurse managers (Mokoka *et al*., 2010: 8).

Competent managers will be aware of gaps in practice of the nursing staff members and seek development opportunities for staff to gain knowledge and skills as required. Managers who act as role-models for practice and set the example that staff are expected to follow, contributes to improving the image of nursing as experienced by doctors, patients, families and society. Organisations need to invest in leaders who will be role models and will enhance ethical practice (Gallagher, 2016:131).

Managers in the public sector should expand their thinking if they wish to improve their understanding of employee behaviours and attitudes to improve job satisfaction (Mafini, 2014: 128). It was found that those staff members who felt supported by their superiors were less likely to report moral distress (Rathert *et al*., 2015: 46). Managers must support nurses in using ethics resources such as stress management, debriefing, referral to professional support or collegial support (Langley *et al*., 2015: 40; Varcoe *et al*., 2012: 54; Corley *et al.,* 2005: 388). Resources that will assist nurses to deal with the impact of moral distress on their personal lives should also be provided (Wilson *et al.,* 2013: 1464), such as free and accessible stress management and counselling services to help nurses deal with their stressful working conditions (Hall, 2004: 34), which is easily available to ward staff (Mbangula, 2015: 51). Cultures where staff feel safe, supported and able to act with integrity can be created where managers build and foster courage among their staff (Kerfoot, 1999: 239).

5.5.3 Improving nurse–doctor relationships

By improving relationships between doctors and nurses, professional nurses will feel acknowledged and valued as a member of the multi-disciplinary team. Miscommunication regarding prescriptions and expectations can be addressed collegially without it resulting in complaints of incomplete tasks, disregard for performing doctor's prescriptions and reporting professional nurses to their superiors, which will result in further breakdown of the already fragile relationship.

Organisational systems that continuously give rise to moral distress can be addressed through inter-professional collaboration in order to create an organisational culture where professional nurses can fulfil their obligations without compromising their integrity (Hamric, 2010: 10). Harmonious working conditions in the public sector of South Africa will be created if absenteeism, poor performance – organisational or individual – and high turnover is counteracted by motivated employees (Mafini, 2014: 128). Organisations need to create an environment where nurses are convinced that they are practicing in a constructive culture, they can have good relationships with colleagues (clinical as well as management), they have sufficient influence and the ethical challenges of their work is acknowledged and respected (Asher, 2006: 20; Trautmann, 2015: 288).

As nurses and doctors are the prominent role players in the team providing patient care in hospitals, an ethical climate of mutual support, respect and shared decision making between them should be improved (Hwang & Park, 2014: 38). Moral distress caused by the gap between these two professions will then also be addressed (Schluter *et al*., 2008: 319). Nursing input could be promoted and respected by improving inter-professional teamwork, nurse autonomy and interdisciplinary respect, thereby decreasing experiences of moral distress (Langley *et al*., 2015: 41). Nurturing an environment that stimulates teamwork and provides support for such teamwork, together with allowing autonomous practice would also improve the perceived working conditions (Mafini, 2014: 128).

5.5.4 Creating a supportive work environment

Various recommendations relate to creating a supporting working environment, namely recognising and acknowledging the presence of moral distress, creating opportunities for debriefing, creating an ethical organisational culture, mentorship and orientation as well as change and diversity management.

Recognising and acknowledging moral distress – As participants were not familiar with the term moral distress they were seemingly also not aware that it is what they were experiencing. Not being aware of the experiences and their consequent reactions should be addressed in order to prevent the “abnormal” in the organisation to be accepted as the norm. Likewise, the broader organisation was possibly also not aware of the presence of moral distress at the institution. As moral distress was present in the hospital under study and this information is now known, awareness should be created. The reality, potential consequences and likely causes of moral distress as specifically experienced at the specific hospital should be made a priority in order for top management to implement appropriate interventions.

Moral distress should be recognised and identified in order for it to be addressed (Austin *et al*., 2005: 39). Hamric (2010: 10) found an important first step when dealing with moral distress is for nurses to speak up. Organisations must encourage staff to raise concerns instead of silencing them (Gallagher, 2010), thereby giving them the opportunity to sustain moral strength (Lindh, Severinsson & Berg, 2009: 1888). In order to limit the effects, events leading to moral distress should be recognised timeously in order for early interventions to be implemented (Wilson *et al.,* 2013: 1464). It is equally important for other nurses, doctors, managers and administrators to recognise and support the concerns (Hamric, 2010: 10). Therefore, interventions are also needed to assist nurses to identify their feelings of moral distress (Wilson *et al.,* 2013: 1463). Behavioural, emotional and cognitive strategies can be applied in order for nurses to move from being the victim of moral distress, to being empowered in recognising their own moral consciousness (Rushton *et al.*, 2016: 45). There is a need to engage with all levels of policy in moral distress discussions and it is important to get moral distress on agendas at all levels (Varcoe *et al*., 2012: 60).

Creating opportunities for debriefing – Opportunities must be created for professional nurses to talk about the difficulties they experience and influences that it has on them. De Veer *et al*. (2013: 107) found that nursing staff could benefit from being able to talk about the problems they face and reflect on their challenges with their colleagues. This enables them to deal better with daily challenges, recognise moral aspects in situations, and reduce the related distress. Opportunities should, therefore, be created by management that encourage nurses to talk and discuss their views with colleagues as listening to and validating experiences of moral distress brings a sense of relief (Epstein & Hamric, 2009: 10). Moral distress is also decreased if nurses receive adequate support from family members and colleagues (Vaziri *et al.,* 2015: 36). Researchers (Austin *et al.,* 2005: 39; Rodney, 2013: 314; Langley *et al*., 2015: 41) concurred that the use of stories, open dialogue amongst healthcare providers to discuss and work through moral distress, and creating and support of a relational space in health care are ways to address moral distress.

Creating an ethical organisational culture – If professional nurses are expected to act ethically, the organisational culture should support and promote ethical practice. The emphasis should be on hospital's organisational culture to ensure professional nurses experience it as the preferred employer. The organisational culture should be experienced as managable and not merely the result of consequences that can not be changed (Jacobs & Roodt, 2008:73).

Ethical decision making is more complex than merely for an individual to know the difference between right and wrong. Individual coping mechanisms to address moral distress is

therefore not enough. However, if the focus is on the work environment, interventions might prove more successful (Kälvemark *et al.,* 2004: 1083). Instead of focussing on disciplinary action, the SANC can protect and advocate for nurses' ethical practice and ensure that organisational environments are suitable for ethical practice, which will also improve patient outcomes (Mathibe-Neke, 2015: 77).

Attention to ethical climate and respect, and perceptions of orginisational support could help to retain staff, compared to incentives and mandated staffing ratios (Ulrich *et al.,* 2007: 1716; Pauly *et al*., 2009: 570) as it will enhance job satisfaction (Filipova, 2011: 61). As staff shortages appear to be a long term problem, focussing on creating a positive ethical work environment will reduce moral distress (Pauly *et al*., 2009: 571) as an effective short- and long-term solution.

Mentorship and orientation – Sufficient mentoring and orientation will assist new employees to understand their role in the organisation and the expected standard to which duties must be performed, minimising uncertainty and the risk of discrepancies, thereby improving their confidence and patient care. It will also provide an opportunity for all professional nurses involved to stay up to date with practice standards and seek opportunities for continuous professional development.

Mentors and preceptors are crucial team members involved with the orientation of new nurses (West, 2007: 7). More experienced nurses can be paired with new appointees to help them adapt in their new environment (Rice *et al*., 2008: 367). Inexperienced nurses would lack the knowledge and skill to challenge boundaries, a skill they can learn from their more experienced colleagues, reflecting empowerment (Corley *et al.,* 2005: 388). More experienced nurses play an essential role in the development of new graduates (community service professional nurses) into competent practitioners; however, they are the ones leaving the profession due to moral distress or retirement (Ellerton & Gregor, 2003: 107). A good mentorship programme can help improve job satisfaction, staff retention and patient care provided by new appointees (West, 2007: 7).

Change and diversity management – To address resistance to change and underlying racial tension between groups, formal change and diversity management processes are needed. Change must be implemented to remove the old ways and introduce new approaches in an attempt to retain professional nurses. The current situation must be "unfreezed", change implemented and the new working condition "refreezed" to become the new status quo (Mokoka *et al.,* 2010: 8). The SANC could also contribute by assessing

nurses' and patients' needs in order to understand and address it, considering the strengths and weaknesses of an organisation (Mathibe-Neke, 2015: 79–80).

In light of the historical background of South Africa, race can play a role in bullying in the workplace. Managers should be aware of racial tensions and discrimination in order to implement appropriate interventions (Pietersen, 2007: 63). To deal with the realities of workplace diversity, employee assistance possibilities should be created to help staff understand and come to terms with the changed environment. Diversity management should be part of the strategic plan and objective of an organisation, under the leadership of senior management (Gwele, 2009: 7, 9). There should be a desire from employees towards efforts such as education and induction, as well as support from the organisation in order to address the challenges (Almutairi, McCarthy & Gardner, 2015: 22). Support and diversity management strategies could further include policy review or formulation, recruitment and retention strategies and its monitoring of short- and long-term targets over specific timeframes (Gwele, 2009: 9).

5.6 FUTURE RESEARCH

The following areas for future research are proposed:

- *Experiences of moral distress amongst professional nurses at public and private hospitals and primary healthcare facilities in the MDHS*
- *The effect of organisational culture on experiences of moral distress at public and private hospitals and primary healthcare clinics*
- *Nursing operational managers' experiences of moral distress*
- *The effect of regular, structured debriefing and support sessions on professional nurses' experiences of moral distress*
- *The effect of increased staffing on professional nurses' experiences of moral distress*

5.7 DISSEMINATION

Study findings will be disseminated though the publishing of articles in an attempt to contribute to the limited body of knowledge available on moral distress in South Africa. Study findings will also be reported to the Western Cape Department of Health, and presented at provincial and national conferences.

5.8 CONCLUSION

In chapter 5 the study findings were discussed in relation to the study objectives. The aim of the study was to understand professional nurses' lived experiences of moral distress.

If professional nurses knew what the right thing was to do, why were they not doing it? Research findings indicate that professional nurses at the institution were explicitly aware of what the right thing was to do. They were fully familiar with their roles, responsibilities and the expectations placed upon them by their employer, regulating body, patients, family members, society and their own moral convictions. Their ability to do what is right was compromised by a variety of factors.

Staffing played a significant role in preventing professional nurses from doing what was expected. Not only did shortage of staff add to their workload, it is also the reason why they choose to break the rules in order to ensure that patient care was provided and patients' needs were met. They were aware of the consequences of the shortcuts they employed and were willing to bear the consequences.

The existing staff also added to the workload as they disregarded the authority of the professional nurses and blatantly refused to perform tasks delegated to them. Such open disrespect and defiance is suggestive of vertical violence and resulted in a sense of powerlessness and despair, and participants questioning their own worth and capabilities as professional nurses. The strained relationships contributed to poor patient care being delivered.

Managers were experienced as unprofessional, inexperienced, perpetrators of bullying and unsupportive - whether to escalate challenges reported to them to senior management, to manage conflicts between staff members in the ward, or to assist with clinical duties and patient care. Relationships between doctors and nurses were strained, especially due to prescribed tasks, which added to the workload.

The work environment was unforgiving and focused on completion of tasks and no complaints from patients or their family members. All duties had to be completed irrespective of the challenges experienced, or professional nurses were being threatened with disciplinary action. There was a subtle racial undercurrent and an organisational culture characterised by resistance to change.

Effects were evident in negative emotional, psychological, personal, and professional responses that professional nurses attempted to cope with by using various strategies that differed in effectiveness. There was an apparent distinction in coping mechanisms based on years of experience in the profession; however, it was not preventing those who had less than five years of employment at the institution to acknowledge their intention to leave their position due to the working conditions.

Findings indicated that moral distress was experienced by professional nurses in the general wards in a public district hospital in Cape Town's Metro District. Considering the challenges and conditions of the district health services in Cape Town, it was plausible that the phenomenon of moral distress is also present at other hospitals within the MDHS. Consequently, over time it could result in a rise in complaints regarding poor nursing care; and increased shortage of professional nurses as more would leave their employment or the profession; and the cycle of staff shortage leading to compromising professional standards, resulting in moral distress, would continue. Efforts must be made to address working conditions and consequent causes of moral distress, especially related to staffing and management issues. Greater efforts must be made to ensure new graduates and newly employed professional nurses receive the necessary support through orientation and mentorship in order to gain confidence in their role and develop moral courage to address and manage their challenges with confidence.

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APPENDICES

APPENDIX 1: ETHICAL APPROVAL FROM STELLENBOSCH UNIVERSITY

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot · your knowledge partner

Approval Notice
New Application

18-May-2016
Voget, Ursula U

Ethics Reference #: S16/03/055
Title: Professional Nurses' Experiences of Moral Distress

Dear Miss Ursula Voget,

The **New Application** received on **31-Mar-2016**, was reviewed by members of **Health Research Ethics Committee 1** via Expedited review procedures on **18-May-2016** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **18-May-2016 -17-May-2017**

Please remember to use your **protocol number** (**S16/03/055**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired.
The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics

approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 0219389657.

Included Documents:
CV M van der Heever.pdf
CV U Voget.doc
HREC Application.pdf
Declaration M van der Heever.pdf
Consent form.doc
CV A van der Merwe.pdf
Declaration U Voget.pdf
Interview guide.docx
Protocol.docx
Protocol Synopsis.docx
Declaration A van der Merwe.pdf

Sincerely,

Franklin Weber
HREC Coordinator
Health Research Ethics Committee 1

APPENDIX 2: PERMISSION OBTAINED FROM INSTITUTIONS / DEPARTMENT OF HEALTH

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_2016RP14_67
ENQUIRIES: Ms Charlene Roderick

Stellenbosch University

Private Bag x1

Matieland

7602

For attention: Ms Ursula Voget

Re: PROFESSIONAL NURSES' EXPERIENCES OF MORAL DISTRESS.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Karl Bremer Hospital	**Dr De Vries Basson**	**021 918 1205**

Kindly ensure that the following are adhered to:

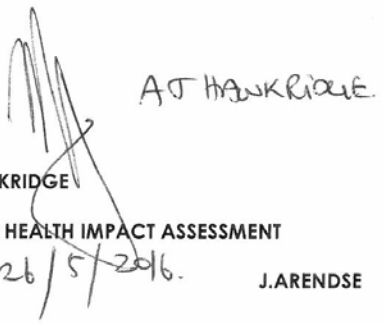
1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely



DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 26/5/2016.

J.ARENDSE **DIRECTOR: NORTHERN TYGERBERG**

APPENDIX 3: PARTICIPANT INFORMATION LEAFLET AND DECLARATION OF CONSENT BY PARTICIPANT AND INVESTIGATOR

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: PROFESSIONAL NURSES' EXPERIENCES OF MORAL DISTRESS

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: URSULA VOGET

ADDRESS: Nursing
Faculty of Medicine and Health Sciences
Stellenbosch University
Teaching Block, Second Floor
Francie van Zijl Drive
Tygerberg
7505

CONTACT NUMBER: 083 7448202

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research. The HREC can be contacted on 021 938 9075 if there are any queries regarding this specific research.

You have been approached to participate in this study as you are deemed most knowledgeable regarding the study topic and would be able to provide valuable information.

10 Professional Nurses permanently employed at a district hospital in the MDHS, working in a Medical or Surgical general ward will be recruited. The purpose of the study is to explore professional nurses' experiences of moral distress, the influence the experiences has on them as well as the possible causes of moral distress in their organisation.

Participation in the research will entail a one-on-one interview of approximately 30-45 minutes (or longer) at a date, time and venue of your convenience. You have the option for the interview to be conducted in Afrikaans, English or isi-Xhosa.

The interview will be audio-recorded. You will be given a pseudonym in order to protect your identity and the name of your hospital will not be revealed. Audio data of the interviews will be downloaded onto a laptop after each interview and deleted from the recorder. All transcripts will be kept in a locked filing system and computers on which data will be stored will be password protected and only accessible to the researcher, her supervisor and translator.

Your responsibility for participation includes honest participation and sharing of your experiences.

There are no personal benefits in participating in the research. However, based on the information you provide a better understanding of moral distress experienced by professional nurses will be developed. An understanding of these experiences can be used in future to address related issues in an attempt to decrease moral distress and increase moral courage and job satisfaction.

There are no anticipated risks to participate in the study. Due to the nature of the topic there is a possibility that it might elicit uncomfortable emotions. In such case you will be referred to ICAS (Independent Counselling and Advisory Service, contact number 0800 611 093) for the necessary emotional and psychological support.

You are under no obligation to participate in the research, and can withdraw at any time during the process. There will be no consequences for doing so.

You will not be paid to take part in the study. Should you incur any costs it will be refunded to you.

Declaration by participant

By signing below, I ..... agree to take part in a research study entitled ***Professional Nurses' Experiences of Moral Distress***.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2016.

....

Signature of participant **Signature of witness**

Declaration by investigator

I *(name)* ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. *(If a interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ..... on (*date*) ..... 2016.

....

Signature of investigator **Signature of witness**

Declaration by interpreter

I *(name)* ..... declare that:

- I assisted the investigator (*name*) ..... to explain the information in this document to (*name of participant*) ..... using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) ..... on (*date*) .....

....

Signature of interpreter **Signature of witness**

APPENDIX 4: INTERVIEW GUIDE

Title: Professional Nurses' Experiences of Moral Distress

Semi-structured interview guide

1. Please tell me about challenges you experience in your work
   Probes: lack of resources, staff shortage, competence of colleagues

2. What influences do these challenges have on your practice?
   Probes: doing the right thing, taking short cuts, accepting wrongs, motivation, interest

3. Could you tell me about situations in your work where you were unable to do (what you consider) the right thing?
   Probes: examples; unethical behavior; ethical decision making, short cuts, not following protocol

4. Could you tell me more about situations that left you with painful, psychological feelings because you could not do the right thing due to barriers or challenges?
   Probes: examples; causes; influences on self and others; personal relationships; professional relationships; emotional impact

APPENDIX 5: CONFIDENTIALITY AGREEMENT WITH DATA TRANSCRIBER

CONFIDENTIALITY AGREEMENT

I FRANCOIS TJAART JANSEN VAN VUUREN

agree to receive and **transcribe** the recorded audio files sent to me by Ursula Voget. The recorded files are the interviews done by the sender at a District Hospital in fulfilment of the master's programme.

I fully understand that the information in the recorded files is sensitive and confidential and therefore may not be shared with anyone else but Ursula Voget.

I agree that I will not use the information on the recorded files for any purpose other than what it was intended for.

Recipient: FT JANSEN VAN VUUREN
ID Number 9312295118089
Signature
Date 26 AUGUST 2016.

Discloser: URSULA VOGET
ID Number **7909060135089**
Signature
Date 26 AUGUST 2016

APPENDIX 6: EXTRACT OF TRANSCRIBED INTERVIEW

I: Right sr, we went through all the formalities so you're welcome to just relax... (chuckle) *"hmmmmm"*.... Make yourself comfortable. Are you happy to start

P: yes we can start

I: OK, so could you maybe just share with me some of the challenges that you experience as a registered nurse within your work

P: yho, there's a lot of challenges in this profession. I especially its staff.. the staff members... yho... the managers... the patient....the families. There's a lot man. Hmmm. It's a lot to deal with. It's too much sometimes.

I: so why don't we start if you tell me a bit more about the staff.. what specifically relating to staff poses a challenge

P: you see there this things mos there's hmmm this old staff that they work maybe they've got 20 year in this profession and its me and me im 2 years I just came mos on on this profession.... Yhooo... its very difficult to... they're very difficult to change mos now we we things mos change in time but yoooo... they just j\give you a hard time. I really.... A hard time to change they don't want to change. They really don't want to change. I think they are still in that aaaaaaa old nursing hmmmm so it's really its difficult man yho

I: tell me more about that hard time. You can specific as you recall maybe certain uhm examples

P: eish uhhhhh yho how can i..... yho how can I say.... The hard times uhhh.....its when maybe you you see mos theres those old nurses and im young. And then maybe asks a person to do whatever you ask them to do. First before they do whatever you ask them to do they will ask "but why can't you ask that one, why can't you ask that one. You see. Stuff like that. Hmm. Otherwise.... Yho.. hayi eish I don't know man

I: ok its fine you can just you can just relax

P:It's it's its really hard

Appendix 7: Declarations by language and technical editors

Lize Vorster Communication

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the language editing and technical formatting of Ursula Voget's thesis entitled: Professional nurses' experiences of moral distress. Editing is done in track changes and the student has final control over accepting or rejecting changes by using their own discretion. This may result in a document still containing mistakes. Technical formatting entails complying with the Stellenbosch University's technical requirements for theses and dissertations, as presented in the Calendar Part 1 – General.

Yours sincerely

Lize Vorster
Language Practitioner

Vygie street 9, Welgevonden Estate, Stellenbosch, 7600 * e-mail: lizevorster@gmail.com * cell: 082 856 8221