Abstract

Background
Supporting the older person to age well within residential and community care environments requires a healthy and sustainable workforce. Moral distress is a complex phenomenon, and emerges when a worker “…as a result of real or perceived constraints, participates, either by act or omission, in a manner he or she perceives to be morally wrong” (Nathaniel, 2006, p. 421). Morally distressing situations create physical and psychological effects; contribute to decreased quality of care and diminished workplace satisfaction for staff, lead to physical and emotional illness, burnout, and staff turnover. Understanding and reducing the frequency of exposure to, and the intensity of, moral distress felt by workers, is necessary in providing a psychologically safe work environment. Health care delivery is complex, resource pressures and differing beliefs on what constitutes health and health care mean that moral challenges are inevitable. The moral agency of nurses is frequently challenged and as such moral stress is unavoidable. While moral distress has been investigated across a range of clinical contexts and countries, little research exploring moral distress in either the Australian or the aged care contexts is evident. Despite the lack of current evidence, anecdotally moral distress does exist within the Australian aged care workforce. Accurate data regarding moral distress will support the development of targeted interventions to reduce the occurrence, intensity and consequences of the experience. Interventions that consider the needs of the worker and individual contexts of Australian workplaces will reduce the intensity of moral distress, and allow workers to better manage the psychological strain stemming from moral challenges.

Research Design
The aim of this mixed methods study was to explore the effect of moral distress on Australian aged care workers in residential and community aged care. An explanatory mixed methods approach, grounded in pragmatism was used. The Job Demand-Control-Support model (JDCS) was used to explore links between moral distress, the worker, and organisational support structures. Participants consisted of Registered Nurses, Enrolled Nurses, and Personal Care Workers (Assistants in Nursing) working in community and residential aged care facilities in Queensland and Victoria. The study was conducted in two phases.
In Phase 1 the Moral Distress Scale– Revised was amended, tested and validated with participants (n=106). This instrument uses a 5 point Likert scale to measure both the frequency and intensity of moral distress. Amendments to suit the Australian aged care environment were made, resulting in a 20 item instrument, the Moral Distress Scale – Revised (aged care). Psychometric testing for reliability and validity was conducted.

To further illustrate the experience of moral distress for this population a series of telephone interviews and case study scenarios were used in Phase 2. Participants for this phase were drawn from Phase 1 participants who elected to participate in Phase 2. Initially telephone interviews (n=9) were used to explore participants' understanding of moral distress, identify situations in which participants encountered this distress, and elicit the specific outcomes of moral distress on the worker. A reflective journal was used to record observational, theoretical and methodological notes during the telephone interviews; with member checking at time of interview and investigator triangulation used to ensure trustworthiness of data. Interviews were transcribed verbatim, with thematic analysis relying on constant comparison of textual data used to identify themes and inform the development of case study scenarios.

Data from the telephone interviews and contemporary moral distress literature were then used to develop two case study scenarios. Scenario 1 focussed on unmet care needs, and Scenario 2 futile treatment. Scenarios (n=16) were returned and data subsequently subjected to thematic analysis relying on constant comparison of data. These data were used to inform the final findings; identifying common experiences emerging from participants' experiences of moral distress.

Results

In Phase 1 statistical testing of the amended instrument indicated strong reliability: the frequency component of the instrument demonstrated a Cronbach's alpha of 0.89, the intensity component 0.95, and the instrument as a whole 0.94. Item mean scores indicated moral distress occurred with low frequency (0.36-1.73) but moderate intensity (1.66-2.93) within this population. Exploratory factor analysis identified three factors, labelled as: Quality of Care, Capacity of Team and Professional Practice.
Phase 2 qualitative data demonstrated workers experiencing a range of psychological effects such as sadness, unhappiness, powerlessness and extreme frustration related to the impact on themselves, other workers, and the older person. Inadequate resourcing, lack of time, futility of the situation, inadequate consultation, and division about the correctness of decisions emerged as contributing factors. The role of the nurse as central to resolution of these issues was highlighted: with participants clearly identifying a desire to either; work harder and do more (“Doing Work”) or engage in communication with others (“Speaking with Others”).

**Conclusion**

The Moral Distress Scale - Revised (aged care) is a valid and reliable instrument. Moral distress does exist within the Australian aged care workforce, albeit at a relatively low frequency. However, when it occurs it causes a moderate level of distress for the worker. Psychological effects such as sadness, unhappiness, powerlessness and frustration were experienced. Participants clearly expressed a desire to be centrally involved in communication strategies aimed at reducing the occurrence and outcomes of moral distress. This is the first study demonstrating links between the JDCS and moral distress, and using the JDCS to frame moral distress provides a valid foundational structure for evidence-based interventions.
Declaration by author

This thesis is composed of my original work, and contains no material previously published or written by another person except where due reference has been made in the text. I have clearly stated the contribution by others to jointly-authored works that I have included in my thesis.

I have clearly stated the contribution of others to my thesis as a whole, including statistical assistance, survey design, data analysis, significant technical procedures, professional editorial advice, and any other original research work used or reported in my thesis. The content of my thesis is the result of work I have carried out since the commencement of my research higher degree candidature and does not include a substantial part of work that has been submitted to qualify for the award of any other degree or diploma in any university or other tertiary institution. I have clearly stated which parts of my thesis, if any, have been submitted to qualify for another award.

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Contributions by others to the thesis

Dr Anthony Tuckett, Dr Robert Eley and Associate Professor Deborah Parker contributed to the conceptualisation and design of the project, the analysis and interpretation of data, and to the writing and editing of this document. Additionally Dr Tuckett facilitated entrée to two of the four sample populations.

Statement of parts of the thesis submitted to qualify for the award of another degree

None.
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List of Abbreviations used in the thesis

AIN    Assistant in Nursing
BSSERC Behavioural and Social Sciences Ethical Review Committee
CC    Community Care
EFA Exploratory Factor Analysis
EN    Enrolled Nurse
ERI Effort-Reward Imbalance model
JDC Job Demand-Control model
JDCS Job Demand-Control-Support model
JDR Job Demand-Resources model
MCAR Missing Completely At Random
MD Moral Distress
MDQ Moral Distress Questionnaire
MDS-R Moral Distress Scale - Revised
MDS-R (aged care) Moral Distress Scale – Revised (aged care)
MDT Moral Distress Toolkit
MNAR Missing Not At Random
NHMRC National Health and Medical Research Council
PCA Personal Care Assistant
PCW Personal Care Worker
RACF Residential Aged Care Facility
RN Registered Nurse
Chapter 1  Introduction & Background

1.1 Introduction

Increasing demand for services, an ageing workforce, and inadequate numbers of freshly qualified workers have all been identified by the Productivity Commission (2005) as critical areas of concern for the nursing workforce. An ageing population in Australia will increase demand for aged care services, with Access Economics suggesting a 56.8% increase between 2007 and 2020 (Access Economics, 2009, p. 22). They further estimate that the aged care workforce will only increase by approximately 14.1% (Access Economics, 2009, p. 22), leaving a notable deficit between demand and delivery capacity. The Department of Education, Employment & Workplace Relations (Australian Government, 2008) estimates approximately 75,000 new workers per annum will be required to service the acute care and aged care sectors alone, in an industry whose total nursing workforce in 2009 was reported as totalling just 276,751 nurses (Australian Institute of Health and Welfare, 2011b).

Fostering a robust nursing workforce depends on retaining current members as well as successfully educating and integrating new members. Issues of workload, stress and emotional demands have been identified as specific issues for the Australian aged care workforce (Eley et al., 2007). Ensuring safe workloads and supportive and safe workplaces (Queensland Nurses Union, 2011) is viewed as essential in stemming the flow of nurses from the profession, and to meet the need for delivery of increasingly complicated nursing services.

Adverse working conditions (such as inadequate staffing levels and excessive workloads) affect workers throughout the healthcare industry, regardless of clinical context. Moral distress precipitates a range of detrimental effects on the worker, and can lead to burnout and the exodus of nurses from the profession, and many losses within the nursing workforce occur when nurses become overworked, overstressed and under-appreciated (Chang, Hancock, Johnson, Daly, & Jackson, 2005; Letvak & Buck, 2008) or suffer from burnout (Spooner-Lane & Patton, 2007). Hofmeyer (2003) laments that “it is puzzling that the profession advocates for quality public health care, but fails to advocate for a
sustainable and quality work-life for nurses” (p.16). Systematic and dynamic workplace reform needs to address these issues. Factors impacting on education, recruitment, and retention must be understood and appropriately addressed.

1.2 Aims, Objectives and Significance
The aim of this mixed methods study was to explore the effect of moral distress on Australian aged care workers in residential and community aged care. The objectives of the study were to:

- Review the literature, identify knowledge gaps, and identify existing instruments that measure moral distress;
- Identify, amend and test an appropriate measurement instrument to measure moral distress within the Australian residential and community aged care workforce; and,
- Explore Australian residential and community aged care workers experience of moral distress.

The significance of this study resides in the impact the research has for the aged care worker. Moral distress is known to exist across the healthcare setting, and generates negative effects on workers (Burston & Tuckett, 2013). However little research into the moral distress experience within the aged care sector or the Australian context exists (Burston & Tuckett, 2013; Pijl-Zieber et al., 2008; Rittenmeyer & Huffman, 2009). This study provides a validated instrument for measuring moral distress in aged care, provides insight into the experience of moral distress for this specific population, and supports the development of evidence-based interventions targeted to improve the work life of Australian aged care workers.

1.3 Organisation of the Thesis
Chapter 1 provides an overview of the aims, objectives and significance of this study, as well as the organisation of the thesis. The structure of international and Australian nursing workforces and the governance of health in Australia are detailed. An overview of the Australian aged care sector is provided noting the challenges faced in attracting, recruiting and retaining direct care workers. The nature of workplace stress, and most specifically moral distress, is considered.

Chapter 2 details the literature review process. Two literature reviews were undertaken. The first review identified a range of contributing factors, outcomes and interventions
related to moral distress, and provided the foundation used in developing the methods for this study. This first review was published in the peer-reviewed journal *Nursing Ethics* (Appendix A):


A second review of the literature was conducted prior to writing the discussion (Chapter 7) and recommendations (Chapter 8) for this thesis. The second review accommodated the significant volume of moral distress research that was published during completion of this study, and supported the development of a robust discussion and contemporary evidence-based recommendations.

**Chapter 3** outlines key theoretical models used to understand the phenomenon of workplace stress. Four models of workplace stress are discussed; the Effort-Reward Imbalance (ERI) model (Siegrist, 2008), Job Demands-Resources (JDR) model (Bakker & Demerouti, 2007), Job Demand-Control (JDC) model (Karasek, 1979), and the Job Demand-Control-Support (JDCS) model (Johnson & Hall, 1988). The JDCS has been used extensively in general workforce (Fila, Paik, Griffeth, & Allen, 2014; Hausser, Mozisch, Niesel, & Schulz-Hardt, 2010), nursing workforce (Peterson, McGillis Hall, O’Brien-Pallas, & Cockerill, 2011), and Australian aged care workforce (Gao, Newcombe, Tilse, Wilson, & Tuckett, 2014; Rodwell, 2009; Rodwell & Martin, 2013) studies, and as such was selected for use in this study. Finally the theoretical links between the Job Demand-Control-Support model, moral distress, and aged care workers are identified.

**Chapter 4** details the methodological basis and justification for the study, identifying the aims, objectives, and research questions. The design of the study has been divided into 2 phases to assist with conceptual clarity, and each phase involved 2 distinct stages. Participants were aged care workers from Queensland and Victoria, Australia. Participants completing Phase 1 were provided the opportunity to opt in for Phase 2 of the study.

Phase 1 (Stage 1) involved the identification and amendment of an instrument suitable for measuring moral distress within the Australian aged care workforce. Based on instruments identified in the first literature review (Chapter 2), the Moral Distress Scale – Revised (Hamric, Borchers, & Epstein, 2012) was selected for use. Amendments to the instrument
were undertaken and subjected to expert review. The amended instrument was labelled as the Moral Distress – Revised (aged care) (Appendix B). Phase 1 (Stage 2) involved pilot testing of this amended instrument with a sample of aged care workers.

In Phase 2 (Stage 1) telephone interviews were used to explore the experience of moral distress for the Australian aged care worker. Although participants described stress in the workplace, distinctions between general workplace stress and moral distress lacked clarity. Consequently an additional strategy (Phase 2 Stage 2) involved the development of case study scenarios focussed specifically on situations known to cause moral distress. Data from both stages were subjected to thematic analysis relying also on the constant comparison of data.

Chapter 5 reports the findings from Phase 1 of this study. The purpose of Phase 1 was to address research question 1: Do Australian aged care workers in residential aged care experience moral distress?

The Moral Distress Scale - Revised was selected and amended for use in the Australian aged care setting. Instrument amendments were subjected to expert review and the amended instrument named as the Moral Distress Scale – Revised (aged care). The twenty (20) item instrument uses a 5 point (0-4) Likert scale to measure both the frequency and the intensity of the moral distress experience. The data were collected from four (4) sample populations using both an electronic platform and paper surveys (total n=106). Exploratory factor analysis was undertaken to assess construct validity, with three (3) factors identified. Factors were labelled as Quality of Care, Capacity of Team, and Professional Practice. The frequency component of the instrument demonstrated a Cronbach’s alpha (α) of 0.89, the intensity component of the instrument 0.95, and the instrument as a whole 0.94.

Results from Phase 1 have been published in the peer-reviewed journal International Journal of Older People Nursing (Appendix C):

Chapter 6 details findings from Phase 2 of this study. The purpose of Phase 2 was to address research questions 2 and 3: What do Australian aged care workers understand about moral distress in residential and community care?, and How does moral distress impact upon residential and community aged care workers and their workplace? Initially telephone interviews were undertaken with nine (9) participants. Interviews were transcribed verbatim, with thematic analysis relying on constant comparison of textual data used to identify themes. Although participants struggled to delineate moral distress from other workplace stress, two preliminary themes emerged: challenges emerging from insufficient resources to deliver care, and the futility of care provision in certain circumstances. To gather additional data a second strategy was implemented. These themes and contemporary literature were used as the basis for development of two (2) case study scenarios.

Scenario 1 asked participants to consider a situation of an older person frustrated by a lack of time being spent in meeting her care needs. Scenario 2 required participants to contemplate the transfer of an older person to an acute care facility for treatment. Thematic analysis relying on constant comparison of textual data revealed a range of contributing factors, outcomes and interventions. Contributing factors included Insufficient Time, Repetition and Staffing (Scenario 1) and Futility, Inadequate Consultation and Decision Division (Scenario 2). Effects On Staff and On Older Person were described from Scenario 1, but only effects on staff emerged from Scenario 2. In response to both case study scenarios, participants proposed solutions (interventions) that involved Doing Work and Speaking with Others (communicating with others).

Chapter 7 provides an integrated discussion of the findings detailed in Chapters 5 and 6. Moral distress occurred with similar levels of frequency and intensity to other studies, however some differences across clinical contexts were noted. Exploratory factor analysis identified three factors, labelled as Quality of Care, Capacity of Team and Professional Practice.

Similar to other studies identified in the Literature Review (Chapter 2) (Burston & Tuckett, 2013) moral distress of Australian aged care workers does generate from issues of futility and insufficient resourcing. Participants expressed a clear desire to engage in
communication with others to address moral distress, and also expressed a desire to do more work. However what this specifically entailed was not always clearly elicited.

Additionally, commonalities between the Job Demand-Control-Support (JDCS) model and moral distress are explained, and the validity of using the JDCS to frame moral distress is discussed. Limitations of this study, including the inability to conduct test-retest for reliability, limitations of the sample size (n=106) in Phase 1, the exclusion of workers not currently employed, and the use of a cross-sectional design are detailed. Also methodological challenges encountered in our study are explained.

Finally, Chapter 8 presents an argument for targeted evidence-based interventions to address the moral distress of Australian aged care workers. A range of interventions targeted at the individual and the organisational level are proposed. Ideas for future research in the area of moral distress aimed at consolidation of existing knowledge, further exploration of unknown knowledge for this study population, and intervention-based research, are detailed.

1.4 The International Health Workforce

The health workforce is under strain with clear challenges in meeting future demand evident (Crettenden et al., 2014); a problem that has been recognized internationally (Armstrong, 2004; Cavanaugh & Huse, 2004; Robinson, Jagim, & Ray, 2005), appears to be somewhat cyclical and is not new (Clarke & Aiken, 2008). In 2010 the World Health Organization identified a nursing and midwifery shortage in “…70% of the respondent Member States” (World Health Organization, 2010, p. 73). In Europe the emerging shortage of nurses is viewed as a critical problem (Kroezen et al., 2015), with a specific shortage of nearly 20,000 nurses identified in the United Kingdom alone (Ford, 2013). As a further example, predictions for deficits in the vicinity of 800,00 nurses by 2020 in the United States have been posited (Rosenkoetter & Nardi, 2007).

Shortages pose a significant workload challenge to nurses, and the ability for health systems to meet the needs of consumers (Oulton, 2006). The demand for workers within (what the OECD describe as) long-term care is expected to double in many countries including Australia (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011). Health policy
targeting more efficient use of human resources is required (Correia, Dussault, & Pontes, 2015).

A varied belief around the source of the shortage exists. Buchan and Aiken (2008) contend the issue resides in a shortage of nurses willing to work in present working conditions, rather than a true deficit of educated personnel. Kingma (2009) also identifies issues of increased workload and deterioration of working conditions, but further suggests a general reduction in staff numbers and international migration as additional contributors. Oulton (2006) argues shortages are a result of both supply and demand driven challenges. In addition to all of these contributing factors she identifies an aging population; globalization and a growing private sector; public demand for services; inadequate support staff; violence; stress and burnout; wage disparities; little involvement in decision making; and changes in health human resources practices compounding the shortage (Oulton, 2006, p. 36s). Socioeconomic development indicators and professional infrastructure (particularly general education) have been identified as affecting the types and numbers of nurses available (Squires & Beltrán-Sánchez, 2011). What is evident is that the problem is multifaceted (Buchan & Aiken, 2008), and any resolutions proposed must account for this.

The global migration of workers has been identified as a problematic issue, particularly for those countries (which tend to be developing countries) providing the supply of workers to countries able to offer better working conditions and remuneration. This is of particular importance as the global migration of health workers will continue to expand (Shaffer, Bakhshi, Dutka, & Phillips, 2016). Poverty and low salaries have driven migration of workers from these countries, and improving salaries has been suggested as the main priority to improve this situation (B. Anderson & Isaacs, 2007). Despite identifying significant problems with working conditions, Hagopian et al. (2009), while investigating workforce morale, satisfaction and motivation in the Ugandan workforce, identified that around 80% of the nursing workforce intended to stay in their current position for at least the next three years. Perhaps these findings suggest that nurses in developing countries do not necessarily want to leave their home country, but may in fact do so out of a sense of social and economic hopelessness.
Additionally, migrant nurses often send money home to family members which is used for the provision of food, housing and education – thus improving the efficacy of health care systems in their home countries. This money sent home is known to exceed that provided in many countries by official development assistance programs (International Centre on Nurse Migration, 2014) and as such the net benefits to global health should not be discounted. Nonetheless sufficient concern for the negative impacts of worker migration exist resulting in the development of a Global Code of Practice on the International Health Recruitment of Health Personnel (World Health Organisation, 2010).

Insufficient nursing supply has been connected to expensive and damaging problems such as “…increased mortality, staff violence, accidents/injuries, cross infection, and adverse events” (Oulton, 2006, p. 36s). Individual nurses may become overworked, feel underappreciated, and may find themselves at increased risk for adverse physical and emotional consequences. Strong leadership in policy development and implementation must continue to seek resolution of the issue, by developing effective policies governing nurse workforce planning and management as a priority (O'Brien-Pallas, Duffield, Murphy, Birch, & Meyer, 2005). Policy development requires input from a variety of sources, and is undertaken in an attempt to meet perceived needs. Any policy that is discussed, developed and implemented is generated and directly influenced by individuals with particular value laden beliefs, and is contingent on a range of economic considerations. It is inherently subject to context. Economic imperatives, whilst always crucial, should never standalone from social considerations particularly in the context of preventive strategies that have the capacity to reduce long term burden.

Policies should be developed in concert, and must provide a sustainable and long term solution (Buchan & Aiken, 2008). It is believed that “effective human resource policy and planning (at the macro level) and management strategies (at the micro level) would stabilize the nursing workforce and reduce job stress” (O'Brien-Pallas & Hayes, 2008, p. 3338). Whilst recognizing the importance of strong policy, it is also suggested that regulatory bodies are crucial in ensuring effective application of this policy (World Health Organization, 2010, p. 71).
1.5 The Australian Health System

1.5.1 International Comparisons

Health care system design varies internationally, with a range of financing structures evident. Structural and hence financing components of these systems are commonly founded in the political ideology at the core of their original genesis; for example the United States liberal market system approach in which the user pays, as opposed to the labor influenced welfare system evident in the United Kingdom (Yates & Robinson, 2016). In their comparison report of different health systems Mossialos, Wenzl, Osborn and Sarnak (2016) identify distinct variations in government roles, public system financing, private insurance financing, caps on cost sharing and additional elements such as exemptions and low-income protections; between all 17 countries analysed. Australian health care is positioned at mid-range on the political spectrum, with a mixture of fee-for-service (i.e. user pays) grounded within the welfare style universal access approach of Medicare (Yates & Robinson, 2016)

1.5.2 Australian Health Policy

Public (government) policy is one of the primary drivers influencing the broad scope of health care delivery in Australia. Hancock (2002) describes policy direction in Australia as one of the three main contentious issues that exist between the State and Federal governments (p.135). Complicating this is Australia’s three tiered system of governance (Mossialos et al., 2016), with health care funding particularly contentious and problematic between State and Federal levels.

Policy influences the legislative guidelines that provide the framework for healthcare delivery, but just as importantly drive the provision of economic inputs for the system. However being a democracy, the actual allocation of this funding can be substantially influenced by a myriad of political inclinations and preferences wrapped in the guise of public interest. When describing the challenge facing policy decision makers, Banting & Corbett (2002) highlight that “they must balance the needs and expectations of citizens, the demands of health-care professionals and the pressures on public budgets; and everywhere the trade-offs are becoming more difficult” (p.2). In addition, adequately resourced policies to deal with the ongoing issues of recruitment and retention need to be developed, implemented, and evaluated to determine their utility (O’Brien-Pallas et al.,
The political context of policy development may at times be largely influenced by economic considerations, regardless of actual existing need. The use of resources in general, and specifically health resources, is a balance between different opportunity costs.

An intricate web of issues surrounds the decision-making process in relation to health policy development, and careful consideration of all issues is essential. Consequently, any policy that is discussed, developed or implemented is generated and directly influenced by individuals with particular value laden beliefs. The process is complicated, with many variables impacting on the end product. Lewis (2005) neatly summarises this process (in relation to health policy) as such; “health policy is a complex network of continuing interactions between actors who use structures and argumentation to articulate their ideas about health” (p.14).

The biomedical model of acute health delivery, a system that is largely focused on treatment of illness, has historically dominated the projected notion of health care provision in Australia. However, a vast array of health issues are generated independently of this system, for example socio-economic factors supporting adequate housing and nutrition are commonly recognised as impacting on an individual’s health and well-being. The current obesity epidemic is one such example (Access Economics, 2008), where lifestyle related issues significantly impact on consumer demand and subsequently on the numbers and skills of healthcare worker required. Failures to address these social determinants of health can place an overwhelming demand on the acute treatment services sector particularly, hence planning for allocation of funds and human resources at the preventative level can significantly reduce the ultimate demand. As consumer access to information increases (Kennedy, 2002), consumer awareness, demands and expectations are likely to increase, placing more strain on an already burdened system. Health care consumers are recognised as having growing expectations with improved efficiency identified as an imperative (O’Brien-Pallas et al., 2005). Duckett (2005), also suggests that the roles of health professionals will need to change and workforce reform must account for this.
1.6 The Australian Health Workforce

The Australian health workforce is a significant component of the Australian workforce, and is comprised of a variety of health specific professions as well as other health related social services. About 10 percent of the Australian workforce (almost 1 million people) are employed in the health industry (Duckett & Wilcox, 2011). Of these workers a little over 600,000 are registered health practitioners, with around 350,000 of these registered practitioners being nurses or midwives (Australian Institute of Health and Welfare, 2016a). Challenges in recruiting and retaining nurses clearly have the capacity to create significant on-flow effects in care delivery.

1.7 The Australian Nursing Workforce

Nursing care in Australia is delivered by a range of practitioners with differing degrees of education, qualifications, and standards of practice. The Nurse Practitioner, Registered Nurse, and Enrolled Nurse are the three nursing professions that require formal education, and for regulatory purposes, registration with the Nursing & Midwifery Board of Australia (NMBA). The scope of each of these roles is clearly defined by the NMBA in documents such as Standards for Practice, Codes of Ethics and Codes of Professional Conduct (Nursing and Midwifery Board of Australia, 2016b). Enrolled Nurses can participate in a variety of direct cares including some direct interventions and evaluation tasks, but cannot formally assess patients or generate nursing diagnoses. The Registered Nurse extends on this with the capacity to formally assess and generate nursing diagnoses, and also has the scope to delegate tasks to others such as the Enrolled Nurse. Extending beyond the core Registered Nurse role, the Nurse Practitioner is a Registered Nurse who, having undergone additional formal education, is registered to practice at an advanced level (Nursing and Midwifery Board of Australia, 2016a). In this role the Nurse Practitioner may initiate or perform some more advanced diagnostic procedures traditionally within the realm of the medical profession; such as ordering pathology, radiological tests, or prescribing specific medications.

In addition to this is a group of practitioners not requiring registration to practice. Known variously as Personal Care Assistants (PCA), Assistants in Nursing (AIN), or Personal Care Workers (PCW), these workers may have no formal education or may have attained a Certificate level vocational education qualification only. They are involved in the delivering of what has historically been described as basic nursing cares; for example
assistance with personal hygiene and maintenance of activities of daily living (ADL). Areas with lower levels of acuity (such as residential aged care) have higher proportions of this worker group.

The number of nurses in Australia reached a high point of 12.1 per 1000 head of population in 1991 but then remained quite stagnant for the next two decades (Organisation for Economic Co-operation and Development, 2011). Based on available 2015 data, gross population estimates of 23,723,800 (Australian Bureau of Statistics, 2016) and gross nursing numbers of 356,417 (Australian Institute of Health and Welfare, 2016b) indicate the number of nurses per 1000 head population has since risen slightly to 15.0. It must be noted also that current reported nursing numbers do not include the PCA/AIN workforce who commonly provide nursing type care, which historically was in the domain of the RN/EN. Therefore the number of workers actually delivering nursing care is higher.

Concurrently, the percentage of population aged over 65 years has increased from 13% in 1995 to 17% in 2015. However given the corresponding increase in gross nursing numbers (exclusive of PCA/AIN) from 186,200 to 356,417 (Australian Institute of Health and Welfare, 2003, 2016b) during that same time period, the number of nurses per 1000 head of population aged 65 or over, has actually increased from 10.3 (in 1995) to 15.0 (in 2015). This tempers immediate concerns regarding the ability to deliver care to this population (over 65 years) who are known to consume a disproportionate amount of health resources. However caution is required as the Australian nursing workforce continues to age and many nurses are nearing retirement (Health Workforce Australia, 2014).

Health Workforce Australia’s (HWA) report ‘Health Workforce 2025 – Doctors, Nurses and Midwives’ notes that whilst a relatively even geographical distribution of nurses (/1000 head population) across Australia exists at the moment, the average age of the nursing workforce is higher in rural and remote areas. In addition, role diversity in rural and remote areas is greater, hence any deficit will have greater impacts for service delivery (Health Workforce Australia, 2012a). Consequently any shortages in rural and remote areas will be felt more intensely.
A range of projected scenarios related to future workforce needs within the Australian healthcare environment are detailed within the HWA report. In the best case “graduate growth” scenario, the demand for nurses nationally is expected to outstrip supply by approximately 17.35% by the year 2025: that is a shortfall of 54,226 registered nurses on a demand of 312,385. (Health Workforce Australia, 2012a). In the worst case “high demand” scenario, the demand for nurses nationally is expected to outstrip supply by approximately 38.70% by the year 2025: that is a shortfall of 147,250 registered nurses on a demand of 380,459. (Health Workforce Australia, 2012a). The future supply of nursing workforce in Australia is vulnerable (Buchan, Twigg, Dussault, Duffield, & Stone, 2015).

1.8 The Australian Aged Care System

The Australian aged care system consists of for profit, not-for profit, and government organizations. Residential aged care facilities (RACF) are designed to provide care for those who cannot meet their care needs at home, whilst Community Care (CC) provides support for people in their home. Funding in aged care for direct service provision, is generated from both Australian government and consumer contributions (Australian Government, 2016; Baldwin, Chenoweth, & de la Rama, 2015). National costs to provide aged care in 2011 were calculated at around $11 billion dollars per year (Productivity Commission, 2011a), however currently sit closer to $15 billion dollars per year (CEPAR - ARC Centre of Excellence in Population Ageing Research, 2014). Currently care recipients directly cover 7% of this yearly cost (CEPAR - ARC Centre of Excellence in Population Ageing Research, 2014).

RACF funding is an area of particular concern with Access Economics (2009) forecasting an emerging need for those that can afford to pay direct costs to do so. Recent funding cuts by the Australian government have raised serious concerns regarding the capacity of the system to deliver quality care, with concerns emerging about the development of a distinctly two-tiered system (O'Keefe, 2016). The change to a user pays system for alternate treatments (which can include alternate pain management strategies for example) will exclude those with low financial resources (O'Keefe, 2016).

1.8.1 Direct Care Workers Representation in the Workforce

There are over 235,000 direct care workers (estimated) in the RACF sector, with 71% working as personal care attendants (PCA), 9% as Enrolled Nurses (EN), and 15% as
Registered Nurses (RN), and 5% other (Mavromaras et al., 2017). The CC sector consists of just over 130,000 direct care workers, with 84% working as community care workers (CCW), 2% as Enrolled Nurses (EN) and 8% as Registered Nurses (RN), 6% other (Mavromaras et al., 2017). Low recruitment level and loss of nurses are prevalent in aged care (Chenoweth, Jeon, Merlyn, & Brodaty, 2010), and “attracting, retaining and managing this workforce will be critical to meeting society’s expectations regarding the future care needs of older people” (Clarke, 2015, p.192).

1.8.2 Workforce Planning

Workforce planning, while critical at a local business level, should also be viewed as a priority nationally. Australian health workers are part of the general labour pool and as such are not immune to the broader socio-economic impacts affecting worker supply and demand. Many of the issues impacting on the Australian workforce will also be relevant issues facing the health workforce specifically. Poor planning at the national level, with lack of direction or targeted outcomes, may impact quite negatively in the long term; promoting issues such as staff shortages, turnover, and diminished worker quality.

Chiarella and Roydhouse (2011), discussing the acute care hospital context, argue that workforce instability itself (along with casemix and management instability) also inhibits workforce planning.

Worker numbers, workforce demands, consumer and employer demands fluctuate and at times compete with each other, and workforce planners must contend with this. What has been acknowledged is that Australia must focus on achieving self-sufficiency in supply of workers for our health workforce (Australian Health Ministers Conference, 2004), with workforce planning at both national and state levels identified as a priority (Chiarella & Roydhouse, 2011). The Australian health system should not become, or as some may argue – remain, reliant on migration of international health workers to support the system. Of primary concern for the supply of new workers are; inadequate education numbers, the ageing population and decreasing hours of work, and increased health demand (Australian Health Workforce Advisory Committee, 2004).

The healthcare workplace is a conglomeration of resources, both physical and human, that is context driven and continually evolving. It inevitably involves that most unreliable element of all, the human, with all the attendant fluctuations in motivation, engagement,
attitudes, expectations, and perceptions that arise. Service provision occurs within a highly regulated and structured practice environment. Given the nature of this highly regulated service driven environment, conflicts in expectations and demands between funding bodies, service delivery personnel, and consumers inevitably arise. Understanding the multiple facets of this environment is important in facilitating a productive workplace that delivers safe evidence based healthcare.

One means of addressing any shortfall (real or predicted) is to investigate options that enable workers to remain in the workforce both at increased capacity and for a longer period of time. However it is suggested that little research investigating the older nursing workers retirement intentions, strategies to retain these workers longer, or health service managers’ attitudes towards older workers (Graham & Duffield, 2010) has been conducted in Australia. Schofield et al. (2008) posit that strategies to reduce workforce attrition from chronic disease specifically, will become more critical in improving the overall labour pool and retaining experienced workers in the industry for longer. This will benefit the workforce in two key ways; less attrition through delay in retirement, and extended opportunities for experienced workers to share their knowledge and experience (i.e. mentorship) with novice practitioners. Opportunistically, facilitating healthier workers would also benefit the health system indirectly through reduction of demand on service.

**1.8.3 Future Demand and Capacity**

Twigg et al. (2010) caution that securing sufficient Registered Nurses is essential and a significant challenge for the Australian healthcare sector generally. Supply of direct care workers at a time of significantly increasing demand is problematic, and addressing excessive voluntary nursing turnover of further critical importance (Galletta, Portoghese, Battistelli, & Leiter, 2013). Germane to the research being reported here, direct care delivery is psychologically demanding (Phillips & Miltner, 2015); and providing improvements to psychosocial support in the work environment is identified as crucial to securing sufficient staff (Winsløw & Borg, 2008) and improving retention (Radford, Shacklock, & Bradley, 2015).

It is generally accepted that with an ageing population in Australia demand for aged care services will increase. Of particular concern is the expectation that increasing demand will outstrip the ability to supply needed care (CEPAR - ARC Centre of Excellence in
Population Ageing Research, 2014). Health Workforce Australia (2012b) predicts a worker shortfall ranging from 29.7% (best case scenario) to 40.1% (worst case scenario) in the aged care workforce by 2025; with overall gross demand for aged care services steadily climbing to reach 3.5 million older Australians in the year 2050 (Productivity Commission, 2011a).

Concurrently ageing of the workforce, an issue identified many years ago (Moyle, Skinner, Rowe, & Gork, 2003), and one that continues (Australian Institute of Health and Welfare, 2011b; D. King et al., 2012) will make this care more difficult to deliver. Additionally competition from other sectors (particularly health and social services) for the same pool of aged care workers is strong (Productivity Commission, 2011a). Of relevance to this research are issues of workload, stress and emotional demands, which have been specifically identified as key issues for the Australian aged care workforce (Eley et al., 2007), and attention to these is necessary if shortages are to be alleviated or avoided.

1.8.4 Retention

The challenge of workforce retention is complex (Chan, Tam, Lung, Wong, & Chau, 2013), and is not unique to the nursing workforce (Australian Council of Social Services, 2013; Productivity Commission, 2011b, 2014). Broadly, it has been described as multi-factorial, incorporating elements such as “…job satisfaction, organizational commitment and organizational culture…”(Brown, Fraser, Wong, Muise, & Cummings, 2013, p. 459). More specifically in nursing Dawson, Stasa, Roche et. al. (2014) identified “… limited career opportunities, poor support, a lack of recognition, and negative staff attitudes” as contributors (p.1). Differences in remuneration levels between the acute care and aged care sectors are also recognised as generating retention issues for the aged care sector (Productivity Commission, 2011a).

Retention of the current workforce is one key to resolving staff shortages; and (by consequently facilitating healthy work environments), also to attracting nurses to the workplace (Oulton, 2006). In Australia nursing turnover is estimated by some to cost on average just under $50,000 per nurse that leaves (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014), with mean turnover rates across New South Wales, Western Australia and the Australian Capital Territory calculated at 15.1% (Roche, Duffield, Homer, Buchan, & Dimitrelis, 2015). Additionally, differences in retention and turnover motivators between
workers in the residential aged care and community sectors have been identified (Radford et al., 2015). This turnover is a costly burden on organizational resources (Li & Jones, 2013), within an industry that experiences financial inequities, difficulty in obtaining finance, and constrained pricing for service delivery (Productivity Commission, 2011a).

King et. al. (2012) found turnover to be an issue primarily at the organizational level, suggesting mobility within the aged care sector as opposed to leaving the aged care industry is more evident. Additionally, turnover is not identified as a widespread issue within the aged care workforce, but one that emerges “…unevenly and from different sources…” (Howe et al., 2012, p. 86). Strategies to reduce job stressors (and specifically in its form as moral distress), and increase supervisor support have been identified as positively reducing intentions to quit in the Australian aged care workforce (Karantzas et al., 2012).

Reform targeting workforce retention has been identified as the most likely strategy to reduce the gap between nursing workforce supply and demand within the next ten years (Crettenden et al., 2014). However the same authors also acknowledge their modelling is sensitive to exit rates; and given their workforce retention scenario relies on consistent exit rates over the coming years, and the rates used are lower (post global financial crisis and delayed retirements) than earlier years, a degree of caution is warranted.

Howe (2012) posits research exploring these issues of turnover should use what they describe as a dual driver model. This model seeks to account for both intention to leave and retention factors when exploring turnover of staff. The author recommends that consideration of both elements is critical, as factors affecting intention and retention are different and also operate differently in residential and community care workforces.

1.8.5 Job Satisfaction

One important element known to affect retention of staff, is job satisfaction (Brown et al., 2013). Quality patient contact and teamwork (Moyle et al., 2003), social support and empowerment (Joiner, Stanton, & Bartram, 2004), and investment in learning and development (Johnson, Hong, Groth & Parker, 2011), have all been shown to relate positively with job satisfaction. High satisfaction correlates with a decreased intention to leave the workplace (De Milt, Fitzpatrick, & McNulty, 2011). Stress (Coomber & Barriball,
stress resiliency (Larrabee et al., 2010), perceptions of the adequacy of staffing and missed nursing care (Kalisch, Tschanen, & Lee, 2011), and issues around professional status, remuneration and autonomy (Cowin, 2002), have all been identified as contributing to decreased job satisfaction, and may lead to turnover (Coomber & Barriball, 2006).

A key theme that emerges from the literature is the importance of organizational factors in contributing to both job satisfaction and dissatisfaction. Coomber & Barriball (2006), in a review of the literature related to job satisfaction and intent to leave, identified organisational factors as more influential than individual factors. In this context the role of the immediate manager is one of the most crucial relationships for an employee (Utriainen & Kyngas, 2009), the quality of the relationship is vital (Han & Jekel, 2011), and their engagement in facilitating job satisfaction is imperative (Moyle et al., 2003). Appropriate management of work related stress will therefore improve job satisfaction and consequently improve the ability to retain staff.

1.8.6 Resourcing, Skill Mix and Quality of Care

The efficient use of resources is an important element of sound business practice, and one to which healthcare is not (nor should be) immune. Supply can at times be restricted and it is important that resources are not wasted or used inefficiently. Costs of care delivery, be it in acute or non-acute sectors, continue to rise and strong fiscal management is necessary. Ultimately, the consumer pays in one form or another, be it through taxation (pre and post access), contributions to health funds, or direct payment. Residential aged care is a particular area of concern, with Access Economics (2009) forecasting an emerging need for those that can afford to pay direct costs to do so, enabling those that cannot afford care continued access.

This is particularly pertinent when dealing with human resources, that is, real people with their attendant emotional, psychological and physical needs. The Australian health workforce is a sizeable and expensive element of the health care system. The provision of high quality health care to consumers stems from effective and efficient management of these resources. Nursing staff must be utilized in an efficient and professional manner, with Twigg et al. (2010) cautioning that securing sufficient nursing resources is a significant challenge for the Australian healthcare sector. Unlike other physical resources nurses require things in return, and providing improvement to the psychosocial aspects of
work environments is identified as a key to securing sufficient staff (Winsløw & Borg, 2008).

It is acknowledged that the health workforce (Australian Institute of Health and Welfare, 2011a) generally, but most specifically nurses as the largest component of this workforce, utilise a significant proportion of health care funding, with direct salaries (for all staff) consuming up to 62% of all expenditure in public hospitals (Australian Institute of Health and Welfare, 2011a). As such the nursing workforce has a direct and consistent financial effect on service provision. Commonly nursing performance is linked to quality of care delivery. However the difficulty in measuring the concept of quality care is acknowledged (Spilsbury, Hewitt, Stirk, & Bowman, 2011), and tends to focus on adverse outcomes to consumers; with Bae’s (2011), systematic review identifying staffing (levels) as a common theme contributing to a reduction in adverse events.

Funding in the aged care sector is determined using the Aged Care Funding Instrument (ACFI). It is a 12 question tool which considers the care needs of individual service user within three categories; activities of daily living, behaviour, and complex health care (Department of Health, 2016). However, it is criticised for the disconnection between the level of funding available to managers, and the funding actually needed to employ the required skill mix (Access Economics, 2009). Inappropriate skill-mix can increase workload pressures, contribute to workplace stress, and lead to disengagement from work, leading to absences or workers quitting positions (Dawson et al., 2014). Workload related to understaffing has been identified as a factor in causing moral distress (Hamaideh, 2014; Karanikola et al., 2014; Papathanassoglou et al., 2012).

### 1.8.7 Addressing Challenges in the Aged Care Sector

A range of strategies are suggested to address the situation. Central to these is the idea of building relationships among staff (Han & Jekel, 2011), in a collaborative environment (Wallis & Kennedy, 2013) where staff feel able to use their skills and feel valued (King, Wei & Howe, 2013). Improving staffing levels (Luo, Lin, & Castle, 2012) and adapting strategies to suit generational differences of staff (Shacklock & Brunetto, 2012) are also suggested as improving job satisfaction and reducing intention to leave.
One means of addressing any real or predicted shortfall is to investigate options that support workers to remain in the workforce at increased capacity, maximising their ability to perform the job. However little research investigating the older nursing workers’ retirement intentions and strategies to retain these workers longer (Graham & Duffield, 2010) has been conducted in Australia. Schofield, Shrestha, Passey, Earnest and Fletcher (2008) suggest that in the vicinity of 663,000 older Australians were not working because of ill-health, and argued that specific strategies to reduce workforce attrition from chronic disease in workers, will become more critical in improving the overall labour pool and retaining experienced workers in the industry for longer. This will benefit the workforce in two key ways; less attrition through delay in retirement, and extended opportunities for experienced workers to share their knowledge and experience (i.e. mentorship) with novice practitioners. Facilitating healthier workers would also benefit the health system indirectly through reduction of demand on service. Here, the emphasis is on physical health, but additionally an emphasis needs to be placed on the previously highlighted emotional demands and psychosocial environment in which the direct care worker works.

Aside from broader issues of workload and gross nursing numbers, staff skills and experience are deemed crucial, with aged care nurses identified as having shortfalls in these areas (Eley et al., 2007). Inadequate or inappropriate skill mix has been described as contributing to stress (Tuckett, Parker, Eley, & Hegney, 2009), and has been shown to directly impact patient mortality rates (Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005), particularly when the percentage of Registered Nurses is reduced (King, Wei & Howe, 2013). Despite this understanding Welton (2011) identified a tendency of “for profit” organizations to run with a lower percentage of RN staff per bed than not for profit or governmental organizations. Whilst this model may save money in the short term, implications for quality of care in the form of inappropriate or missed care, and actual long-term cost implications through provision of unnecessary care or medical errors, exist. Recently a New South Wales government inquiry investigating Registered Nurses in nursing homes, identified significant concerns about this particular issue, consequently recommending minimum staffing ratios in aged care facilities (New South Wales Parliament, 2015).
While prevention of adverse outcomes is certainly a desirable outcome, when specifically considering the notion of quality of care other components of the nursing role must be included. Subjective outcomes are inherently influenced by things such as: one’s personal beliefs and value system; one’s perceptions of interactions and outcomes; and the expectations of the consumer, service provider and broader community. Impacting also on quality of care are external contributors such as funding cuts and pressure on bed usage which according to Jackson and Haigh (2010) leaves nursing “…in danger of being subsumed by the demands of service delivery” (p.3).

Management decision on staffing numbers, skill mix of staff required, and subsequent management of these staff contribute to this issue. Frequently it is the frontline manager that is positioned at the nexus between staffing demands and fiscal constraints, and as such strong leadership and the motivation to negotiate workable solutions is required. Leadership and management style (alongside in-service education) have been identified as the “…really important aspects of skill mix…” (Pearson, Hocking, Mott, & Riggs, 1992, p. 776) in the nursing home environment.

1.8.8 Education

Increasing nursing intake numbers is contingent on three key factors; availability of willing students, the availability of academic education places, and the availability of appropriate clinical placements. Of these, the latter is arguably the most problematic in the current climate. Clinical placements for nursing students are becoming increasingly difficult to negotiate, exacerbated by some health care providers requesting financial recompense for allowing students the opportunity to learn within their workplace. Those placements that are available are struggling with increasing numbers of students, a situation that if left unaddressed may in fact cause higher rates of attrition in the longer term. The problem here is twofold. First, students are not afforded appropriate supervised opportunities to learn and practice the myriad of skills required of a contemporary nurse; and have insufficient time to receive appropriate feedback and support available. Hence students do not develop as well as they might otherwise, and are more likely to graduate with skill or knowledge deficits that impact their ability to effectively integrate into the workforce. Second, current nursing staff can become disillusioned and suffer increased stress as they do not feel that they are supporting students properly or providing the level of direct care (due to student demands) they believe is required. Numbers of experienced nurses in the
clinical environment are reducing, and they must be supported to find meaningful experiences within the workplace. Retaining these workers is vital (Hayward, Bungay, Wolff, & MacDonald, 2016).

At face value the provision of increased academic education capacity may not appear difficult, simply inject funds, construct teaching space, and educate new workers. However the provision of suitably qualified academic staff to teach into academic programs has been identified as a contemporary issue (McDermid, Peters, Daly, & Jackson, 2016), and any increase in gross education places would exacerbate this. Additionally, current models of education do not adequately address the education needs for a contemporary nurse requiring enhanced generalist skills (Chiarella & Roydhouse, 2011) that allow flexibility in dealing with diverse patient casemix, and as such re-structuring of teaching programs may be required. Jackson and Haigh (2010) suggest that a contemporary nurse must not only be clinically skilled but also politically confident, able to negotiate the “...politics of contemporary healthcare” (p.4), able to ensure they are involved in decision making processes that impact on nursing care and nursing care delivery. Contemporary academics must drive the delivery of relevant pre-registration education and should also consider incorporating these evolving elements into post-graduate programs that up-skill current workers.

1.9 Stress in the working environment
Stress (Coomber & Barriball, 2006), stress resiliency (Larrabee et al., 2010), perceptions of the adequacy of staffing and missed nursing care (Kalisch et al., 2011), and issues around professional status, remuneration and autonomy (Cowin, 2002), are identified as contributing to decreased job satisfaction and may lead to higher turnover (Coomber & Barriball, 2006). Moral distress is linked to depersonalization, burnout and decreased job satisfaction (Özden, Karagözoğlu, & Yıldırım, 2013). Conversely, quality patient contact and teamwork (Moyle et al., 2003), social support and empowerment (Joiner et al., 2004), and investment in learning and development (Johnson et al., 2011), have all been shown to correlate positively with job satisfaction. High satisfaction correlates with a decreased intention to leave the workplace (De Milt et al., 2011).
Improving the psychosocial working environment (Winslöw & Borg, 2008), fostering quality relationships amongst staff (Galletta et al., 2013), and nurturing a suitable ethical climate (Wang & Hsieh, 2013) are important organizational responsibilities. Consequently, to understand the relationship between the worker and the workplace is important (Vanderheide, Moss, & Lee, 2013). Both inherently depend upon the reliable and consistent functioning of the other to facilitate productive outcomes.

Organizations must be prepared to actively foster a supportive work climate that engages nurses in a professionally rewarding manner. This commitment has been identified as an important factor in ensuring workers remain engaged and productive (Carver & Candela, 2008; Simpson, 2008). Organizational efforts should specifically target the enhancement of the professional status of nurses and development of supportive and cohesive coworker interactions (Simpson, 2009). An environment of positive engagement has been shown to improve front end recruitment, by enhancing the attractiveness of the organization (Salanova, Agut, & Peiro, 2005), while an environment of low engagement has been linked to moral distress (Lawrence, 2011). A corollary of this is that the supportive environment with a foundation of meaningful engagement and attendant relationships will foster a workplace able to cope with job related stress including moral distress.

### 1.10 Moral Distress

Jameton (1984) originally described the idea of moral distress as one in which one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). Building further on this Wilkinson (1987) sought to explore the phenomenon of moral distress and described the phenomenon of moral distress and the phenomenon of moral outrage. As a result of these investigations Wilkinson proposed the Moral Outrage Equation (considers experience and effect) and a Moral Distress Model (discussing situations, actions, cognitions and feelings involved in the experience) (Wilkinson, 1987).

Corley (1995) employed Jameton’s (1984) definition as well as the results from Wilkinson’s (1989) investigations, as a basis for the development of a scale to measure this concept of moral distress. Two specific contributing elements were noted by Corley (1995): the seriousness of the situation (later described as intensity), and the frequency of occurrence.
Also contributing to this foundational understanding, Corley (2001) later describes the conceptual influence of both House & Rizzo’s (House & Rizzo, 1972) ‘Role Conflict Theory’, and Rokeach’s (1973) text on ‘The Nature of Human Values’, on her conceptual understanding and subsequent instrument development.

Hanna (2005) describes moral distress as “…an act of interior aversion which occurs with the perception of harm to an objective good” (p.119), and further delineates moral distress into three distinct categories; shocked moral distress (abrupt, intense); muted moral distress (interior experience with exterior silence); and suppressed moral distress (frequent exposure leading to ‘professional blunting’ (persistent, chronic). Hanna (2005) identified an important and previously unrecognised point of difference in her study population, that moral distress “…can occur when nurses act in accordance with what they believe is good and right” (p.115). This contrasts with the more common belief of others (Jameton, 1993; Tiedje, 2000; Wilkinson, 1989) - that it is the inability to engage in the desired course of moral action that is a critical component in generating feelings of moral distress.

Nathaniel (2006) in discussing the process of moral reckoning in nursing and in a bid to formulate an explanatory theory of moral distress, proposed a synthesized definition. Nathaniel’s definition was based in the foundational ideas of both Jameton (1984) and Wilkinson (1987), but also incorporates that element more clearly described by Hanna (2005), that of moral distress occurring despite a desired moral action taking place. Most specifically Nathaniel explains:

“moral distress is pain affecting the mind, the body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action, yet, as a result of real or perceived constraints, participates, either by act or omission, in a manner he or she perceives to be morally wrong” (p.421).

Commonly, the initial ideas put forth by Jameton and supported by Wilkinson and/or Corley, have been used as a basis for investigations or discussion of moral distress (Wendy Austin, Vangie Bergum, & L Goldberg, 2003a; Fry, Harvey, Hurley, & Foley, 2002; Green & Jeffers, 2006; Hamric, 2000; Laabs, 2005; Nathaniel, 2006; Redman & Fry, 2000; Silen, Tang, Wadensten, & Ahlstrom, 2008), and continue to exert influence to this day.
Some authors discuss the notion of moral distress without clearly identifying a specific definition of the concept (Oberle & Hughes, 2001; Severinsson & Hummelvoll, 2001); even despite reporting a ‘low level of moral distress’ (Garel, Etienne, Blondel, & Dommergues, 2007), or desiring to ‘understand the moral distress of nurses’ (Ferrell, 2006). Austin et al (2008), using Jameton’s original ideas as well as Nathaniel’s synthesised definition, introduced the importance of perception in framing the concept of moral distress for the individual practitioner. Whilst using earlier definitions as a foundation, some authors (Meaney, 2002a; Mekechuk, 2006) very carefully and clearly describe their definition of moral distress within their specific context. Interestingly, Godfrey & Smith’s (2002) investigation found Nurse Practitioners did not agree with Jameton’s original definition of moral distress at all, and suggested further context specific conceptual investigation.

At face value this would seem reasonable, as agreement does reside in the view that it is the perception and contexts of the constraints, the values accorded by the individual involved in the given situation, and the contextual specifics of the varied clinical climates that seem to shape the specifics of any understanding of moral distress (Tiedje, 2000). However, a caution suggests that “…moral distress should not be framed or located as an individual concern (i.e. as a failing or vulnerability of individual nurses)” (Pauly, Varcoe, Storch, & Newton, 2009, p. 569). It could be argued that changes of this nature will in fact further dilute the clarity of definition, rather than providing consolidation.

Moral distress has been formally identified in the literature for 30 years, and during that time the definition of the concept, whilst showing degrees of evolution, has also become somewhat disparate in terms of clarity, and at times is poorly defined (Suhonen, Stolt, Virtanen, & Leino-Kilpi, 2011). Hanna (2005) expressed concern that “…investigators have reached an impasse regarding the concept’s definition”(p.96). Recent attempts to address the conceptual clarity (Lutzen & Kvist, 2012; Pauly, Varcoe, & Storch, 2012) may prove critical in progressing future research.
1.11 Conclusion

Chapter 1 detailed the aims, objectives and significance of this study. The structural organisation of the thesis was described providing insight to the scope of the study. Detailed discussion outlining the international and Australian nursing workforces, healthcare delivery in Australia, and the Australian aged care sector was provided. Challenges faced in attracting, recruiting and retaining direct care workers related to the provision of financial and human resources, retention of workers within an ageing workforce, and education of new workers, were identified. The psychosocial nature of the work environment, effects of stress in this environment, and the concept of moral distress were introduced.

Chapter 2 describes the literature reviews undertaken as part of this study. Two literature reviews were conducted; the first review occurred in early 2013, and a second review was conducted in mid-2016. Rationales for conducting the literature review twice are provided. The experience of moral distress is introduced, and a range of contributing factors and outcomes of this distress identified.
Chapter 2  Literature Review

This literature review was published in the peer-reviewed journal Nursing Ethics (Appendix A):


2.1 Introduction

Chapter 1 provided an overview of the aims, objectives and significance of this study. Following this the international and Australian nursing workforces, as well as the structure and governance of health in Australia and the Australian aged care sector were outlined. A range of challenges faced in attracting, recruiting and retaining direct care workers were identified and discussed.

Chapter 2 describes the literature review undertaken as part of this study. The literature review was conducted twice; the first review occurred in early 2013, with an update conducted in mid-2016. A comprehensive literature review is important as it aids in identifying key academic arguments and ideas that exist (Bettany-Saltikov, 2012), facilitating an understanding of the historical evolution of knowledge in the topical area, the exploration of trends, and identification of knowledge gaps (Oliver, 2012). This knowledge is used to highlight the importance of the planned research and frames the methodology of the study (Creswell, 2014).

The purpose of the first literature review was to provide an overview of the contemporary literature and knowledge gaps related to moral distress generally, and within aged care nursing. Findings of the first literature review were used to determine the basis for the study, identifying knowledge gaps in existence at that time and providing a foundation for the methods used. The purpose of the second literature review (update) in 2016 was to ensure the discussion and recommendations included as thesis Chapters 7 and 8 were informed by contemporary literature.
Moral distress has been widely reviewed across many care contexts (Bernhardt et al., 2009; Carpenter, 2010; Hamric & Blackhall, 2007; Harrowing & Mill, 2010; Iglesias, Vallejo, & Fuentes, 2010; Zuzelo, 2007) and amongst a range of disciplines (Austin et al., 2008; Kälvemark Sporrong, Höglund, & Arnetz, 2006; Knapp, Gottlieb, Berman, & Handelsman, 2007; Schwenzer & Wang, 2006). Interest in this area has produced a plethora of studies, commentary and critique (Hanna, 2004). The definition of moral distress has evolved, but at times is poorly defined (Suhonen et al., 2011). Repenshek (2009) cautions that some discussions about moral distress may in fact be around the difficulty with moral subjectivity as distinct from moral distress.

In its original form, moral distress was defined by Andrew Jameton as “…aris(ing) when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984, p. 6). Jameton further developed this theory by highlighting two distinct phases: initial and reactive moral distress (Jameton, 1993); an approach subsequently used by others (Fry et al., 2002). An important distinction highlighted by Jameton (1993), is that between moral distress (knowing the correct course of action, but not being able to pursue this) as distinct from moral dilemma (not knowing the correct moral choice when faced with a number of options with different and important values).

Hanna (2005) describes moral distress as an inner response by the self when there is a perceived threat to “an objective good” (p.119), which suggests that it is our own perception of reality that shapes the moral distress experience. Agreement resides in the view that the perception and contexts of the constraints, the values accorded by the individual involved in the given situation, and the contextual specifics of the varied clinical climates seem to shape our understanding of moral distress. However, a caution suggests that moral distress should not be solely targeted to the individual nurse, as some sort of failing or personal weakness on his/her behalf (Pauly et al., 2009, p. 569).

In many cases the experience of moral distress is known. However others experience moral distress yet fail to recognize it (Solum & Schaffer, 2003); in many cases the experience of moral distress is a negative one, whilst others have experienced a heightened sense of autonomy and potential for moral growth (Green & Jeffers, 2006;
Meaney, 2002a). Continuing this narrative turn, on the one hand it is suggested that encounters of moral distress are not frequent, but when confronted, occur with moderate to high intensity (Corley, Minick, Elswick, & Jacobs, 2005; Pauly et al., 2009); whilst on the other hand, Godfrey & Smith (2002) suggest that generally “…the problems (attributable to moral distress) were not significant in their drama or publicity, but in their commonness and frequency” (p.335). There is however, some accordance.

An overview of the literature around moral distress reveals a commonality among factors contributing to moral distress, the attendant outcomes of this distress and a core set of interventions recommended to address these. The relevance of this literature overview resides in the implications moral distress has on the nurse and the nursing workforce.

2.2 Method of literature selection

The objective of this review was to identify literature on moral distress within the aged care environment. Initial searching identified limited literature in this specific area. The search criteria were expanded to include literature from nursing contexts outside of aged care. For this literature review the following electronic databases were utilized: Cumulative Index to Nursing and Allied Health (CINAHL) 1982-2011; PsycINFO 1980-2011; Medline 1982-2011 and Social Science Citation Index (SSCI) plus Arts and Humanities Citation Index 1982-2011. Each database was searched using key words: moral distress, moral distress scale, nursing home* and long-term care. Articles were selected based on their relevance and ability to inform about moral distress within and outside the context of nursing practice. Typically, initial search and assessment for inclusion relied on title, abstract and keywords before full-text papers were pearled for inclusion. In addition, the literature reviewed relied on mining articles’ reference lists (i.e. snowball sampling) for relevant publications. Articles were limited to those written in English and the review excluded doctoral dissertations and abstracts to meetings. Furthermore, a number of electronic journal and online content alerts were established using the key words described above, to capture the most recent articles. Whilst the review of the literature did not set out to answer a specified question, it was nevertheless conducted in a systematic manner providing a rigorous representation of the literature.
2.3 Literature themes

The consequence of the search strategy described above meant that the literature emerged and was grouped under three core themes: Theme 1 specialist critical nursing; Theme 2 specialist nursing and Theme 3 specialist-non-nursing (Table 2-1 below). For the purpose of this review with its focus on nursing, primarily only that information (data) pertinent to Theme 2 is reviewed here. It was hypothesized this would provide greater diversity of ideas and thus improve the probability of capturing as many ideas as possible, but with an end-point. In other words, data saturation and thus a rigorous representation of the literature (Rice & Ezzy, 2000).

Table 2-1 Core themes from the moral distress literature

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<tr>
<th>Theme 1</th>
<th>Theme 2</th>
<th>Theme 3</th>
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<td>Specialist critical nursing</td>
<td>Specialist nursing</td>
<td>Specialist non-nursing</td>
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<tr>
<td>Critical care</td>
<td>Military</td>
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<td>ICU</td>
<td>Medical/Surgical</td>
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<td>NICU</td>
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<td>PICU</td>
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<td>Nurse Managers</td>
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ICU = Intensive Care Unit
NICU = Neonatal Intensive Care Unit
PICU = Paediatric Intensive Care Unit

2.4 Contributing Factors, Outcomes and Interventions

What follows is an examination of moral distress in terms of contributing factors, outcomes and interventions. Based on our review, it is clear that a cluster of factors contribute to moral distress in nursing with attendant outcomes or consequences. Typically, the literature also reveals key interventions that are recommended to counter the effects of moral distress (refer Figure 2-1 below).
2.4.1 Contributing Factors

A mechanism for considering the contributing factors to moral distress is to review three primary sources; individual practitioners, site specific systems, and broader external influences (Corley & Minick, 2002; Epstein & Delgado, 2010; Hamric & Blackhall, 2007; Malloy et al., 2009; E. Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008). It is worth noting that within the literature reviewed here, some of the contributing factors assigned as site specific are not necessarily mutually exclusive from broader external influences. For example, ward level healthcare delivery is necessarily (but not entirely) influenced by broader policy and economic imperatives, and as such the two are in many ways
intertwined. Consider funding availability directly impacts on staffing levels and skill mix and an imbalance between care demand and suitable staffing can contribute to moral distress. However staffing and skill mix issues may originate specifically at a local ward level regardless of broader external influences.

2.4.1.1 Individual

The experience of moral distress is grounded within the individual, who they are, their perception of events (Hanna, 2005; Tiedje, 2000; Wilkinson, 1989). This includes individual character traits or personal qualities; a nurse’s world view (understood to encapsulate for example personal values, role perceptions and culture) and the personal experience a nurse has or has had. In addition, inter-personal relationships directly influence the nurse’s experience, or their reality of, moral distress.

Character traits/personal qualities. Moral distress is linked to how the nurse perceives their role (Hanna, 2005; Tiedje, 2000; Wilkinson, 1989). It is known that in whatever role the nurse is, both knowledge (Laabs, 2007) and perceived skill level of the nurse and the nurse’s confidence all compound the moral distress experience (Pauly et al., 2009; E. Rice et al., 2008). Ohnishi et al. (2010) also found an increased level of moral distress related to an increase in the level of authority a nurse had. In addition, the nurse needs to be able to not only communicate ethical dilemmas in a language accessible to medical staff (Krishnasamy, 1999), but also have the capacity to make ethical decisions in ethically challenging situations if moral distress is to be avoided (Malloy et al., 2009). This capacity to make ethical decisions extends to include treatment decision making (Montagnino & Ethier, 2007) with a strength of character to manage different opinions about treatment options between staff and family members (Green & Jeffers, 2006). Nurses may at times be viewed as risk averse, with Tiedje (2000) suggesting that the courage to take additional risks may be “the greatest challenge in moving from moral distress to moral action” (p40). Ethics education is suggested as instilling practitioners with the confidence to accomplish moral action more effectively (Lang, 2008), and in fact may have a “…significant positive influence on moral confidence and moral action…” (Grady et al., 2008, p. 1).

Worldview. It is apparent from the literature that moral distress can emanate from a variety of causes with variations also between practitioners in the same clinical situation. A nurse’s worldview such as expectations of standards of care (Wendy Austin, Vangie Bergum, & Lisa Goldberg, 2003b), moral sensitivity (Lützén, Blom, Ewalds-Kvist, & Winch,
2010) and individual ethical perspectives (Cutcliffe & Links, 2008) all contribute to the moral distress experience. Additionally, the nurse’s value perspective (Laabs, 2007) will likewise contribute. This last opinion also resonates in the observation within the context of midwifery; that the specific elements contributing to moral distress develop from a combination of our personal value systems and the nature of enculturation to the workers role (Hanna, 2005; Tiedje, 2000; Wilkinson, 1989). Whilst the workplace culture then influences moral distress, so too does a person’s own cultural background (Montagnino & Ethier, 2007; Yam, Rossiter, & Cheung, 2001).

Experience. Perceptions of moral distress may develop from cumulative life experiences and prior experiences in similar or identical situations. The notion that professional experience is a contributing factor is intriguing. There has been some suggestion made that the length of experience in nursing increased the exposure frequency to episodes of moral distress (Rice et al., 2008). Furthermore, nurses lacking experience in addressing ethically challenging situations may be at higher risk of experiencing moral distress (Meaney, 2002a). Wilkinson (1989) posits that “...more experienced nurses probably encounter fewer instances of moral distress” (p.516). One wonders if this is simply a reduced encounter rate, an evolved perception of what constitutes “real” moral distress, an improved ability to pre-empt and resolve issues more rapidly, or a dampening of the psyche from frequent exposure to morally difficult situations.

Others however identified no correlation between nursing experience (along with other demographic detail) and moral distress (Pauly et al., 2009). Corley et al. (2005) describe a significant but low negative correlation between age and moral distress intensity, however suggest that experience alone is of only limited help in dealing with it.

Relationship. The hierarchical nature of the nurse / physician relationship may also intensify issues of moral distress. The core of the problem in this relationship may stem from the differing philosophical approaches to healthcare delivery (Malloy et al., 2009; Redman & Fry, 2000), such as a curative as opposed to a care based approach. As a consequence, conflict in professional relationships is a most common contributor to moral distress (Solum & Schaffer, 2003). For example, it has been demonstrated that nurses “felt that they lacked either power to speak against physician’s opinions”, or “believed that their opinion would not be accepted” (Malloy et al., 2009, p. 724). This affirms both Meaney
(2002a) and Pendry (2007), who recognize the notion of “responsibility with no authority” as a contributing factor. As a consequence, nurses become adept at “politically, manoeuvring information in order to present it in a palatable manner for the physician” (Malloy et al., 2009, p. 726). In other quarters, the literature revealed nurses were “...faced with the choice of either overstepping the boundary and acting, or waiting for the physician, watching the suffering of their patients” (Torjuul & Sorlie, 2006, p. 410).

Other than the nurse / physician relationship as contributing to moral distress, the literature revealed how relationship in terms of closeness to an event and to the client/patient also impacts the moral distress experience. For example, Hanna (2005) suggests proximity to, and the type of procedure as confounding elements. And, a long standing relationship with the patient (Klein, 2009) and/or a large amount of contact time (Ahlström & Wadensten, 2010) also potentially increasing the intensity of moral distress.

2.4.1.2 Site Specific

As a contributing factor to the nurse’s experience of moral distress, site specific variables refer to matters such as resourcing (like time and money), staffing, the nature of care being provided and the general organizational structures (what we have termed the “world of work”).

Resourcing. The availability of resources to an industry or imbalances between supply and demand, are examples of external influences affecting an institution’s ability to garner sufficient resources for service delivery. However executive decisions regarding allocation of resources within the organization also impact. These decisions may facilitate or directly contribute to situations of moral distress (Austin et al., 2003b; Godfrey & Smith, 2002; Green & Jeffers, 2006; Tiedje, 2000). Typically, this is discussed in the context of a lack of resources (Kain, Gardner, & Yates, 2009; Nordam, Torjuul, & Sørlie, 2005). For example, in the discussion on humanitarian nursing challenges, Almonte (2009) describes the relative inability to provide any tangible level of health care to indigenous populations due to a lack of health care resources as a contributing factor to moral distress.

Whilst staffing is also discussed as contributing to moral distress, two limited resources stand out in the literature: time and money. The literature assigns cost containment (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; Tiedje, 2000)
Staffing. Another external factor that is also arguably attributable to broader external influences and contributes directly or facilitates an environment of moral distress is staffing. Our review suggests that staffing contributes to moral distress in three ways. Firstly, unsafe staffing levels have been found to contribute to the highest intensity and frequency of moral distress (Corley et al., 2005). Typically, the highest intensity of moral distress is related to low staffing levels within the ward (Ohnishi et al., 2010). Others concur with this relationship between moral distress and staffing levels (Kain et al., 2009; Oberle & Hughes, 2001; Silen et al., 2008). Secondly, staffing patterns that limit access to patient care or implementing managed care policies have been identified as a compounding variable (Grace, Fry, & Schultz, 2003). Finally, staff training, more specifically inadequately trained staff are another contributing factor (Brazil, Kassalainen, Ploeg, & Marshall, 2010).

Care. Dimensions of site specific care and caring contribute to moral distress. Kälvemark et al. (2004) identify a lack of beds for patient care delivery, and others an inappropriate environment for the provision of palliative care (Kain et al., 2009) as contributing factors. In a similar care context, Brazil et al. (2010) identified a lack of access to care as a contributor to the moral distress of nurses. Further to this notion of “lacking”, a lack of health care knowledge of either parents or other organizational members contributing to ethical issues (Solum & Schaffer, 2003); a general lack of information (Brazil et al., 2010) and a lack of knowledge (literature/system) regarding the relationship between personal assistants and the disabled person (Ahlström & Wadensten, 2010) all cause moral distress to occur.

Not surprising, issues pertaining to a number of ethical principles in care were identified in the literature as well. For example, Nordum, Torjuul and Sørlie (2005) identified disrespectful care delivery by other practitioners, and in the context of the School Nurse, maintaining client confidentiality (Solum & Schaffer, 2003) as potentiating moral distress. Elsewhere, a patient’s refusal of care deemed appropriate by nursing staff (Dudzinski & Shannon, 2006) was identified as significant. A similar conflict was noted by both
Montagnino (2007) and Kirk (2007), although they identified this situation within the nurse / family member relationship. Concurring, Brazil et al. (2010) identified this contributing factor as emerging from patient autonomy in decision making.

Also not surprising, moral distress has been linked to perceived futile care situations (Rice et al., 2008). In their commentary, Couillard and Brownell (2009) described a case of a patient with a progressive neurological deterioration causing loss of oral communication. They postulate that moral distress is likely to arise in this situation when members of the healthcare team offer differing opinions about appropriate care options. They “…may believe that the care they are providing is actually harming the patient, and yet they have no way to influence the care decision about continuing her life” (p.161). The provision of overly aggressive or futile treatment is a concept that emerges strongly as one causing moral distress (Brazil et al., 2010; Epstein, 2010; Ferrell, 2006; Kain et al., 2009; Oberle & Hughes, 2001).

As stated above, dimensions of site specific care and caring contribute to moral distress. It is the case therefore, that Fry et al. (2002) within the military practice setting, recognize the atypical patient conditions and the military triage system as furthering moral distress for nurses. Of particular interest is the military triage system, where “…the least wounded or ill may receive priority treatment, particularly if medical resources are scarce…” (p.379). Elsewhere, and in concordance, efficiency (Tiedje, 2000) and a push for efficiency rather than quality of care (Mauleon, Palo-Bengtsson, & Ekman, 2005) are invoked as causative agents.

*World of work.* At the hospital ward level, others describe this contributing factor in terms of the uniqueness of the practice setting (e.g. as dangerous) (Fry et al., 2002) or in terms of patient and role boundary issues (Severinson & Hummelvoll, 2001). Others point to the ethical (Corley et al., 2005; Pauly et al., 2009; Silva, Gibson, Sibbald, Connolly, & Singer, 2008) or moral climate (Lützén et al., 2010) all of which contribute to the nurse’s moral distress.

Examples are borne out in the literature demonstrating these organizational structures and the impact of the uniqueness of the nurse’s world of work. A number of authors (Austin et al., 2003b; Ohnishi et al., 2010) identified high frequency of encounters of moral distress in
the psychiatric care environment. Ohnishi et al. (2010) notes that this high frequency (but low intensity) is in contrast to previous findings of other researchers such as Corley, Minick, Elswick and Jacobs (2005) who identified low frequency but high intensity of moral distress in the acute care (non-psychiatric) environment. However, Deady and McCarthy (2010) also identified low frequency with high intensity, but in the acute care psychiatric environment. In their investigation into the psychological and ethical cost for midwives exposed to termination of pregnancy for fetal abnormality, Garel, Etienne, Blondel and Dommergues (2007) identified midwives as reporting low levels of moral distress. This low level of moral distress may be explained by the self-selection of staff that choose to work in this specialised area and who are free from conflict regarding the morality of termination. What is apparent is that despite variations in intensity and frequency, moral distress occurs across multiple clinical settings regardless of clinical specialty or level of acuity.

A further insight is revealed in examining moral distress and the use of the multi-disciplinary approach to care. While this approach can have significant benefits for care provision, a poorly functioning team may generate a range of detrimental effects such as discontinuity or omission of care, conflicting advice or education, and subsequent poor use of valuable health resources. Deady and McCarthy (2010, p. 209) found that “while multidisciplinary teams appear to function well on the surface, situations that give rise to moral distress are not always acknowledged or dealt with effectively”. An additional factor that appears to filter out from Sturm’s (2007) investigations, is that the distress experienced by different team members may generate from different elements within the one situation.

Adding to this effect of the multi-disciplinary team, at the ward level and more generally is also the decision making hierarchy (Oberle & Hughes, 2001), the hierarchical imposition of obedience (Mauleon et al., 2005), discrepancies between authority and a nurse’s professional obligations (Mauleon et al., 2005), and, a dash of responsibility with lack of real authority (Krishnasamy, 1999). It is in this world of work that the ward nurse finds themselves constrained and left feeling unable to pursue the right course of action when it is called for. Elsewhere in the literature, a number of writers concede that matters are not improved for the hapless ward nurse because of a lack of confidence in reporting systems (Attree, 2007), a general lack of support (Godfrey & Smith, 2002) specifically related to
decision making (Nelson, 2009), and a lack of professional recognition (Nordam et al., 2005).

2.4.1.3 Broader External Influences

The site specific variables, could in turn, be attributable to broader external influences. For example, at a more macro level, economic factors (Silen et al., 2008) including issues of efficiency, cost containment and resource allocation (Tiedje, 2000); all compounding staffing levels (Corley et al., 2005; Kain et al., 2009; Oberle & Hughes, 2001; Silen et al., 2008) and access to care, (Brazil et al., 2010) and all in turn contribute to moral distress.

Additionally, the literature reveals the broader healthcare regulations (Pendry, 2007) or organizational policy and procedures (Silen et al., 2008; Solum & Schaffer, 2003) as constraining the nurse in taking the most ethically appropriate course of action. An example of the broader external factors impacting moral distress, is the tension caused between hospital practice and evolving evidence-based best practice (Godfrey & Smith, 2002). Other variables can be reviewed under three streams: standards, the law and other parties. Firstly, nurses are distressed by child protection reporting, pressure to work outside of nursing practice standards (Solum & Schaffer, 2003) and by accreditation requirements (DeWolf-Bosek & Ring, 2010). Secondly, nurses can feel constrained in following the most ethical path by legal restrictions (Hanna, 2005; Laabs, 2005) and more specifically by rules around confidentiality (Laabs, 2007; Solum & Schaffer, 2003) or Do Not Resuscitate (DNR) policy (Solum & Schaffer, 2003). Thirdly, the nurse’s capacity to do what is right and good is compromised by the vested interests of third parties (Curl, 2009) to include directives from funding bodies (Pendry, 2007) and interagency conflict (Meaney, 2002b).

A vivid example of the manner in which macro-policy and the interests of others generates moral distress, involves a nurse’s scope of practice. Delivery of quality health care frequently requires effective multi-disciplinary investment, but restrictions related to scope of practice can also contribute to feelings of disillusionment and distress. Sharing of health information with patients is an area in which conflict can arise when nurses must avoid relaying information that constitutes a ‘medical diagnosis’. Avoidance of this conflict through “…deception by omission, vague responses and half-truths in order to avoid disclosing the truth about diagnoses to patients” (Torjuul & Sorlie, 2006, p. 410) have been identified as a mechanism employed by nurses furthering the moral distress they feel.
In summary, the literature reveals a trifocal lens for examining the contributing factors for moral distress. Firstly, the nurse’s experience of moral distress comes down to her/his individual traits, their view of the world, what they have or have not experienced and the nature of their professional relationships. Secondly, site specific characteristics impact the nurse’s experience of moral distress. These include characteristics like a lack of resources; staffing numbers, skill-mix and education, and the composition of work teams; the nature of care and the absence of caring and lastly, organizational structures. Thirdly, and last of all, there are broader external influences that contribute to the nurse’s moral distress and these do include economic rationalism and the ability or not to meet the requirements of standards, the law and third-party expectations.

### 2.4.2 Outcomes

Outcomes describe the impact or consequences of moral distress. The overview of literature suggests that nurses’ are affected primarily in two ways: moral distress has consequences for the self and others, and consequences also for the system. The former refers to those consequences of moral distress that a nurse personally feels (“I would feel…”); and also includes those consequences that would be expressed towards or onto another (“I would act…”). The latter describes the consequences of moral distress but analyses these as they affect the healthcare system or workplace itself (“I would do…”).

Generally speaking, moral distress predisposes the nurse to stress (Pendry, 2007) and risks exacerbating underlying illnesses (Hanna, 2005). Whilst not all ethically challenging events invoke a heightened moral distress nor are evaluated negatively (Garel et al., 2007; Green & Jeffers, 2006; Meaney, 2002a) in most cases moral distress has a deleterious effect on the nurse and the workplace.

#### 2.4.2.1 Towards the self (“I would feel…”)

A nurse may feel anger (Ferrell, 2006; Krishnasamy, 1999; Tiedje, 2000) towards her/himself when knowing the right thing to do and institutional constraints make it nearly impossible to pursue the right course of action. Under these circumstances, the literature further reveals the nurse experiencing horror and anticipatory dread (Hanna, 2005); experiencing diminished confidence (Nelson, 2009) self-doubt (Laabs, 2007) and an
eventual loss of self-esteem (Wilkinson, 1989). In this context, feeling demoralized, helpless, hopeless (Ferrell, 2006) with a diminished sense of purpose (Nelson, 2009), the nurse’s moral distress produces personal and professional disillusionment (Krishnasamy, 1999). The nurse feels a sense of resignation (Hanna, 2005) and ultimately experiences depression (Green & Jeffers, 2006).

In addition, the tension between what is done versus what ought to be done produces guilt (Ferrell, 2006; Tiedje, 2000), remorse (Hanna, 2005), regret (Laabs, 2007) pain, pain of failure, and a heightened sense of personal grief (Hanna, 2005). The nurses’ personal integrity and values are eroded (Krishnasamy, 1999). It is not surprising then that the literature further bears out the nurse experiencing higher levels of exhaustion (Ohnishi et al., 2010) including emotional exhaustion (Pendry, 2007) and emotional detachment (Laabs, 2007). These latter emotional elements typically delineate a feeling of being burnt out (Nordam et al., 2005). That is, experiencing burnout (Meaney, 2002b; Ohnishi et al., 2010; Schwarz, 2003; Weissman, 2009).

2.4.2.2 Towards others (“I would act…”)
A nurse may also express anger (Ferrell, 2006; Krishnasamy, 1999; Tiedje, 2000) towards another when experiencing moral distress. The literature further reveals being powerless towards the other in the given situation, notably powerlessness over treatment decision making (Ferrell, 2006; Krishnasamy, 1999; Laabs, 2007; Montagnino & Ethier, 2007; Nordam et al., 2005; Wilkinson, 1989). In the ward situation, amongst patients and peers, the nurse risks becoming callous and bitter (Meaney, 2002a); cynical (Ohnishi et al., 2010); exasperated (Krishnasamy, 1999) and demonstrating shock and dismay (Hanna, 2005). A dominant expression of the nurse’s moral distress identified in the literature is frustration (Ferrell, 2006; Green & Jeffers, 2006; Krishnasamy, 1999; Laabs, 2005; Nordam et al., 2005; Tiedje, 2000).

2.4.2.3 Towards the system (“I would do…”)
It should be alarming that when the morally correct course of action is impossible to pursue nurses chose not to discuss the problem or take no direct action at all (Cohen & Erickson, 2006). In the context of care and caring, more alarming still that a nurse would avoid the patient (Wilkinson, 1989), avoid a conflict situation (Laabs, 2007) and on occasions this led to the nurse ending care delivery altogether (Kirk, 2007). Consequently, moral distress leads to issues with quality of care, and patient satisfaction (Pendry, 2007).
Contrary-wise, some have even reported nurses over-compensating with extra care (guilt response) to counter the negative experience (Wilkinson, 1989).

Epstein and Hamric (2009) describe the “crescendo effect” as both a contributor to, but also an outcome of moral distress. The crescendo effect is said to generate from repeated incidents of moral distress, with a resultant moral residue (or what Jameton earlier described as reactive distress) increasing over time. This residual effect creates a new baseline level for an individual’s moral distress, which in turn increases the intensity of subsequent incidents. Consequently an individual may display stronger emotional reactions particularly in situations similar to earlier experiences. It is viewed as a multi-disciplinary issue, and is evident where “…unit, team, or institutional/system dynamics continue to be unaddressed” (Epstein & Hamric, 2009, p. 333).

An additional and dominant workplace consequence of moral distress is the issue of retention and staff shortages (Pendry, 2007). Nurses not only think about leaving their current position, but consider leaving the nursing profession altogether (Green & Jeffers, 2006); and others do change jobs (Laabs, 2007; Wilkinson, 1989) and leave the profession (Schwarz, 2003; Weissman, 2009).

It is obvious then that moral distress has a negative effect on organizational culture (Nelson, 2009). Perhaps even more worryingly, Kalvemark et al. (2004) identified instances of practitioners either being forced to act, or voluntarily breaking the rules, due to systems based limitations. In the specific context of the nurse practitioner, one of the more concerning strategies was that of working around systems constraints (Godfrey & Smith, 2002). The inherent danger of this “working around the system” is the continuation of systemic problems that should otherwise be corrected. At risk then, is that a strategy like this aimed at countering moral distress, can have a negative effect on broader community relationships (Nelson, 2009).

### 2.4.3 Interventions

So far, the overview of the literature has examined moral distress in terms of contributing factors and outcomes. This final section highlights some of the interventions deemed appropriate in rectifying nurses’ moral distress. Emerging from the review are two sub-
terms: interventions or practices which focus on the individual nurse and interventions that take a more collaborative or involvement of others approach.

2.4.3.1 An individualistic approach
Education is a key recommendation for improved understanding of, and developing coping strategies for moral distress. A positive correlation between ethics education and the moral action of nurses has been demonstrated (Grady et al., 2008). Malloy and colleagues (2009) and Meaney (2002c) concur that education must focus on the individual practitioner and their own ethical skills. In addition, improving communication is a common theme that emerges as a strategy to reduce the frequency and intensity of moral distress (E. Rice et al., 2008; Torjuul & Sorlie, 2006).

Whilst individuals ought to engage in education and communication strategies to counter the consequences of moral distress, others make more targeted recommendations. For example, Wilkinson (1989) insists that practitioners must actively seek assistance in dealing with the consequences of moral distress. Two authors contribute to this, suggesting the individual seek morally sensitive support (Brazil et al., 2010) and/or chaplaincy support (Ferrell, 2006). Others propose that nurses engage in critical self-reflection (conscious reflexivity) as a self-improvement strategy to facilitate personal growth and coping (Hanna, 2005), cultivate coping skills (Rice et al., 2008), or explore the role emotions play in moral decision making (Krishnasamy, 1999). Perhaps radically, the nurse is even encouraged to lobby for resource funding (Corley & Minick, 2002), engage in political action (Torjuul & Sorlie, 2006), or be prepared to leave the profession (Curl, 2009).

2.4.3.2 A collaborative approach
An inoculation to moral distress is collective action (Tiedje, 2000). Again, education is proposed with a focus on fostering and participation in an inter-professional environment to facilitate greater understanding of the perspectives of other health practitioners (Epstein, 2010; Fenton, 1988; Kälvemark et al., 2004; Pendry, 2007), to improve collaboration (Nordam et al., 2005; E. Rice et al., 2008; Torjuul & Sorlie, 2006) and consequently, interdisciplinary dialogue (Cohen & Erickson, 2006). Implementation of inter-professional forums are suggested as a worthwhile strategy to develop understandings of other disciplines decision making processes (Oberle & Hughes, 2001) as well as the provision of a forum to discuss patient goals (Montagnino & Ethier, 2007).
Not surprisingly, ethics education is also suggested (Bell & Breslin, 2008; Lang, 2008; Nordam et al., 2005). Education of this type aims to raise awareness of potential moral issues, and provide better understanding of relevant policies and laws (Wilkinson, 1989). Collective techniques include role plays, scenarios (Fenton, 1988; Kälvemark et al., 2004; Pendry, 2007), ethics rounds and/or staff meetings (Rice et al., 2008). Meaney (2002c) suggests the potential of a narrative style manual that incorporates a history of an individual’s profession’s ethical decision making processes. This latter approach resonates with Tiedje’s (2000) notion of storytelling, which involves describing and discussing the experience of moral distress and Von Dras et al.’s (2009) use of peer led discussions and guided reflection. Care with design and implementation of programs must be taken though, as in one instance despite use of ethical education and forums, participants’ moral distress did not change significantly (Kälvemark Sporrong, Arnetz, Hansson, Westerholm, & Höglund, 2007).

Corley et al. (2005) implore administrators to particularly target those experiencing high levels of moral distress intensity. Many recommend the use of a mentor or role model to do such a thing (Cohen & Erickson, 2006; Erlen, 2001; E. Rice et al., 2008; Tiedje, 2000). A mentor can offer support and support definitely finds its place in this literature (Nordam et al., 2005; E. Rice et al., 2008). For example, the male nurses in Nordam et al.’s (2005) study suggested that support from co-workers and good patient relationships were key factors in improving the practitioners experience. A cultural shift towards a more open, approachable system that engenders trust and confidence (Attree, 2007), could significantly improve the ability of staff to manage ethical conflicts, reducing the perceived degree of moral distress and its consequences. A supportive culture that respects and values the issues experienced by nurses, their ethical decision making processes, and their moral concerns, must be fostered (DeWolf-Bosek & Ring, 2010; Glasberg, Eriksson, & Norberg, 2008; Nelson, 2009; Redman & Fry, 2000).

Finally, collective action in the form of practical guidance and discussion forums for sharing of concerns (Mauleon et al., 2005) must extend to the patient and their family (Rice et al., 2008). Dudzinski & Shannon (2006) talk about a “negotiated reliance response” which they suggest may alleviate distress for practitioners. This involves discussions between all stakeholders, including the patient’s family when appropriate; to facilitate a coordinated plan that recognizes the desires of all parties. Kirk (2007) also
advocates the benefits of including the family unit, suggesting that we owe a moral obligation to all parties.

### 2.5 Conclusion and relevance to clinical practice

A review of the moral distress literature highlights an assortment of inter-disciplinary literature. Factors contributing to moral distress stem from; individual characteristics, site specific systems, and/or broader external influences. Respectively, these can include for example, a nurse’s personal traits and life experiences; a ward’s staffing mix and care context and broader external influences like meeting care standards or third party expectations.

The attendant outcomes of this distress may manifest internally or externally, and are generally deleterious either to the individual (self), others and/or the system. Respectively, these can include for example, feelings of anger towards one’s self, self-doubt, diminished self-esteem, depression and even burnout; towards another, a feeling of anger, bitterness, cynicism, dismay and frustration. Finally, effects of moral distress towards the system include the nurse engaging in avoidance behaviours, changing jobs and leaving the profession.

A range of interventions have been proposed, these include: education to improve ethical understanding, ethical skills and communication; provision of morally sensitive support mechanisms; individual engagement in critical self-reflection; inter-disciplinary dialogue and education; collection of narratives or storytelling; mentorship; and enablement of a supportive organizational culture. While most authors offer recommendations, it must be acknowledged that few intervention studies appear to have been undertaken, and engaging this next step is crucial to generate the evidence about what really works.

Moral distress has implications for the nurse and the nursing workforce. Morally distressing situations contribute to decreased quality of care and diminished workplace satisfaction for staff, lead to physical and emotional illness, burnout, and staff turnover. Lacking from the body of knowledge is research specifically exploring moral distress, and most specifically the causes and effects of this distress, within the Australian aged care environment.
2.6 Limitations of the overview of the literature

This overview of the nursing literature did not set out to answer a specified question but it was conducted in a systematic manner providing a rigorous representation of the literature. The review excluded a critical appraisal and synthesis of the critical care literature. However, the decision to review the extensive literature across the broader sample of nursing specialities gives confidence that the review is both credible (valid) and dependable (reliable). All literature reviews are temporal and thus limited – this overview of literature is no different.

2.7 Update of the literature review

The first literature review included literature published up to and including 2011. The methods used in this study (and comprehensively described in Chapter 4) were directly informed by the first literature review. Following publication of the first literature review the body of research exploring moral distress has continued to expand, hence a second review of the literature in mid-2016 was performed. The purpose of this focussed update was to maintain currency with the contemporary moral distress literature, support an informed discussion (Chapter 7) and guide the development of relevant recommendations (Chapter 8) for clinical practice.

Consequently the search strategy was a modified version of the initial strategy used. For this second literature review the following electronic databases were used: Cumulative Index to Nursing and Allied Health (CINAHL) 2012-2014; PsycINFO 2012-2014; Medline 2012-2014 and Social Science Citation Index (SSCI) plus Arts and Humanities Citation Index 2012-2014. Each database was individually searched using key word: moral distress. Initial screening of results relied on title, articles not identifying moral distress in the title were excluded. Article abstracts were then reviewed, with articles selected based on their ability to inform new or evolving understandings of moral distress.

The search strategy initially returned 323 articles. Of these one article was excluded as it was the authors own literature review, leaving 322 articles. A further 252 articles were excluded based on title and abstract. This resulted in 70 articles remaining for consideration (refer Figure 2-2 below).
The 70 articles were scrutinised with a view to informing the discussion (Chapter 7) and recommendations (Chapter 8) of this study. Of these 70 articles 17 studies specifically investigated moral distress in the acute care sector, predominantly in high acuity areas such as intensive care units. The theoretical basis and conceptual understandings of moral distress were considered in 19 articles. Thirty (30) articles described a variety of investigations including (for example) students’ (Pratt, Martin, Mohide, & Black, 2013; Sasso, Bagnasco, Bianchi, Bressan, & Carnevale, 2015; Wojtowicz, Hagen, & Van Daalen-Smith, 2014), a chaplain (Guthrie, 2014), health promotion practitioners (Sunderland, Harris, Johnstone, Del Fabbro, & Kendall, 2014), sibling stem cell donors (Begley & Piggott, 2013), and home patients (Kayser, Nault, & Ostiguy, 2012). Only 4 articles reported studies with tenable links to aged care.

Of the studies with links to aged care the first study drew participants from multiple health care contexts, primarily acute care but including gerontology (Woods, Rodgers, Towers, & Grow, 2014). The second study investigated moral distress in long-term care (Edwards, McClement, & Read, 2013), and the third study was conducted in a palliative care setting (Rushton, Kaszniak, & Halifax, 2013a). The fourth article reported on the instrument validation conducted as part of this study (Burston, Eley, Parker, & Tuckett, 2016), as detailed in Chapter 5.
Frequently, contemporary literature either explores moral distress using existing instruments (Kleinknecht-Dolf et al., 2014; Lazzarin, Biondi, & Di Mauro, 2012; Papathanassoglou et al., 2012), or uses qualitative inquiry methods to further explicate understandings from different perspectives (Peter & Liaschenko, 2013; Pratt et al., 2013; Rushton et al., 2013a). Commonly this recent literature however does not add new understanding to the concept, primarily reinforcing known causes or effects of moral distress, or highlighting known conceptual discrepancies. Contributing factors, outcomes and effects identified are consistent with those described in the first literature review.

The most significant area of debate in the literature still centres on determining a clear and consistent definition of moral distress. Hamric (2012) laments that inconsistency significantly affects the capacity to study the concept. There is concern that the distinction between moral distress and moral dilemma is frequently disregarded in the literature, and that many definitions are too narrow in scope (Fourie, 2013). Fourie (2013) continues on to suggest that different definitions, for example moral-constraint distress or moral-conflict distress may be more useful.

Lutzen and Kvist (2012) contend that moral distress is primarily a psychological issue (as opposed to physical), and as such greater clarity of focus in defining the concept is required. This psychological approach is being used to develop frameworks for understanding moral distress (Rushton, Kaszniak, & Halifax, 2013b). Additionally feminism (Peter & Liaschenko, 2013), critical realism (Musto, Rodney, & Vanderheide, 2014), and various theoretical models (Barlem & Ramos, 2014; Rushton et al., 2013b) have been applied to the study of moral distress in a bid to further clarify understanding of the concept.

Varcoe, Pauly, Storch, Newton and Makaroff (2012) express concern over defining moral distress as being unable to act, finding that nurses consistently act but the real problem is in these actions being devalued or ignored. Barlem and Ramos (2014), in their theoretical re-framing of moral distress, argue that nurses must ask why as professionals they “…renounce the possibility to ethically resist situations that bring about moral distress” (p.6). Continuing to support this notion even since the second literature review, Rodney (2017) argues that a shift away from the common narrative of powerlessness and despair is needed.
Johnstone and Hutchinson (2013) argue the notion of moral distress is conceptually flawed, going so far as to suggest that moral distress should in fact be abandoned. They place greater emphasis on “…improving the quality and safety of moral decision-making, moral conduct and moral outcomes…” (p.1), a view that aligns closely with the development of moral habitable environments (Vanderheide et al., 2013). The overarching ethical climate of the healthcare environment (previously identified as an issue in the initial literature review) is increasingly recognised as a consistent factor in experiences of moral distress. Musto, Rodney and Vanderheide (2014) describe organisational structure and moral agency as existing in a state of reciprocity, that is they do not stand alone. Austin (2012) suggests as necessary the provision of a safe environment that allows “…ethically messy questions to be raised and discussed…”(p.36), and as such the environment of healthcare must be one that facilitates and supports moral agency.

An emergent new idea is a link between moral distress in healthcare workers and an environmental ethic. Andrew Jameton, the ethicist who first introduced the concept of moral distress in the early 1980’s, most recently suggested that “…scaling down health care is inevitably a necessary element for mitigating climate change” (Jameton, 2013, p. 297). This scaling down would directly exacerbate issues of resource allocation, thus intensifying exposure of healthcare workers to factors noted as contributing to moral distress. In a similar fashion Dunphy (2014) suggests that moral distress also originates when healthcare professionals are unable to consolidate their preferred individual environmental sustainability practices (such as reducing use of resources, recycling) with those of the resource intensive healthcare environment.

The notion of gender differences impacting on the perception or effects of moral distress is not evident in earlier literature. One small recent study (n=31) reported statistically high levels of moral distress in female participants (O’Connell, 2014). Whilst the authors of that study note findings are not generalizable, it does provide support for further exploration of potential differences that may exist.
2.8 Conclusion

A paucity of research exploring moral distress in both the Australian and the aged care contexts is apparent. Rittenmeyer and Huffman’s (2009) systematic review identified only three studies with Australian specific content. Pijl-Zeiber et al.’s. (2008) review of the aged care literature lamented that “…there is no research that examines moral distress” (p.40). This trend has continued as evidenced in the second literature review conducted in 2016. Also this recent search of relevant databases indicates that concerns around conceptual clarity of moral distress remains. Some new ideas such as Jameton’s (2013) environmental ethic and O’Connell’s (2014) link to potential gender differences in the experience of moral distress have been presented. However commonly research in this area focuses on replicating similar exploratory studies using known measurement instruments, and predominantly in acute care areas of nursing.

Chapter 2 provided a comprehensive overview of the moral distress literature. The literature reveals a range of factors that contribute to moral distress, and clearly exposes a variety of consequences for the individual, for healthcare teams, for organisations, and for healthcare consumers. While many individual and collaborative interventions have been suggested, and some tested, greater development of interventions is warranted. Widely recognised is the need to develop conceptual clarity regarding moral distress. Despite three decades of discussion little new progress towards this is apparent in recent years.

Chapter 3 will consider workplace stress frameworks, discussing the application of moral distress within a recognised job stress framework. Contemporary models of job related stress and their applicability to the Australian aged care worker, in the context of moral distress, are considered. The discussion will focus on the theoretical basis of these concepts and their direct application and impact within the Australian aged care environment.
Chapter 3  Theoretical Framework

3.1 Introduction

Chapter 2 provided a comprehensive overview of the moral distress literature. Moral distress as a concept was identified over 30 years ago and significant debate about the theoretical basis and the definition of the concept continues to occur. The review identified an extensive body of studies exploring moral distress within a variety of healthcare settings, within which a wide range of healthcare personnel were included. A range of individual, site specific and broader external factors contributing to moral distress were identified and discussed. The attendant outcomes of this distress towards the self, towards others and towards the system were described. Interventions recommended within the literature were identified, and were either targeted at the individual or collaborative levels. However little intervention-based research is evident. A clear and distinct knowledge gap regarding the extent, causation and effects of moral distress within the Australian aged care environment was identified and provides justification for this study.

Chapter 3 discusses contemporary models of job related stress including the: Effort-Reward Imbalance (ERI) model (Siegrist, 2008); Job Demands-Resources (JDR) model (Bakker & Demerouti, 2007); Job Demand-Control (JDC) model (Karasek, 1979); and the Job Demand-Control-Support (JDCS) model (Johnson & Hall, 1988). The applicability of these models to the Australian aged care worker in the context of moral distress are considered. Finally the theoretical links between the Job Demand Control Support (JDCS) model (Johnson & Hall, 1988), moral distress and the Australian aged care worker will be explained.

3.2 Theoretical models of job related stress

A number of models describing the relationships between job stressors and stress exist. Commonly these models seek to explicate links between work requirements such as physical tasks or emotional labour, and the resultant experience of stress. Parker, Jimmieson and Way (2013) describe three key models; the Effort-Reward Imbalance model (refer section 3.2.1), Job Demand-Resources model (refer section 3.2.2), and the Job Demand-Control (Support) model (refer section 3.2.4); each of which warrant
consideration. To ensure clear understanding of the Job Demand-Control (Support) model, the foundational predecessor Job Demand-Control model (refer section 3.2.3) will also be discussed. Section 3.2.5 details the justification for the selected model used in this study.

### 3.2.1 Effort-Reward Imbalance (ERI) Model

Siegrist’s (1996) Effort-Reward Imbalance (ERI) model was originally designed and tested with a sample of male blue collar (industrial) workers and middle managers, and measured stress outcomes in the context of cardiovascular disease emergence. This model considers two key components; level of effort and level of reward. Level of effort incorporates both extrinsic components (such as job demands, obligations) and intrinsic components (such as critical coping and need for control). Level of rewards are described as being conveyed by society and include money, esteem, and status control, with threats to these rewards causing stress (Siegrist, 2008) (refer Figure 3-1 below).

**Figure 3-1 Effort-Reward Imbalance model**

![Effort-Reward Imbalance Model](image)


In this model Siegrist proposes that an imbalance between job demands and conveyed rewards (i.e. high effort – low rewards) acts as a precursor to emotional distress and adverse health outcomes. Immediate effects of this imbalance are suggested as “…recurrent feelings of threat, anger, and depression or demoralization…” (Siegrist, 1996,
p. 30); effects that have been shown to manifest similarly in psychologically founded states such as moral distress (Ferrell, 2006; Tiedje, 2000). The ERI model has been recently re-evaluated to incorporate challenges resulting from increasing globalization, particularly in relation to a globalized labour market (Siegrist, 2008). This model has been used to explore nursing contexts but not aged care, and demonstrated clear links between an effort-reward imbalance and risk of burnout (Bakker, Killmer, Siegrist, & Schaufeli, 2000).

### 3.2.2 Job Demands-Resources (JDR) model

The Job Demands-Resources (JDR) model posits that risks for psychological strain are related to either *job demands* or *job resources* (Bakker & Demerouti, 2007; Demerouti & Bakker, 2011). The authors assert their categorisations look beyond just the work environment factors accounted for in other models (such as the ERI); allowing for more inclusive consideration of risk factors, particularly emotional demands on the worker (Bakker & Demerouti, 2007). Social support and decision latitude (as components of *job resources*) are specifically highlighted. Subsequently the model is less limited and more broadly applicable across occupational settings (Bakker & Demerouti, 2007). Stress from excessive job demands are viewed as predictive of exhaustion, and stress from inadequate job resources as predictive of disengagement (Demerouti, Nachreiner, Bakker, & Schaufeli, 2001) (refer Figure 3-2 below).

![Figure 3-2 Job Demands-Resource model](image)

*Figure 3-2 Job Demands-Resource model*

3.2.3 Job Demand-Control (JDC) Model

Karasek (1979) investigated the links between workers decision making latitude and the demands of the job, using a random sample of male Swedish and American workers, and specifically focussed on individual (worker) factors, rather than organisational processes. The two key components described in this model, which are job control (latitude for decision making afforded the worker) and job demands (actual work load demands and associated stressors of the job itself), are identified as contributors to job strain (refer Figure 3-3 below). The primary supposition of the model is that job control is just as important a contributor to job strain as job demands. Job strain is defined as occurring “when job demands are high and job decision latitude is low” (Karasek, 1979, p. 287). The primary group of workers identified most commonly at risk were those in the lowest status jobs.

Workers with high job demands but correspondingly low levels of decision making capabilities are said to experience significantly higher consequences of unresolved job strain. Job control particularly is viewed as “…the constraint which modulates the release or transformation of stress (potential energy) into the energy of action” (Karasek, 1979, p. 287); with an inability to release this stress resulting in job strain. Organizational structure is functionally linked to this job decision latitude. It is proposed by Karasek (1979) that alleviating this job strain could be achieved without sacrificing productivity.

Figure 3-3 Job Demands-Control model

3.2.4 Job Demand Control Support (JDCS) Model

Johnson and Hall (1988) expanded upon the JDC model, to include consideration of work related social support of co-workers as a third factor. They propose a higher level of social support is an alleviator of job stress, and identified workers with the lower levels of social support experiencing higher prevalence of job strain. In contrast to other studies (Karasek, 1979; Siegrist, 1996) female workers were included in this randomly sampled Swedish population.

This expanded Job Demand-Control-Support (JDCS) model is an “…influential theory for understanding how work characteristics relate to employee well-being, health, and performance” (Luchman & González-Morales, 2013). It has been used and reviewed extensively; in workforce studies generally (Fila et al., 2014; Hausser et al., 2010; Luchman & González-Morales, 2013; Van der Doef & Maes, 1999), within the nursing workforce (Y. L. Chiu, R. G. Chung, C. S. Wu, & C. H. Ho, 2009; Peterson et al., 2011; Widerszal-Bazyl, Radkiewicz, Hasselhorn, Maurice Conway, & van der Heijden, 2008), and more specifically within the Australian aged care workforce (Gao et al., 2014; Rodwell, 2009; Rodwell & Martin, 2013).

3.2.5 Justification of Model Selection

Each of the four models (ERI, JDR, JDC and JDCS) have relative advantages and disadvantages. The ERI model considers both the level of (extrinsic and intrinsic) effort and the level of rewards on offer for the worker, as key components in the level of stress experienced. However it does not explicitly account for the climate of the workplace as it relates to social support. With consideration of job demands and job resources as broad categories, the JDR model provides a more inclusive framework that does facilitate consideration of the supportiveness of the work environment and autonomy in decision-making. However as support and autonomy are components within the much broader job resources category; they risk being subsumed by each other or other elements (such as physical resources) within the category.

While the JDC covers job control and job demands, it has been superseded by the JDCS which includes the additional category of social support. The JDCS considers similar components to the JDR, however the different categories used (job control, job demands, and social support) more clearly separate level of social support and latitude in decision-
making as separate entities. As this study is seeking to understand the aged care workplace environment with a view to improving the retention of workers who often have restricted decision-making capacity, the JDCS was selected for use.

3.3 Link between Job Demand Control Support (JDCS) model, moral distress and aged care workers

A detailed discussion regarding the contributing factors to moral distress has previously been included in Chapter 2. Three primary sources contributing to moral distress were identified: individual practitioners (personal traits / life experience), site specific systems (ward staffing mix / context of care), and broader external influences (regulatory care standards / third party expectations) (Burston & Tuckett, 2013) (refer Figure 3-4 below).

![Figure 3-4 Moral distress - Contributing factors](image)

The following discussion uses these contributing factors to illustrate the links between moral distress and the Job Demand-Control-Support (JDCS) model. The links between moral distress and the JDCS model are summarised in Table 3.1 below (refer section 3.3.4).
3.3.1 Job Demands

Specific demands of the job experienced by workers (job demands) were identified by Karasek (1979) as one of the two contributors to job strain. Demands of the job as contributing to moral distress are clearly detailed in the literature (Burston & Tuckett, 2013). Table 3.1 (below) provides a summary of the link between moral distress and job demands.

3.3.1.1 Individual

Karasek (1979) describes job demands as related to actual work load demands and associated stressors of doing the job. At the individual level the moral distress literature reveals minor contributing factors linked to job demands. Nurses “lacking the power to speak” or feeling as though their ideas would “not be accepted” (Malloy et al., 2009, p. 724) is evidenced. This results in a sense of feeling responsible but lacking authority (Meaney, 2002a; Pendry, 2007).

3.3.1.2 Site Specific

Contributing factors for moral distress related to job demands at the site specific level, are more commonly identified. A lack of time to do what ought to be done (Kälvemark et al., 2004; Laabs, 2005; Torjuul & Sortie, 2006) clearly emerges as a significant concern. The relationship between moral distress and staffing levels has been demonstrated (Kain et al., 2009; Oberle & Hughes, 2001; Silen et al., 2008), as well as issues with staffing patterns that limit access to patient care (Grace et al., 2003). Additionally inadequately educated staff are an additional contributing factor (Brazil et al., 2010) directly impacting on job demands.

Dimensions of care and caring also contribute to moral distress. A lack of beds for patients Kalvemark et al. (2004); an inappropriate environment for care provision (Kain et al., 2009); a lack of access to care (Brazil et al., 2010); and a lack of health care knowledge of either parents or other organizational members (Solum & Schaffer, 2003) contribute to ethical issues and moral distress of nurses. These situational job demands are known workplace stressors.

Issues pertaining to ethical principles in care were also identified in the literature. Disrespectful care delivery by other practitioners (Nordam et al., 2005), maintaining client
confidentiality (Solum & Schaffer, 2003), a patient’s refusal of care deemed appropriate by nursing staff (Dudzinski & Shannon, 2006), and patient autonomy in decision making (Brazil et al., 2010) were identified as significant elements of job demands contributing to moral distress. Moral distress has also been linked to overly aggressive or futile care situations (Brazil et al., 2010; Epstein, 2010; Ferrell, 2006; Kain et al., 2009; Oberle & Hughes, 2001; E. Rice et al., 2008). When considering these job demands in the broader context of multi-disciplinary team functioning, the demands of managing these types of challenges can either be poorly recognised, poorly managed (Deady & McCarthy, 2010, p. 209) or experienced and hence relatively valued quite differently (Sturm, 2007).

3.3.1.3 Broader external

Dilemmas for nurses also arise within the realm of information sharing with patients and significant others. Differentiation between what can be shared, and that which can only be shared by others (for example a medical diagnosis which can only be conveyed by a member of the medical team) is apparent and can create significant challenges. Nurse use strategies such as “…deception by omission, vague responses and half-truths…” (Torjuul & Sorlie, 2006, p. 410) in a bid to avoid moral distress related to these job demands.

These work load demands and associated stressors of the job itself (job demands) contribute to job strain (Karasek, 1979). The job demands of the aged care worker contributing to moral distress are significant, and emerge from a variety of individual, site specific, and broader external sources. Although the majority of these link to site specific factors contributing to experiences of moral distress, consideration of the individual and broader external factors is warranted.

3.3.2 Job Control

The level of control afforded the worker over decision-making (job control) was identified by Karasek (1979) as the second of two contributors to job strain. It is through the moral distress literature revealing a variety of factors impeding decision-making that the link between job control and moral distress can be found. Table 3.1 (below) provides a summary of the link between moral distress and job control.
3.3.2.1 Individual

Direct care workers face a range of challenges to their decision-making capacity at the individual level. If moral distress is to be avoided, workers must have the inherent capacity to make appropriate ethical decisions (Malloy et al., 2009) including decisions about treatment options (Montagnino & Ethier, 2007). The capacity to communicate effectively with medical staff about ethical dilemmas (Krishnasamy, 1999) and the strength of character to manage different opinions (Green & Jeffers, 2006) are critical skills in negotiating this space, and minimising or avoiding moral distress. Inability to do this effectively may result in workers making poor decisions, “…either overstepping the boundary and acting, or waiting for the physician, watching the suffering of their patients” (Torjuul & Sorlie, 2006, p. 410). It is this very restriction on decision-making (job control) afforded the worker that Karasek (1979) underscores as a contributor to job strain.

3.3.2.2 Site Specific

Within the nursing environment the hierarchical nature of the nurse / physician relationship (Malloy et al., 2009; Redman & Fry, 2000), the hierarchical imposition of obedience (Mauleon et al., 2005), discrepancies between authority and a nurse’s professional obligations (Mauleon et al., 2005), and responsibility with lack of real authority (Krishnasamy, 1999; Meaney, 2002a; Pendry, 2007) all contribute to moral distress, and are heavily influenced by a restricted decision-making capacity. Complicating this, Brazil et al. (2010) identified patient autonomy in decision-making as an additional factor; and as a consequence, conflict in professional relationships is a common occurrence and contributor to moral distress (Solum & Schaffer, 2003).

Furthermore executive decisions regarding allocation of resources within an organization also facilitate or directly contribute to situations of moral distress (Austin et al., 2003b; Godfrey & Smith, 2002; Green & Jeffers, 2006; Tiedje, 2000). Typically, this is discussed in the context of a lack of resources (Kain et al., 2009; Nordam et al., 2005). Cost containment (Kälvemark et al., 2004; Tiedje, 2000) reimbursement issues (Meaney, 2002b) or economic (Torjuul & Sorlie, 2006) and financial constraints (Oberle & Hughes, 2001) all invoke moral distress.

Of relevance to this research, decisions regarding the number of staff, and the skill-mix of staff provided are commonly outside the decision-making remit of the direct care workers. Clear links between resourcing, moral distress, retention and decision-making capacity are
evident and many authors identify a clear relationship between moral distress and staffing levels (Kain et al., 2009; Oberle & Hughes, 2001; Silen et al., 2008). Unsafe staffing levels have been found to contribute to the highest intensity and frequency of moral distress (Corley et al., 2005). These situations place increased demands on the worker (job demands), in circumstances which they have minimal discretion in deciding how to meet the demands (job control).

3.3.2.3 Broader external

The capacity for and scope of decision-making, and the attendant impacts on healthcare delivery, are also influenced by factors beyond the individual and the organization. Broader macro-economic factors (Silen et al., 2008) issues of efficiency, cost containment and resource allocation (Tiedje, 2000); which compound staffing levels (Corley et al., 2005; Kain et al., 2009; Oberle & Hughes, 2001; Silen et al., 2008) and access to care, (Brazil et al., 2010) all in turn contribute to moral distress. Constraints on ethical action can stem from broader healthcare regulations (Pendry, 2007) or organizational policy and procedures (Silen et al., 2008; Solum & Schaffer, 2003); for example the tension caused between hospital practice and evolving evidence-based best practice (Godfrey & Smith, 2002).

Pressure to work outside of nursing practice standards (Solum & Schaffer, 2003), accreditation requirements (DeWolf-Bosek & Ring, 2010), constraint in following the most ethical path by legal restrictions (Hanna, 2005; Laabs, 2005) and more specifically by rules around confidentiality (Laabs, 2007; Solum & Schaffer, 2003) or Do Not Resuscitate (DNR) policy (Solum & Schaffer, 2003) compound further. Finally the nurse’s capacity to do what is right and good is compromised by the vested interests of third parties (Curl, 2009), directives from funding bodies (Pendry, 2007) and at times interagency conflict (Meaney, 2002b).

Each of these elements are evidenced within the practitioner as job strain, as they directly impact upon the individual workers latitude for decision making (job control) (Karasek, 1979). The scope of decision-making for the worker is framed within, and constrained by, legal and ethical responsibilities, healthcare regulations, and organizational policies. Additionally clinical decision-making is limited by funding models and executive decisions on resource allocations.
3.3.3 Social Support
Expanding Karasek’s (1979) original model, Johnson and Hall (1988) determined social support as the third key element impacting on job strain. They identified workers with the lowest level of social support experienced higher prevalence of job strain. Like Karasek’s (1979) model, social support within the work environment also has clear links to moral distress. Table 3.1 (below) provides a summary of the link between moral distress and social support.

3.3.3.1 Site Specific
Failings in the ethical (Corley et al., 2005; Pauly et al., 2009; Silva et al., 2008) or moral climate (Lützén et al., 2010) can contribute to the nurse’s moral distress. A lack of confidence in reporting systems (Attree, 2007), a general lack of support (Godfrey & Smith, 2002), lack of support specifically related to decision making (Nelson, 2009), disrespectful care delivery by other practitioners, and a lack of professional recognition (Nordam et al., 2005) have also been identified as contributors to moral distress. These situations align with understandings that identify social support relating positively with job satisfaction (Joiner et al., 2004) and higher levels of psychological health (Teo, Yeung, & Chang, 2012). Clearly these contributors to moral distress speak to the need of providing appropriate social support in an endeavor to minimize the extent of job strain.

3.3.4 The direct (aged) care worker
Of specific relevance to this study is the identification by Karasek of nurse’s aides within the high risk group for job strain (Karasek, 1979). A comparable example of the nurse’s aide role in the Australian context is that of the un-registered care worker (Assistant in Nursing / Personal Care Assistant/Personal Care Worker), however the key principles also apply to the Enrolled Nurse. Both groups of workers have limited decision making capabilities, are legally bound to practice under the direct supervision of a Registered Nurse, and must only conduct activities that have been delegated to them. Although they do have the capacity to refuse delegation of an inappropriate activity (a choice that involves a degree of critical appraisal and decision making), there is constrained scope for independent decision making in the majority of care delivery (Nursing & Midwifery Board of Australia, 2016).
Occupational stress for nurses generates from a variety of organisational sources such as unsupportive management and high workloads (Happell et al., 2013); the silencing of voices in relation to ethical decision making (Malloy et al., 2009); and the degree of openness in the working culture (Jakobsen & Sørlie, 2010). Aged care nursing has clearly been demonstrated as a stressful experience (Eley et al., 2007), with nurses describing low levels of job satisfaction experiencing this stress more acutely (Fiabane, Giorgi, Sguazzin, & Argentero, 2013). Nurses with a higher degree of stress resiliency demonstrate an increased intent to stay (Larrabee et al., 2010).
<table>
<thead>
<tr>
<th>Job Demand Control Support (JDCS) Model</th>
<th>Known Contributors to Moral Distress</th>
<th>Examples identified in Literature Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Moral Distress Categorisation</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Lack of power to speak against physician</td>
<td></td>
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<td></td>
<td>Belief that opinions would not be accepted</td>
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<td></td>
<td>Responsibility with no authority</td>
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<tr>
<td>Site specific</td>
<td>Lack of time to do what ought to be done</td>
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<td></td>
<td>Unsafe staffing levels / skill mix</td>
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<td></td>
<td>Inadequately trained (educated) staff</td>
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<td></td>
<td>Lack of beds, inappropriate environment for care delivery (palliative care)</td>
<td></td>
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<td></td>
<td>Lack of knowledge/information (parents, organizational members)</td>
<td></td>
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<td></td>
<td>Disrespectful care delivery by others</td>
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<td></td>
<td>Patients refusal of care</td>
<td></td>
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<td></td>
<td>Provision of overly aggressive or futile treatment</td>
<td></td>
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<tr>
<td></td>
<td>Poorly functioning team, poorly functioning multi-disciplinary team</td>
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<tr>
<td>Broader external</td>
<td>Sharing of information vs medical diagnosis (omission, vague responses, half-truths)</td>
<td></td>
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<tr>
<td>Individual</td>
<td>Restricted ability to make ethical decisions regarding treatments</td>
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<tr>
<td>Site specific</td>
<td>Choice of either overstepping boundaries and acting, or waiting for the physician watching the suffering of patients</td>
<td></td>
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<tr>
<td>Job Control (decision-making)</td>
<td>Executive decisions regarding allocation of resources</td>
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<td></td>
<td>Cost containment, re-imbursement issues, financial constraints</td>
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<td></td>
<td>Unsafe staffing levels/skill mix</td>
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<td></td>
<td>Patient autonomy in decision-making (when differs to nurses)</td>
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<td></td>
<td>Decision-making hierarchy, hierarchical imposition of obedience</td>
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<td></td>
<td>Discrepancies between authority and professional obligations</td>
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<td></td>
<td>Clash of responsibility with no real authority</td>
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<tr>
<td>Broader external</td>
<td>Efficiency, cost containment, resource allocation -- staffing levels and access to care</td>
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<td></td>
<td>Healthcare regulations and organisational policies vs evidence-based practice</td>
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<td></td>
<td>Reporting/accreditation requirements</td>
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<td></td>
<td>Legal constraints on ethical practice</td>
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<td></td>
<td>Directives from funding bodies &amp; interagency conflicts</td>
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<tr>
<td>Social Support</td>
<td>Lack of confidence in reporting systems</td>
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<tr>
<td>Site specific</td>
<td>Lack of support</td>
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<td></td>
<td>Lack of professional recognition</td>
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<td></td>
<td>Ethical or moral (work) climate</td>
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</table>

3.4 Conclusion

Chapter 3 considered the applicability of the Effort-Reward Imbalance (ERI) (Siegrist, 2008); Job Demands-Resources (JDR) (Bakker & Demerouti, 2007); Job Demand-Control (JDC) (Karasek, 1979); and the Job Demand-Control-Support (JDCS) (Johnson & Hall, 1988) models in aiding understanding of moral distress. To facilitate the understanding of moral distress within a recognised workforce stress framework; theoretical links between the JDCS, moral distress and the Australian aged care worker were subsequently explicated.

Aged care workers are exposed to a range of job demands grounded in individual, site specific and broader external factors, each of which contribute to their experience of moral distress. Latitude for decision making (job control) for these workers is constrained by many variables, primarily regulatory or related to funding structures. Site specific contributors to moral distress are grounded in the social support of the workplace. All three components compound the emergence of job strain in the form of moral distress. Framing moral distress within a recognised job stress model is important in solidifying moral distress as a discrete and important entity within the realm of workplace stress.

Chapter 4 details the aims, objectives, research questions, methodology and methods of this study. To aid conceptual clarity the study has been divided into two phases with each phase involving two distinct stages. Phase 1 (Stage 1) involved the selection and amendment of an instrument to measure moral distress, with pilot-testing of the amended instrument undertaken in Phase 1 (Stage 2). Following Phase 1, exploration of the experience of moral distress using telephone interviews Phase 2 (Stage 1) and case study scenarios Phase 2 (Stage 2) was conducted.
Chapter 4  Methodology

4.1 Introduction

Chapter 3 discussed organizational responsibility to address workplace stress, and theoretical models used to understand this stress. Four different models were considered, these were the: Effort-Reward Imbalance (ERI) (Siegrist, 2008); Job Demands-Resources (JDR) (Bakker & Demerouti, 2007); Job Demand-Control (JDC) (Karasek, 1979); and the Job Demand-Control-Support (JDCS) (Johnson & Hall, 1988). The Job Demand-Control-Support (JDCS) model was unpacked within the realm of moral distress, and clear links between these were identified.

Chapter 4 outlines the methodological basis for the study; identifying the aims, objectives, research questions, methodology and methods. This study has been divided into two phases to assist with conceptual clarity, with each of these phases involving two distinct stages. **Phase 1 (Stage 1)** involved the selection and amendment of an instrument to measure moral distress within the Australian aged care environment. Following this amendment stage, in **Phase 1 (Stage 2)** the amended instrument was pilot tested with a population of aged care workers.

**Phase 2 (Stage 1)** consisted of telephone interviews exploring workers understanding and experience of moral distress. While participants were able to discuss their experience of workplace stress, difficulty in distinguishing between moral distress and other forms of stress was identified. To facilitate clearer understanding of the moral distress experience **Phase 2 (Stage 2)** used data from Phase 2 (Stage 1) to develop two case study scenarios specifically describing situations of moral distress, which were then distributed to a second sample of workers.

4.2 Aim

The aim of this mixed methods study was to explore the effect of moral distress on Australian aged care workers in residential and community aged care.
4.3 Objectives

The objectives of the study were to:

- Review the literature, identify knowledge gaps, and identify existing instruments that measure moral distress;
- Identify, amend and test an appropriate measurement instrument to measure moral distress within the Australian residential and community aged care workforce;
- Explore Australian residential and community aged care workers experience of moral distress.

4.4 Research Questions

RQ 1. Do Australian aged care workers in residential and community aged care experience moral distress?

RQ 2. What do Australian aged care workers understand about moral distress in residential and community aged care?

RQ 3. How does moral distress impact upon residential and community aged care workers and their workplace?

4.5 Methodology

A positivist approach contends that measurable (or quantifiable) truths or laws exist (Topping, 2010), and is based in the assumption that “…there must be one or more reasons that can be understood” (Polit & Beck, 2004, p. 14). It relies upon a “…singular knowable reality…” (Grbich, 2007, p. 4) and aims to provide an objective description of this reality. The focus of the approach is on the use of valid and reliable instruments to gather facts, with a view to generalization of results (Sarantakos, 2013). Burns and Groves (2009) profess this approach as “…essential to develop the body of knowledge needed for evidence-based practice” (Burns & Grove, 2009, p. 33) – a practice approach considered a core foundation for delivery of contemporary clinical care (Hoffmann, Bennett, & Del Mar, 2013). This approach aligns well with the cross-sectional survey method employed in Phase 1 of this study.

However the human experience is not always quantifiable, and evolves over time (Grbich, 2007). Interactions in society are complex, are grounded in an individual’s construction of meaning, and influenced by societal expectations and constraints. Research exploring the experience of workers must therefore seek to make sense of these experiences (Polit &
Beck, 2004) within the context of societal expectations and constraints (Grbich, 2007). Acknowledgement that there is no single or inherent interpretation of truth and meaning is needed (Topping, 2010), and researchers must account for this. Regardless, the research must also be conducted in a rigorous and systematic manner (Burns & Grove, 2009). This interpretivist perspective is one that aligns well with the semi-structured interview and written scenario methods used in Phase 2 for data generation.

A pragmatist approach seeks to combine (or utilise) elements of each paradigm with a view to solving real world problems. Emphasis is placed on answering the research questions “…by whatever mix of data collection approaches appear to be most useful” (Grbich, 2013, p. 313). Although recognising that causal type relationships may exist, pragmatists also acknowledge that these relationships are “…transitory and hard to identify” (Teddlie & Tashakkori, 2009, p. 93). Therefore the overall approach is multi-faceted and centred upon what works in practice (Creswell & Plano Clark, 2011). The use of a pragmatist approach is evident in nursing research (Herrestad, Biong, McCormack, Borg, & Karlsson, 2014; Snowden & Atkinson, 2012), and is a “…common-sense fit.”(McCready, 2010, p. 201).

The purpose of using a mixed methods approach is to allow the use of the most appropriate means to obtain useful data that facilitates the ability to meet the overall objectives of the research (Taylor, 2007). It does not alter the identity of each methodology nor do the differences in methodologies imply differences in quality (Sarantakos, 2013). The use of a mixed methods approach is clearly evident in health research (Dickson, Lee, & Riegel, 2011; Flick, Garms-Homolová, Herrmann, Kuck, & Röhnsch, 2012; Shaw et al., 2009). Taylor (2007) does warn the use of a mixed methods approach must be carefully considered and justified though; one must not simply select the “attractive options” (p.422). The order and combination of methods must be planned carefully to accrue maximum benefits (Tritter, 2007). Creswell and Plano Clark (2011) describe six major mixed methods designs in common use: convergent parallel, explanatory sequential, exploratory sequential, embedded, transformative and multiphase. In the following section each of these designs are briefly described and analysed, for the purpose of justifying the design selected for use in this study.
The convergent parallel design uses concurrent implementation of both quantitative and qualitative components with mixing of the results informing interpretation (Creswell & Plano Clark, 2011). An explanatory sequential approach involves two sequential phases, with the initial quantitative data (as a priority) driving the focussed collection of qualitative data which is then used to explain the initial quantitative findings (Creswell & Plano Clark, 2011). Similarly the exploratory sequential design uses sequential timing of phases, but collects qualitative data first as a priority, which is then used to test or determine generalize the initial findings (Creswell & Plano Clark, 2011).

Creswell and Plano Clark (2011) describe the embedded design as an approach in which a traditional quantitative or qualitative design is used for the research but supplementary data using the alternate approach (quantitative or qualitative) is also collected. The explicit intent of using the additional data is to enhance the overall design. A transformative design is one in which the researcher structures their methods within a specified framework, such as feminism (Creswell & Plano Clark, 2011). At all times throughout the collection, analysis and interpretation the specified framework is used to guide and explain understandings. Finally a multi-phase study is described as consisting of a number of sequential phases (for example qualitative phase, quantitative phase and then mixed methods phase) and is commonly used to assess an overall program objective or provide program evaluation (Creswell & Plano Clark, 2011).

Careful selection of the design approach is warranted, as a considered use of most appropriate approach will enrich the outcomes of the research (Sarantakos, 2013). To maximise the benefits of the research the order and combination of the methods must be logically planned (Tritter, 2007). Of the six designs the explanatory sequential mixed methods was chosen because it best enhanced the capacity to answer the research questions for this study.

In an explanatory sequential mixed methods approach the initial quantitative data can be used to inform the types of participants and questions for the qualitative phase (Creswell, 2014; Tritter, 2007). In this study it clearly facilitated identification of participants that had experienced moral distress. An explanatory sequential mixed methods approach also uses the qualitative element as a means to derive deeper understanding of the quantitative data (Stevenson, 2005). It can be used to provide a stronger, or more complete understanding
of the research problem (Creswell, 2014; Stevenson, 2005). The nature of this methodological binary is evident because “you can explore the detail of individual experiences beyond the statistics, and conversely statistics can provide an overview and context for narratives” (Grbich, 2013, p. 79). In this study key findings from the quantitative phase (Phase 1) were used to provide a focussed base for the qualitative phase (Phase 2). Also, as a primary component of Phase 1 of this study was to validate an amended measurement instrument, data collected during the Phase 2 telephone interviews were able to be used to support the validation of the instrument and the completeness of the instrument as a whole; a strategy supported by Daigneault and Jacob (2014).

4.6 Overview of Methods

The study was conducted in two phases, with each phase divided into two clear stages. Phase 1 (Stage 1) commenced with a review of the literature (Chapter 2) pertinent to the area of study, and concluded with the amendment of an instrument measuring moral distress (refer section 4.7). The purpose of the first literature review was twofold: to provide an overview of contemporary literature and knowledge gaps; and to identify existing instruments to measure moral distress in aged care. Instruments measuring moral distress were identified; an appropriate instrument was adapted for contextual relevance; with additional expert review.

In Phase 1 (Stage 2) a survey design was used to pilot-test the amended instrument (refer section 4.7). Survey research is used to obtain data explaining “…trends, attitudes, or opinions of a population…” (Creswell, 2014, p. 13), as well as “…beliefs, experiences and behaviour” (McKenna, Hasson, & Keeney, 2010, p. 220). It is a common research approach (Monteverde, 2013; Ohnishi et al., 2010; Pelletier, Donoghue, & Duffield, 2005; Severinsson & Hummelvoll, 2001). Burns and Grove (2009) describe the survey as a “…data collection technique, not a design” (p.245); and as such it must fit within a sound research design.

More specifically a cross-sectional survey approach was used in Phase 1 (Stage 2) of the study. A cross-sectional survey is used to provide information about a population at one point in time (White & McBurney, 2013), and can be used to measure the prevalence of a health issue (McKenna et al., 2010). An advantage is that the approach is practical to conduct (easy and relatively economical) (Polit & Beck, 2004). Cross-sectional studies are
frequently used in nursing research (Brandon, Ryan, Shane, & Docherty, 2014; Choi, Cheung, & Pang, 2013; Davison, McCabe, Knight, & Mellor, 2012; Fiabane et al., 2013). However, they are temporal and as such do not necessarily reflect past or future situations (Cannon, 2011).

Phase 2 of this study involved an exploration of the experience of moral distress, through the use of telephone interviews (Stage 1) and case study scenarios (Stage 2) (refer section 4.8). The use of telephone interviews allows participants to share their understanding of experiences (in this instance moral distress), and is an approach that facilitates a deeper and richer understanding of a topic (Taylor, 2007). Telephone interviews were conducted with individual aged care workers in residential and community aged care who completed the Phase 1 instrument and elected to participate in Phase 2. Thematic analysis relying also on the constant comparison of data as an “…accessible and theoretically flexible approach…” (Braun & Clarke, 2006, p. 77) was used to analyse interview data.

Data from the telephone interviews combined with knowledge from the literature (refer Chapter 2, section 2.4.1.2) was used to develop two case study scenarios describing situations known to cause moral distress. The use of these scenarios allowed the collection of textual data from participants, a suitable form of data for thematic analysis (Guest, MacQueen, & Namey, 2012). The purpose for using these case study scenarios in this study was to obtain data more specifically linked to morally distressing situations and inform the final findings.

4.6.1 Study location and population
This study involved nurses and care workers employed in the community care and residential aged care facilities in Queensland and Victoria, Australia. “Employed” was taken to mean those staff who were currently employed at time of data collection; on either a full-time, part-time or casual basis. Licensed and unlicensed care workers employed in the aged care sector were included in the study. Workers not currently employed or not employed in roles providing or directly facilitating care delivery were excluded from the study.
As detailed in Chapter 1, Australia has a two-tiered system of nursing regulation, with Registered Nurses (RN) and Enrolled Nurses (EN) required by law to be registered or enrolled (licensed) by the Australian Health Practitioner Regulation Agency via the Australian Nursing and Midwifery Board (Wickett & Wickett, 2010). Registered Nurses require an undergraduate qualification, with Enrolled Nurses requiring a diploma level qualification. Those employed in nursing type care delivery, variably titled personal care assistant (PCA) / assistants in nursing (AIN) / personal care workers (PCW) have historically been completely unqualified, but in more recent times have become increasingly required to undertake basic certificate level (vocational) education. A mixture of participants from all three categories were sampled.

4.7 Phase 1 Research Design

4.7.1 Phase 1 - Overview and Purpose

The purpose of Phase 1 was to identify the degree to which Australian aged care workers experienced moral distress. This was approached through a review of the relevant literature (as detailed in Chapter 2), identification of instruments measuring the experience of moral distress, and the amendment and pilot testing of an appropriate instrument (refer Figure 4-1 below).

Specifically research question 1 was addressed:

RQ 1. Do Australian aged care workers in residential and community aged care experience moral distress?
4.7.2 Phase 1 – Ethics Approval

Ethical approval for the study from The University of Queensland’s Behavioural and Social Sciences Ethical Review Committee [BSSERC] (Appendix D) and institutional ethics committees were obtained (Appendix E). Specific ethical information provided to participants is contained in the Participant Information Sheet (Appendix F).
The Participant Information Sheet clearly stated to potential participants that raw de-identified data were to be shared with other researchers to allow further psychometric testing of the instrument.

Most specifically, Dr Anne Hamric has specified as a condition of use for the MDS-R that: “individuals wishing to use the MDS-R must agree to share their data with Dr. Hamric in an SPSS file or a file compatible with SPSS in order to further the psychometric testing of the instrument”.

4.7.3 Phase 1 (Stage 1) – Literature Review
The purpose of the first literature review was twofold: to provide valid justification for this study and to identify and differentiate existing instruments used to measure moral distress. Articles were selected based on relevance and ability to inform about moral distress within and outside the context of nursing practice. While the review of the literature did not set out to answer a specified question, it was conducted in a systematic manner providing a rigorous representation of the literature. A detailed discussion of the method and findings of the first literature review is included in Chapter 2.

4.7.4 Phase 1 (Stage 1) – Identification and selection of the instrument
During the literature review five quantitative instruments were identified (Table 4-1 below):

1. Moral Distress Scale (MDS) (Corley, Elswick, Gorman & Clor, 2001);
2. Un-named survey instrument (Laabs, 2005);
3. Moral Distress Scale – Revised (MDS-R) (Hamric & Blackhall, 2007; Hamric, Borchers & Epstein, 2012);
4. Moral Distress Questionnaire (MDQ) (Sporrong, Höglund, & Arnetz, 2006); and
<table>
<thead>
<tr>
<th>Comparison Criteria</th>
<th>Moral Distress Measurement Instruments</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Country</strong></td>
<td>U.S.A.</td>
</tr>
<tr>
<td><strong>Terms used</strong></td>
<td>Moral Distress</td>
</tr>
<tr>
<td><strong>Instrument type</strong></td>
<td>Survey – 7 point Likert</td>
</tr>
<tr>
<td><strong>Number of Items</strong></td>
<td>32 items</td>
</tr>
<tr>
<td><strong>Sample</strong></td>
<td>nurses</td>
</tr>
<tr>
<td><strong>Sample size</strong></td>
<td>214 nurses</td>
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<tr>
<td><strong>Limits identified by author/s</strong></td>
<td>Likely redundancy of some instrument items.</td>
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</tbody>
</table>

The following section briefly discusses and analyses each of these instruments, providing justification for the selection and use of the Moral Distress Scale – Revised (MDS-R) (Hamric et al., 2012) in this study. Corley’s Moral Distress Scale (MDS) (2001) was first developed in 1995 and has been used many times (Kleinknecht-Dolf et al., 2014; Meltzer & Huckabay, 2004; Ohnishi et al., 2010; Pauly et al., 2009; E. Rice et al., 2008; Silén, Svantesson, Kjellström, Sidenvall, & Christensson, 2011; Zuzelo, 2007). The instrument measures two specific elements contributing to the moral distress experience: (i) the
intensity of the situation, and (ii) the frequency of occurrence. It demonstrated reasonable internal consistency across factors (α 0.97, α 0.82 & α 0.66). However the instrument is lengthy (32 items), and the researchers described the likelihood of redundancy of items particularly related to Factor 1 (α 0.97).

Laabs (2005) developed a (un-named) 16 item survey instrument to explore ethical challenges faced by Nurse Practitioners. Review for content validity of the instrument was undertaken, however no further analysis for validity or reliability is reported. Initially respondents used a 4 point Likert scale indicating how often (never – commonly) and how distressful (not at all – highly) each of these items were. Respondents were then asked to allocate their response to a particular category (moral uncertainty, moral dilemma, moral distress, moral outrage, other); to indicate what was most distressing about the situation for them. The author notes reliance on a small non-random sample and the inability to clarify responses as limitations of the study.

Hamric and Blackhall (2007) initially revised Corley’s MDS, reducing the number of items from 32 to 19 and devising a composite scoring system, creating a revised instrument, the Moral Distress Scale – Revised (MDS-R). This revised instrument was further tested by Hamric, Borchers and Epstein (2012). The instrument demonstrates good internal consistency (α 0.83) and versions of this instrument suitable for doctors, nurse and other health professionals in both the adult and paediatric acute care environments have since been developed. A limitation noted by the authors is the lack of testing in environments other than the acute care setting.

Sporrong et al. (2006) developed the Moral Distress Questionnaire (MDQ) to be used interchangeably between health care workers of differing professions. Developed in Sweden, the instrument initially consisted of 15 items, but has since been refined to a 9 item instrument. The developers report good face validity and internal consistency (α 0.78) of the instrument. A clear limitation of this instrument is that it consists of only nine items which may not be sufficient. Moral distress has clearly been shown to be a multi-faceted construct with many variables contributing to the experience (Burston & Tuckett, 2013).
Eizenberg, Desivilya and Hirschfeld (2009) undertook to develop a questionnaire measuring moral distress in Israel. They conducted exploratory focus groups and used these to guide development of the survey instrument. The 15 item instrument was deemed to demonstrate acceptable reliability and validity ($\alpha$ 0.79). A potential limitation noted by the developers is the culturally specific components built into individual items. On review it appeared that many of these items were not directly applicable to the Australian context. An example of this is Item 3 which asks about “expensive medication not included in the medication basket” (Eizenberg et al., 2009, p. 892). The potential for participants becoming confused about the concept (moral distress) also exists with this instrument. Within their report on the instrument development the researchers use the label “moral distress questionnaire for clinical nurses”, but the instrument itself uses the terminology “stress of conscience” and does not include the words moral distress at all.

Based on these short overviews of the five instruments, the selection criteria used in determining which instrument to use for this study are detailed in Table 4-2 below. None of the instruments were designed specifically for the aged care environment. Based on the review of instruments Hamric, Borchers and Epstein’s (2012) Moral Distress Scale – Revised (MDS-R) was selected. This instrument (initially developed from Corley’s MDS, 2001) has been amended and refined over time, retains relevance as an instrument for exploring the root causes of moral distress (Hamric et al., 2012), demonstrates reliability and consistency, and is user friendly. Whilst not developed with the Australian context in mind, it was developed within a western healthcare system, and hence has in-built applicability. Approval to use the instrument was obtained from Dr Hamric.

The use of this instrument within the aged care sector is important. None of the instruments identified in the literature review (detailed in Chapter 2) were designed for the aged care setting. Also minimal moral distress research exists within aged care (Burston & Tuckett, 2013; Rittenmeyer & Huffman, 2009). While the MDS-R has been amended and refined over time, this study extends the useability of the instrument beyond the acute care sector; providing the first validated instrument suitable for aged care.
<table>
<thead>
<tr>
<th>Instrument</th>
<th>Measures moral distress</th>
<th>Psychometrics</th>
<th>Sufficient complexity</th>
<th>User friendly</th>
<th>Australian relevance</th>
<th>Use by others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corley et al. (2001) Moral Distress Scale (MDS)</td>
<td>Yes</td>
<td>Internal consistency: Factor 1(α 0.97), Factor 2(α 0.82), Factor 3(α 0.66)</td>
<td>Yes - based in Jameton &amp; Wilkinson’s early theoretical explorations</td>
<td>Lengthy at 32 items</td>
<td>Indirect – designed within the United States of America health system</td>
<td>Yes</td>
</tr>
<tr>
<td>Laabs (2005) Un-named survey Instrument</td>
<td>Yes</td>
<td>Content validity only</td>
<td>Probable but unable to determine definitively</td>
<td>Probable but unable to determine definitively</td>
<td>Indirect – designed within the United States of America health system</td>
<td>Not known</td>
</tr>
<tr>
<td>Hamric, Borchers &amp; Epstein (2012) MDS-R</td>
<td>Yes</td>
<td>Internal consistency (α 0.83)</td>
<td>Based on the Corley et al. (2001) MDS</td>
<td>Yes – reduced Corley et al. (2001) MDS from 32 items to 19 items</td>
<td>Indirect – designed within the United States of America health system</td>
<td>Yes</td>
</tr>
<tr>
<td>Sporrong et al. (2006) MDQ</td>
<td>Yes</td>
<td>Report good face validity and internal consistency (α 0.78)</td>
<td>No. 9 item instrument – moral distress is a multi-faceted construct</td>
<td>Yes</td>
<td>Indirect – designed within the Scandinavian health system</td>
<td>Yes</td>
</tr>
<tr>
<td>Eizenberg, Desivilya &amp; Hirschfeld (2009) MDQC</td>
<td>Claims to but uses stress of conscience terminology within instrument</td>
<td>Internal consistency (α 0.79)</td>
<td>Yes. 15 item instrument sufficient to explore scope of moral distress</td>
<td>Yes</td>
<td>Indirect – designed within the Israeli health system</td>
<td>Not known</td>
</tr>
</tbody>
</table>
4.7.5 Phase 1 (Stage 1) – Instrument amendment

In consultation with the Advisors it was determined that the selected instrument required some amendment to better suit the nature of the Australian aged care nursing workforce.

Initial concerns with terminology were identified, a situation that Rattray and Jones (2007) highlight can bias responses. Most specifically with Hamric and Blackhall’s (2007) MDS-R the use of the terms “physician” and “patient” were identified as problematic. The term “physician” is not in common use within Australia, and as such was amended to “doctor”.

The use of the word “patient” has an acute care focus and is not directly relevant in an aged care setting. Within the Australian residential aged care setting the term “resident” is commonly used (Borbasi, Galvin, Adams, Todres, & Farrelly, 2013; Davison et al., 2012; Grealish et al., 2013), however within the Australian community care environment the term “older person” (Low, Chilko, Gresham, Barter, & Brodaty, 2012; Radermacher, Feldman, & Browning, 2009; Smith, 2012) predominates. A third term, “client”, was selected for use so as to provide consistency and clearly represent the consumer or end user of the service.

Subsequent amendments focused on removing the acute care focus of the original instrument and re-fashioning this for aged care. For example, Item 7 in the MDS-R (Hamric & Blackhall, 2007) asks about ventilation support, a treatment option that simply does not exist in aged care. As such this item was amended to better suit aged care, to read “…participate in care for a hopelessly ill person...”. Thus the key underlying conceptual basis of the item was retained. One additional item (Item 11) was deemed redundant as it inquired into the practices of medical students, a situation that is not common in the Australian aged care environment (Appendix G).

Next, we obtained clinical expert review to gain consensus on the amended items (with a view to ensuring face and content validity). Expert review is suggested as “the most convincing test of face validity…” (Gomm, 2008, p. 40), and is a strategy often used when designing measurement instruments (Curley, Hunsberger, & Harris, 2013; Ivankova, 2014; Kennerly et al., 2012; Kostovich, 2012; Zomorodi & Lynn, 2010). Face validity is concerned with determining through discussion that an individual measure represents the “…content of the concept”… it is intended to measure (Singh, 2007, p. 79). Overall this
process is a critical element in ensuring instrument robustness and in improving ultimate construct validity (Polit & Beck, 2012).

Two rounds of review are suggested during this phase (Polit & Beck, 2012). However given the historical development of the MDS - R to date, and the relatively small volume of amendments required, only one round was undertaken. The Advisors identified industry experts appropriate to approach for review of the instrument. Eight academic industry experts were approached. Details of these experts are provided in Table 4-3 below.

**Table 4-3 Overview of industry experts**

<table>
<thead>
<tr>
<th>Expert</th>
<th>Position at time of approach</th>
<th>Clinical Experience</th>
<th>Publications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Academic Program Director: Higher Degrees by Research</td>
<td>community/district nursing, aged care, radiation oncology, palliative and supportive care</td>
<td>35</td>
</tr>
<tr>
<td>2</td>
<td>Editor- International Peer Reviewed Journal</td>
<td>ethics</td>
<td>54</td>
</tr>
<tr>
<td>3</td>
<td>Senior Lecturer/Head of Division (Health Research)</td>
<td>radiotherapy, care of older people, oncology, palliative care</td>
<td>87</td>
</tr>
<tr>
<td>4</td>
<td>Professor of Palliative Care</td>
<td>palliative care, aged care, ethics</td>
<td>291</td>
</tr>
<tr>
<td>5</td>
<td>Senior Lecturer Health Care Ethics</td>
<td>sociology, dementia, palliative and community nursing</td>
<td>44</td>
</tr>
<tr>
<td>6</td>
<td>Head of School - Nursing</td>
<td>health policy and reform, gerontology, chronic disease management, health workforce recruitment and retention</td>
<td>160</td>
</tr>
<tr>
<td>7</td>
<td>Lecturer - Nursing</td>
<td>research methods, evidence based practice, practice improvement, wound care, knowledge translation</td>
<td>24</td>
</tr>
<tr>
<td>8</td>
<td>Principal Lecturer / Program Leader (Nursing)</td>
<td>nursing research and evidence based practice, health psychology, educational management, depression</td>
<td>16</td>
</tr>
</tbody>
</table>
Of those approached, potential reviewers one, five, six and seven were unable to provide feedback at the time. Four experts did provide feedback on the amendments. Specific examples of feedback are shown below in Table 4-4 below.

**Table 4-4 Feedback from expert reviewers**

<table>
<thead>
<tr>
<th>Reviewer</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>I have had a look through the changes you made and they seem acceptable to me in the different setting in which you are using the instrument.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Initial feedback</strong> – I think the changes you have made are appropriate and make the tool more fitting for the setting you are interested in. The only question that was not clear to me was Question 20, but this maybe a different use of the word “provider” and it may be the appropriate work in an Australian context. Does it refer to care staff in the home, or external professionals coming into the RACF? <strong>Follow up feedback</strong> – Thanks for that clarification - that makes it clear to me. I guess this raises the question that within this question you are addressing 2 groups: staff internal to the home and staff external - how do people respond if their views about the 2 groups are different?</td>
</tr>
<tr>
<td>4</td>
<td>I reviewed the changes and they look appropriate. In regards to the last question that is open-ended. While I see its value for an opened response. My concern rests on definition. The question uses the expression moral distress. I believe this needs to be clearly defined so that there is a clear understanding on its meaning by the respondent and that we are on the same page.</td>
</tr>
<tr>
<td>8</td>
<td>The changes you have made are relevant and appropriate.</td>
</tr>
</tbody>
</table>

The feedback was discussed with the Advisors. Feedback from Reviewer 2 regarding the term “provider” in item 20 was considered, however the term was deemed suitable and was retained in the instrument. Feedback from Reviewer 3 regarding the open-ended question was considered. The MDS-R includes a definition of moral distress on the leading page, and the intent was for this to remain in the amended instrument. When providing the amended instrument to the expert reviewers the definition was inadvertently omitted. This oversight was discussed with Reviewer 3 who had no further feedback.
In total twenty changes were made from the original MDS-R. This process resulted in a new instrument: the Moral Distress Scale – Revised (aged care) (Appendix B).

**4.7.6 Phase 1 (Stage 2) – Validation of MDS-R (aged care)**

The MDS-R (aged care) was formatted into the Qualtrics electronic survey platform in preparation for pilot testing. A lack of clarity about items is specifically noted as a defining characteristic between good and bad items (DeVillis, 2012). To target this concern a new set of five industry and academic experts and five non-academics where asked to complete the electronic survey to specifically provide feedback on the useability of the interface and the comprehensibility of the survey items. Pilot testing an instrument for clarity and useability is a recognised strategy in the instrument development process (Zomorodi & Lynn, 2010). Feedback from these testers was generally positive with the instrument “easy to follow” and item wording “quite clear”. Two specific changes were suggested. One suggested change was to split one of the demographic pages into two pages (to reduce volume of content on one page). The second suggestion was to include an indicator within the survey that would show participants their progression through the survey. Both suggestions were deemed valid and acted upon.

A **pilot study** to investigate the reliability and validity of the amended instrument was conducted. A pilot study is an “… essential step in survey research”(Singh, 2007, p. 72), important in determining if the “…questions are intelligible and unambiguous (Jones & Rattray, 2010, p. 378). The pilot study also helps minimise or remove “…ambiguities and other source of bias and error” (Singh, 2007, p. 72). Pilot studies are commonly used in health research seeking to develop new instruments (Curley et al., 2013; Glasberg et al., 2006; Gustafsson, Eriksson, Strandberg, & Norberg, 2010; Halcomb, Caldwell, Salamonson, & Davidson, 2011; Zomorodi & Lynn, 2010).

The pilot study of the Moral Distress Scale - Revised (aged care) included participants from residential aged care facilities and community care in Queensland and Victoria. Facilities were identified in two ways: one through a direct research partnership between the university and a service provider, and second via two key industry contacts. The data were collected using both an electronic platform and paper surveys from: April 2013-April 2014 (Sample One), October 2013 (Sample Two), from June 2014 – August 2014 (Sample Three), and in September 2014 (Sample Four).
The electronic version of the survey (via Qualtrics) was accessible using an existing university license. The use of electronic survey platforms is increasing (Jones & Rattray, 2010), and is a recognised tool in health research (Allen et al., 2013; Browning, 2013; Houston et al., 2013). This approach facilitated anonymous distribution of surveys using a unique hyperlink, and the capacity to collate and download data in a format suitable for analysis (Microsoft Excel spreadsheet or SPSS file). Other specific advantages of this approach included the relatively low cost (Coolican, 2009) and convenience to administer (White & McBurney, 2013), particularly important in this study with a geographically diverse population [with targeted respondents from metropolitan and regional areas of Queensland and Victoria].

Coolican (2009) cautions that responses (from electronic means) may not be representative of the population as a whole, and this was encountered in this study. Specific groups of aged care workers typically work at the bedside rather than a desk or computer workstation, while registered nurses have more consistent access to computers and the ability to respond more readily electronically. Issues of access have been noted as a limitation that can provide a skewed representation of the targeted population (Heiervang & Goodman, 2011). Couper (2000, p. 467) describes this as a “coverage error”, wherein people who should be included are excluded due to a lack of digital/electronic access. In order to avoid a skewed representation of respondents, surveys in a paper format were also distributed. Detail of this distribution is provided in section 4.7.8 (below).

4.7.7 Phase 1 - Sample size
Obtaining a sufficient number of responses for valid factor analysis was important. Complete data from five participants per instrument item (ratio of 5:1) is satisfactory (Hair, Anderson, Tatham, & Black, 1998), while others prefer complete data from ten participants (10:1 ratio) per item (Polit, 2010). For the MDS- R (aged care) as a 20 item instrument a minimum of 100 complete responses was required to provide a satisfactory level of validity.
4.7.8 Phase 1 - Participants

4.7.8.1 Sample One
A convenience sample of aged care workers from one state-wide organisation were approached for inclusion in the study, with electronic distribution of the survey. Convenience sampling is common in nursing research (Taylor, Kermody, & Roberts, 2007), and is used for practical purposes such as ability to access a population (White & McBurney, 2013). In this instance the convenience was in the ability to contact a diverse cross-section of aged care workers across a diverse geographical area. The survey link was distributed via a centrally disseminated electronic newsletter. Forty-five respondents accessed the survey electronically and viewed the participant information sheet, and of these three declined to participate in the survey. Of the remaining 42 participants, 32 completed the survey entirely. Of these 32 respondents, 24 worked as Registered Nurses, two as Enrolled Nurses, two as a Personal Carer / Assistant in Nursing, one as a Service Manager, and 3 did not identify their occupation.

4.7.8.2 Sample Two
During the data collection process it became apparent that insufficient responses were being generated. One of the initial respondents from the electronic survey (an aged care facility manager) contacted the researcher directly offering to distribute paper surveys within her residential aged care facility. In response to this offer surveys were hand delivered to the manager for distribution to those staff within this facility, with a blank survey and participant information sheet subsequently distributed by the manager to each staff member via an internal mailbox. An additional 18 responses were obtained, and all contained sufficient data for analysis. Of these 18 respondents, five worked as a Registered Nurse, one as an Enrolled Nurse, 11 as a Personal Carer / Assistant in Nursing, and one as a Service Manager.

4.7.8.3 Sample Three
An interstate work colleague known to have working relationships with a number of community care and residential aged care facilities in Victoria, Australia was approached and facilitated entry to additional sample populations. This resulted in a snowball sampling type effect (Procter, Allan, & Lacey, 2010), wherein one organisation provided a potential contact for a second organisation, which then provided a third potential source. Snowball sampling is commonly used in health research (Eley & Baker, 2007; Gaudine, LeFort, Lamb, & Thorne, 2011; Linnard-Palmer & Kools, 2005), involves an informant providing
access to participants (Noy, 2008), and is used when one cannot identify elements of the population in advance (Taylor, 2007). In this instance snowball sampling also enhanced the quality of data; by expanding the sample size, broadening the scope of participants to include participants from different states, and including participants from a regional area.

Three additional participant groups were accessed; one independent residential aged care facility, one residential aged care wing attached to an acute hospital, and one residential aged care facility attached to a community health centre. The researcher’s interstate colleague visited each of these facilities during the afternoon shift changeover period, with a view to capturing as many participants as possible. Paper surveys were given to eligible staff and collected on the same day. This method provided 58 additional surveys, of which 52 were completed sufficiently for use in analysis. Of these 52 respondents 17 worked as a Registered Nurse, 26 as an Enrolled Nurse, 8 as a Personal Carer / Assistant in Nursing, and 1 did not identify their occupation.

4.7.8.4 Sample Four
An additional industry colleague provided contact with a fourth sample population. The Investigator and Principal Advisor visited the facility, spoke directly with staff about the study, and distributed paper surveys by hand. At the request of potential participants the surveys were left with them, to be completed and collected at a later time. An additional four responses were obtained from this population, all of which were completed sufficiently for analysis. Of these four respondents one worked as a Registered Nurse, one as an Enrolled Nurse, and two as a Personal Carer / Assistant in Nursing.

4.7.8.5 Complete Sample
Of the 125 surveys commenced or returned, three surveys were unusable because they did not contain any data and a further 16 were discarded as only demographic data were provided. In total 106 healthcare usable surveys were obtained. Of these 106 respondents 47 worked as a Registered Nurse, 30 as an Enrolled Nurse, 23 as a Personal Carer / Assistant in Nursing, two as Service Managers, with four not identifying their occupation (refer Figure 4-2 below).
### 4.7.9 Phase 1 - Data Analysis

#### 4.7.9.1 Data Capture, Storage and Management

Electronic data were downloaded from the survey platform as a Microsoft Excel spreadsheet. Completed paper-based surveys were scanned and stored electronically as Adobe (Adobe Systems Incorporated, 2011) pdf files. Data from the paper-based surveys were then manually entered and merged with the electronic data. The complete data set was then imported into IBM Statistics SPSS (IBM Corporation, 2012) for analysis.

Electronic data files were stored in two separate password secured locations, one computer hard drive and one portable hard drive. All paper based survey data has been stored in a locked filing cabinet, within a secure office facility. The Investigator had sole access to these documents. All data will be kept secured for a period of seven years from completion of the study, at which time it will be destroyed as per National Health and Medical Research Council (NHMRC) guidelines and The University of Queensland (UQ) policy.

The electronic data file was audited for accuracy, screened for out of range values and outliers. Out of range values were those inconsistent with the appropriate response options available. For example a written score of five against a particular item when the

---

<table>
<thead>
<tr>
<th>Sample 1</th>
<th>Sample 2</th>
<th>Sample 3</th>
<th>Sample 4</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>electronic Queensland</td>
<td>paper Queensland</td>
<td>paper Victoria</td>
<td>paper Queensland</td>
<td>Qld 54, Vic 52</td>
</tr>
<tr>
<td>n=32</td>
<td>n=18</td>
<td>n=52</td>
<td>n=4</td>
<td>n=106</td>
</tr>
<tr>
<td>24 RN</td>
<td>5 RN</td>
<td>17 RN</td>
<td>1 RN</td>
<td>47 RN</td>
</tr>
<tr>
<td>2 EN</td>
<td>1 EN</td>
<td>26 EN</td>
<td>1 EN</td>
<td>30 EN</td>
</tr>
<tr>
<td>2 PCW/AIN</td>
<td>11 PCW/AIN</td>
<td>8 PCW/AIN</td>
<td>2 PCW/AIN</td>
<td>23 PCW/AIN</td>
</tr>
<tr>
<td>4 Other</td>
<td>1 Other</td>
<td>1 Other</td>
<td>0 Other</td>
<td>6 Other*</td>
</tr>
</tbody>
</table>

---

*2 Service Managers, 4 did not identify occupation

**Figure 4-2 Overview of Phase 1 sample population**
scoring system range is from one to four. Missing data was identified and dealt with prior to analysis.

4.7.9.2 Missing data

Missing data originates when a respondent fails to answer an item (Denny & Churchill, 2013), is not uncommon in surveys (White & McBurney, 2013), and is common in health research (Shrive, Stuart, Quan, & Ghali, 2006; Wagner & Smith, 2010). It is especially problematic in multi-item instruments (Eekhout, de Boer, Twisk, de Vet, & Heymans, 2012). Missing data can pose a clear threat to the overall validity of a study (Ware, Harrington, Hunter, & D’Agostino, 2012), and as such effective approaches to minimise the impact of missing data are essential.

Corley’s (2001) initial research developing the MDS used mean imputation (a form of estimating missing data) as a strategy for dealing with missing data. Strategies used to address missing data in development of Hamric and Blackhall’s (2007) MDS-R development were not clearly evidenced in the literature. Discussions with Dr Hamric indicated that imputed means had been used. Imputed means involves replacing missing data with a value (mean score) derived for an individual item from across the entire data set (Shrive et al., 2006). This process results in a complete data set being available for analysis (Penny & Atkinson, 2012), and has been shown to produce favourable results when used in scale development (Shrive et al., 2006).

Hair et al. (2010) suggest a four stage process to identify and select a suitable approach to dealing with missing data. The stages they describe are: determining the type of missing data, determining the extent of missing data, diagnosing the randomness of the missing data, and selecting the imputation method (p.45). Using the approach suggested by Hair et al. (2010), with recognition of methods previously used in developing the Moral Distress Scale (MDS) (Corley et al., 2001) and Moral Distress Scale – Revised (MDS-R) (Hamric & Blackhall, 2007), imputed means was used here to account for missing data.

Missing data in the MDS-R (aged care) were evident in 13 (3.65%) of the response options. Almost two-thirds (8 of 13) of the missing data were assessed as missing completely at random (MCAR). Imputed means was used to replace this data.
A further examination into the missing data identified approximately one-third of the missing data as missing not at random (MNAR). Three surveys were identified in which the frequency component of the survey had been completed but not the intensity component. In one survey the frequency and intensity components had been completed for only the first ten items. The use of imputed means with MNAR data is problematic (Penny & Atkinson, 2012) and can lead to incorrect estimates (Eekhout et al., 2012). Therefore the data collected from all four surveys were used in the analysis, but imputed means was not used to replace missing data in these surveys.

4.7.9.3 Normality
Normality was assessed using histograms and measures of shape (kurtosis and skew) (Mariappan, 2013). These assessments are important as they support the assessment of normality (histogram); with measures of shape indicating deviations or variance from this (Kirkwood & Sterne, 2005). They are useful measures that guide approaches to dealing with non-normal data (Rindskopf & Shiyko, 2010). Outcomes of these analyses are detailed in Chapter 5 (refer section 5.3.2).

4.7.9.4 Reliability, face and content validity
Reliability is concerned with determining the capacity of an instrument to measure constructs consistently. That is, can an instrument “…measure the same thing each time it is used” (Singh, 2007, p. 77). Reliability provides a clear assessment of the “…repeatability of a questionnaire…” (Jones & Rattray, 2010, p. 370). Cronbach’s alpha is purported to be the most widely used measure of internal consistency (Polit, 2010; Polit & Beck, 2012), and is a measure frequently reported as a component of instrument validation in nursing research (Åhlin, Ericson-Lidman, Eriksson, Norberg, & Strandberg, 2013; Glasberg et al., 2006; Gur-Yaish, Zisberg, Sinoff, & Shadmi, 2012; Halcomb et al., 2011).

Cronbach’s alpha is represented by a score between 0 and 1.0; the closer a score is to 1.0 the greater the reliability of the instrument. A score of 0.70 indicates relatively strong reliability (Macnee & McCabe, 2008); yet some suggest 0.75 or above (Singh, 2007), and others 0.80 or greater (Bryman & Cramer, 1997). An alpha of 0.70 or above for each subscale (frequency and intensity) and the instrument as a whole was used to determine reliability in pilot-testing the MDS-R (aged care).
Face validity is a subjective assessment (Hair et al., 2010) concerned with improving the capacity of an instrument to measure what it claims to measure (Polit & Beck, 2004). As described earlier in this discussion, clinical expert review to gain consensus on amended items (with a view to ensuring face and content validity) was obtained, and is an approach consistent with other nursing research (Kennerly et al., 2012; Kostovich, 2012; Lynn, Morgan, & Moore, 2009).

The face and content validation process undertaken in this study (expert review) and detailed earlier in this chapter (refer section 4.7.5), is an acceptable strategy (Singh, 2007) and assisted in the development of robust instrument refinements. Whilst arguably a weaker form of validity it is useful (Jones & Rattray, 2010). Strong content validity is beneficial as it can also strengthen the overall construct validity of an instrument (Polit & Beck, 2012).

An additional measure of the survey’s effectiveness is to consider the construct validity of the amended instrument. This type of validity is concerned with determining how well the instrument items “…represent the underlying conceptual structure” (Jones & Rattray, 2010, p. 372). Careful post-study scrutiny is identified as a key part of this process (Polit & Beck, 2012).

Factor analysis is a process that is often used to “…understand underlying structure…” (Tabachnick & Fidell, 2013, p. 25). Factor analysis is frequently used in health research aimed at developing new measurement instruments (Halcomb et al., 2011; Kennerly et al., 2012; LaVeist, Isaac, & Williams, 2009; B. O’Connell, Hawkins, & Ockerby, 2013; Waschgler, Ruiz-Hernández, Llor-Esteban, & García-Izquierdo, 2013). The MDS-R (aged care) is a newly amended instrument, and previous iterations have undergone only initial (Corley, 1995; Corley et al., 2001) or no factor analysis (Hamric & Blackhall, 2007; Hamric et al., 2012). Exploratory factor analysis is an appropriate approach when previous exploratory factor analysis has not been performed (Burns & Grove, 2009); hence exploratory factor analysis (EFA) was used in this study. The results of this exploratory factor analysis are described in Chapter 5 (refer section 5.3.3).
4.8 Phase 2 Research Design

4.8.1 Phase 2 - Overview and purpose

The aim of Phase 2 was to explore qualitatively Australian aged care workers experience of moral distress. Telephone interviews and case study scenarios were used to collect data for Phase 2 of the study, from participants in Queensland and Victoria, Australia. Specifically research questions 2 and 3 were addressed:

RQ 2. What do Australian aged care workers understand about moral distress in residential and community aged care?

RQ 3. How does moral distress impact upon residential and community aged care workers and their workplace?

Phase 2 was undertaken in two stages. In Stage 1 ethics approval was obtained, telephone interviews were used to collect data, and data were reduced and analysed through thematic analysis relying also on the constant comparison of data (Braun & Clarke, 2006; Sarantakos, 2013; Tuckett, 2005a).

In Stage 2 data from Phase 1 (survey instrument) Phase 2 Stage 1 (telephone interviews) and the literature review findings (refer Chapter 2, section 2.4.1.2) were combined to develop two case study scenarios. The case study scenarios were used to collect textual data on the experience of moral distress. This data was also subjected to thematic analysis (refer Figure 4-3 below). In total 9 telephone interviews were conducted, with the 2 case study scenarios generating 16 complete responses (textual data).

The two stage process was a pragmatic choice. Initially Phase 2 was to rely on data collection using telephone interviews only. The first literature review (detailed in Chapter 2) framed the development of questions (Appendix H) for the telephone interviews. However, during the process of conducting the telephone interviews two issues became apparent. Many of the participants experienced difficulty delineating between stress, workplace stress, and moral distress; subsequently the data lacked richness (Geertz, 1973; Patton, 2015). Difficulty securing participants for telephone interviews then compounded this problem. Hence a second stage using case study scenarios (Appendix I) to collect textual data was designed. The first literature review (detailed in Chapter 2) and especially the frequency and outcomes of specific contributing factors identified in the literature review, were assessed with a view to develop relatable scenarios participants were likely to have
encountered. These data were combined with the data gleaned from the telephone interviews to inform the content of the case study scenarios. Data from the case study scenarios were used to inform the final findings.

Figure 4-3 Flow chart outlining Phase 2 process

4.8.2 Phase 2 – Ethics Approval

An amendment to the initial ethics approval for Phase 2 was required, and subsequently obtained (Appendix J). Specific information given to participants is contained in the Participant Information Sheet (Appendix K).
4.8.3 Phase 2 – Data Collection

4.8.3.1 Sampling and the sample

This qualitative phase of the study involved Registered Nurses, Enrolled Nurses and Personal Carer / Assistant in Nursing from residential and community aged care facilities in Queensland and Victoria, Australia. Whilst completing the MDS-R (aged care) in Phase 1 (Stage 2), survey participants were offered the opportunity to voluntarily opt into the Phase 2 (Stage 1) telephone interviews. As a component of the sequential mixed method design of the study, this strategy directly enabled access to a population that could provide relevant data to enhance understanding of the research question. This purposeful sampling technique is a noted strategy (Titter, 2007) and recognised as necessary in qualitative research (Coolican, 2009; Creswell, 2014).

In conducting qualitative studies Travers (2013) notes there are no pre-set rules identifying the number of interviews that need to be conducted; the numbers are dependent on the “…purpose and aims of the project as well as the research questions” (p. 232). Creswell’s (2013) suggestions stem from this basis, highlighting that researchers should be looking to “…collect extensive detail about each site or individual studied” (p. 157). Ultimately, poor decisions regarding the sampling design may compromise the trustworthiness of findings (Marshall & Rossman, 2011).

Polit and Beck (2004) argue that appropriateness of the sample is more important than pure numbers, and this appropriateness is grounded in the conceptual requirements of the study. In discussing the challenge facing qualitative researchers in determining sample size Coolican (2009) suggests that for qualitative explorations with a focus on understanding unique experiences between “…five or six to fifteen…” (p. 564) interviews are appropriate. In determining the number of interviews to be undertaken a degree of pragmatism is also required, with due consideration given to the amount of resources and time available (Travers, 2013). Identification of interview detail for our study is forthcoming in section 4.8.3.4.

4.8.3.2 Data Saturation

Data saturation can be described as “… sampling to redundancy” (Holloway & Wheeler, 2010, p. 146), or more simply is reached “…when you have heard the range of ideas and aren’t getting new information” (Teddlie & Tashakkori, 2009, p. 183). However Marshall
and Rossman (2011) tend away from the idea of saturation and instead (perhaps pragmatically) suggest an acceptance that “…we can never know everything and that there is never one complete truth” (p.220). In doing so, they place the onus on the researcher to explore the available data searching for plausible explanations instead. Holloway and Wheeler (2010) lament that “…no specific rules or guidelines exist…” (p. 147).

Data saturation is considered in light of two key stages: data collection and data analysis; and is not truly determined without due consideration of both elements. The point of saturation is reached when new data consistently fits into developed categories (Liamputtong, 2013), and no new codes emerge (Tilley, 2011). Analysis of new data does not identify unique categories or relationships (Skeat, 2013), and further analysis becomes redundant (Tilley, 2011). At this point the researcher has obtained a rich and complete description (Polit & Beck, 2004).

These understandings about sampling and the sample, data saturation along with the constant comparison of data (Tuckett, 2005a) and the process of member checking at the point of data collection, were used to determine the final sample size for Phase 2 of the study. Details about data analysis is forthcoming in section 4.8.4 of this chapter.

4.8.3.3 Interviewing

A semi-structured interview method was used. Semi-structured interviews allow participants an opportunity to share their experience in a manner that facilitates a deeper and richer understanding of the construct (Taylor, 2007). Coolican suggests that responses from this method are “…perhaps more genuine” (2009, p. 151) than those from a survey or questionnaire. Interviews allow a researcher a degree of control over the questioning, provide historical information and are useful when participants cannot be directly observed (Creswell, 2014, p. 191). As a data generation method the interview approach aligns well with an interpretative philosophy (King & Horrocks, 2010).

Questions used to structure the interview focused on exploring participants understanding of moral distress, their experiences of moral distress, and how it was perceived to affect them and their colleagues. This semi-structured format enabled exploration of understanding with a view to uncovering meaning behind experiences, and hence sits well with interpretivism (Burns & Grove, 2009). The purpose of using this method was to obtain
a thick description of participants’ unique experiences and the individual contextualised meanings of these experiences (Cho & Trent, 2006).

Four demographic questions were included at the commencement of the interview (Appendix H). The demographic data identified were age of respondent, qualification, length of service in the profession and time worked in the current place of employment. The purpose of collecting this information was to search for trends, differences or outliers between different groups of respondents; for example between categories of workers, or participants of different age groups.

4.8.3.4 Telephone Interviews
Telephone interviews are an approach used frequently in health research (Byrne, Harrison, Young, Selby, & Solomon, 2007; Hallin & Danielson, 2007; Laabs, 2007). It is viewed as a method that can provide data of a comparable quality to that obtained from face to face interviews (Coolican, 2009). Telephone interviewing was selected for use in this study for pragmatic purposes; it suited accessing the geographically disparate sample population (Queensland and Victoria), and is inexpensive (King & Horrocks, 2010).

Based on the previous discussion regarding sample size (refer section 4.8.3.1), fifteen (15) telephone interviews were desired. Participants volunteering for Phase 2 of the study were contacted via their preferred contact method (either e-mail or telephone), and a convenient time for conducting the interview was arranged. Although 26 Phase 1 participants chose to opt in to Stage 2, of these 17 were either unable to be contacted or when contacted declined to participate further. Consequently a total of nine telephone interviews were completed. The data analysis process is described in section 4.8.4.

4.8.3.5 Case Study Scenarios
Due to the difficulties experienced in recruiting participants for the telephone interviews, and the nature of the data, a second strategy for data collection was implemented. The rationale for this process is described earlier in section 4.8.1, and the methodological challenges encountered further expounded in Chapter 7 (refer section 7.7). Using data from the Phase 1 (survey instrument), Phase 2 Stage 1 (telephone interviews) and knowledge from contemporary moral distress literature, two case study scenarios were written. The scenarios were designed to specifically describe situations known to cause moral distress and were used in this instance as prompts from which participants
answered a series of questions. In effect, short answers to four written scenarios (or triggers) (Appendix I).

For each of the two case study scenarios participants were asked to respond to four open-ended questions. The use of open-ended questions is an important strategy facilitating exploration of the complexity and richness of qualitative inquiry (Patton, 2015). Overall sixteen participants completed responses to the scenarios, with all participants providing a response to every question. Thematic analysis which included the constant comparison of data were used to analyse the responses to the questions.

4.8.4 Phase 2 – Analysis and Data Reduction: Interviews and Scenarios

4.8.4.1 Analysis of Data
A thematic analysis approach is concerned with extracting the central ideas or themes from the data (Taylor, 2007; Willis, 2013), “…elucidating the specific nature of a given group’s conceptualization of the phenomenon under study” (Joffe, 2012, p. 212). It is an inductive process that requires concurrent data collection and analysis (Sarantakos, 2013). Braun and Clarke (2006) describe a six phase approach to thematic analysis. These phases are: familiarizing yourself with your data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report. This framework has been used as a basis for data analysis (Braun & Clarke, 2006, p. 87). An inductive approach was used for Phase 2 (Stage 1) - telephone interviews, and a deductive-inductive cycle for Phase 2 (Stage 2) - case study scenarios.

Textual data was stored electronically and an electronic spreadsheet used to track the emergent codes, categories and themes as they were developed; however, a manual approach to data analysis was used. That is, data were not subjected to analysis through the use of qualitative data analysis software. While seen as essential for studies such as longitudinal and large scale investigations (Miles, Huberman, & Saldana, 2014), use of this software is not necessary for smaller scale studies.
Constant comparison of data requires immersion in the data (Krathwohl, 2009), hence the use of a manual analytical approach. Additionally, computer aided analysis does not remove the need for critical and analytical thinking by the researcher (Miles et al., 2014), that is it does not do the analysis for you. Consequently those new to qualitative data analysis, and most specifically the use of software to facilitate this, can readily make errors that impact on the trustworthiness of findings (Bazeley, 2013). The use of computer analysis software for this study was discussed at milestone reviews, however no justification for adoption was identified.

In Phase 2 (Stage 1) the nine telephone interviews were analysed as follows. Initial data collected from the first three telephone interviews were transcribed verbatim, then read and re-read by both the Investigator and the Principal Advisor (investigator triangulation) (King & Horrocks, 2010). This process was conducted again after completion of three more interviews – again by both the Investigator and the Principal Advisor, and the cycle completed for the last three interviews. The interview data were then reviewed by the Investigator across the whole data set (n=9). Thematic analysis using an inductive approach was used with interview data.

Constant comparison of data was used during this data collection phase. Creswell (2013) describes the processes of data collection and analysis as interrelated and often simultaneous. Developing a familiarity with data as it emerges facilitates the ability to identify the focal points of a study (Bazeley, 2013), and ultimately enhance coverage of the research topic (Sarantakos, 2013). This constant comparison was used to guide the later telephone interviews, and also to assist identification of the point of data saturation. Data gleaned from Phase 2 (Stage 1) was used solely to inform the development of the case study scenarios in Phase 2 (Stage 2).

Data from the telephone interviews and known contributing factors of moral distress (refer Chapter 2) informed the development of the case study scenarios used in Phase 2 (Stage 2). Additionally the contributing factors, outcomes and interventions espoused in the literature were relied upon during the analysis of the Phase 2 (Stage 2) data. The purpose was to provide a structured approach that promoted synergy in interpretation between existing knowledge, and that discovered in our study. This approach also facilitated the recognition of unusual or atypical data within this population.
Initially in Phase 2 (Stage 2) the Investigator and Principal Advisor engaged with the raw
textual data (n=16) separately, then discussed preliminary thoughts about emerging codes
and categories. Re-reading of the data by the Investigator led to the development of
codes, categories and preliminary themes, which were then sent to the Principal Advisor.
The Principal Advisor considered these codes, categories and themes independently (with
re-reading of the data), and subsequently the Investigator and Principal Advisor discussed
similarities and differences in interpretation. A final reading of the data was undertaken by
the Investigator prior to determining the final themes. The data from Phase 2 (Stage 2)
was used to inform the final findings of the study. Outcomes of this analysis are detailed in
Chapter 6.

This immersive process over time facilitated familiarity with data, the generation of
trustworthy codes, allowed recognition of links or relationships between codes, and
ultimately supported the generation of themes; which must always be “…recontextualised
to the source material” (Bergman, 2010, p. 392).

4.8.5 Phase 2 - Becoming Familiar with the Data: Interviews and
Scenarios

4.8.5.1 *Transcription and auditing*

The process of transcription is described as an immersive process (Willis, 2013), with this
personal involvement important in “…building intimate knowledge of your data” (Bazeley,
2013, p. 73). It informs the initial stages of analysis (Braun & Clarke, 2006). Burns and
Grove (2009) note that interviews are generally transcribed word for word, with Coolican
(2009) identifying this verbatim transcription as essential. The transcription must be
performed accurately, as this text becomes the raw data for analysis (Burns & Grove,
2009).

Telephone interviews were electronically recorded and then transcribed verbatim prior to
analysis. The researcher transcribed the first five telephone interviews. For reasons of
practicality subsequent telephone interviews were transcribed by an external transcription
service, however to facilitate greater familiarity with the data each of these transcriptions
was reviewed and edited by the Investigator for accuracy in conjunction with the original
recording (Braun & Clarke, 2006). Also a journal of definitions, evolving ideas and codes/categories/themes was kept, and is discussed in section 4.8.6.5.

4.8.5.2 Generating initial codes
Accurate coding provides a valid and reliable basis for grouping content (Guest, MacQueen & Namey, 2012). It involves the systematic and careful reading of transcribed text to identify description and meaning in segments of data, and is used to identify similarities in experience (Tuckett, 2005a; Willis, 2013). In conjunction, Joffe (2012) recommends the development of a 'coding frame' (or coding manual) to ensure clear and consistent application of codes within the analysis. Coding of data were undertaken to facilitate the categorisation, or clustering, of like data. Individual words and phrases were identified as pertinent to the emerging understanding of moral distress and were flagged using a colour coding system. Like data were given a numbered code with a view to preliminary clustering of data. An example of this coding is attached (Appendix L).

4.8.5.3 Generating categories
Over time, as coded data were read and re-read, unified categories emerged. During this process a journal of definitions, evolving ideas and atypical data was collated. When determining categories, the researcher is searching for relationships between codes (Willis, 2013). This aggregation of coded data is designed to create smaller categories of information (with a view to later clustering to themes), and can also be used to filter out unnecessary data (Creswell, 2014). During this stage categories can be assessed against each other, looking for similarities or overlap (Willis, 2013), a process that requires continued reference to the source data. This “reading and rereading” of data and researcher notes is a crucial component of a thorough thematic analysis (Creswell, 2013; Taylor et al., 2007; Tuckett, 2005a). An example of how coded data were collapsed into categories is attached (Appendix M).

4.8.5.4 Searching for Themes
Categorised data were clustered into preliminary themes and then a process of re-reading the data was undertaken. This cyclical process further enhanced familiarity with the data, and supported the development of robust themes. The process of determining themes involves interpreting patterns from within the data and sorting categorised coded data into broader theoretical frames, or as Creswell (2013) describes common ideas. Joffe (2012) describes themes as “patterns of explicit and implicit content” (p.209). It is suggested that
some type of visual representation or thematic map is a beneficial part of this process (Braun & Clarke, 2006).

Due care must be applied to the way in which themes and sub-themes are labelled. It is important those reading the final research output are able to clearly and easily comprehend the intended meaning of each theme. Determining appropriate thematic labels requires clear identification of “…the essence of what each theme is about…” (Braun & Clarke, 2006, p. 92), and it is only through a process of deep reflective thinking that this can emerge (Bazeley, 2013). Labels need to be clear, precise and unambiguous, providing an observer with a clear representation of meaning. An example of how categories collapsed into themes is attached (Appendix N).

Bergman (2010) also posits that thematic interpretations need to be “…recontextualised to the source material” (p.392). Bazeley (2013) and Willis (2013) both caution researchers not to simply end thematic analysis at the point of descriptive labelling. Neglecting to reconsider themes in light of the original source may lead to loss of important contextual meaning. Braun and Clarke (2006) describe two clear stages in the process of reviewing themes. The first stage is to review themes at the level of the coded extracts, the second stage to give due consideration of the validity of themes in relation to the entire data set (Braun & Clarke, 2006).

After development of preliminary themes the Investigator returned to the raw data, undertaking a further process of re-reading. During this process specific attention was given to ensuring appropriate codes and categories were derived from the data, and that labelled themes represented participants’ voice. Additionally during the reporting of the Phase 2 data (as detailed in Chapters 6), raw data, codes and categories were re-visited. This process allowed themes to be refined over time.

An additional benefit of this cyclical process of reviewing themes is that previously unrecognised themes or sub-themes may emerge (Taylor et al., 2007). In this study sub-sections of the data set were analysed independently by two researchers (Investigator and Principal Advisor), with subsequent discussion of emergent codes, categories and themes undertaken. This investigator triangulation contributed to rigour (refer section 4.8.6.2).
4.8.6 Phase 2 - Rigour Criteria

Research conducted with rigour is research that can be depended upon by other researchers (Liamputtong, 2013). In the qualitative sphere the term trustworthiness (Lincoln & Guba, 1985) is used to ensure delineation from those methods of rigour involved in quantitative research (such as validity, reliability and objectivity). It is an alternative perspective to the quantitative sphere, and attests to methodological “…soundness and adequacy” (Holloway & Wheeler, 2010, p. 302).

The terminology used to frame trustworthiness, and frequently cited in the literature (Holloway & Wheeler, 2010; Liamputtong, 2013; Marshall & Rossman, 2011; Teddlie & Tashakkori, 2009; Tuckett, 2005b), is that first proposed by Lincoln and Guba (1985) who introduced four key terms: credibility, transferability, dependability, and confirmability. These terms are respectively parallel equivalents to the common quantitative terminology of: internal validity, external validity, reliability, and objectivity (Tuckett, 2005c).

4.8.6.1 Strategies for Achieving Trustworthiness

Davidson, Halcomb and Gholizadeh (2013) contend that “the research is trustworthy if the results reflect the experiences of the participants as much as possible” (p.67). Consequently appropriate strategies to maximise the trustworthiness of this research must be built into the design of the study. A number of the strategies suggested by Teddlie and Tashakkori (2009, p. 213) have been implemented to improve trustworthiness of the research: use of triangulation techniques (dependability/reliability), member checks (credibility/ internal validity), thick descriptions (transferability/external validity), and researcher’s reflective journal (credibility, dependability and confirmability/objectivity) (Morse, 2015; Tuckett, 2005b). Additionally Holloway and Wheeler’s (2010) identification of the importance of the audit (or decision) trail (credibility, dependability and confirmability) has been noted (Morse, 2015; Tuckett, 2005b).

4.8.6.2 Triangulation

Triangulation is an important process used to establish credibility (Tuckett, 2005c). Four distinct types of triangulation exist, namely; sources (data), methods, investigator, and triangulation of theory (King & Horrocks, 2010). Investigator triangulation was used whereby the data set were analysed independently (on multiple occasions throughout the analysis process) by two researchers (Investigator and Principal Advisor), with subsequent discussion of emergent codes, categories and themes undertaken. This technique
improved the credibility of findings, providing more robust outcomes (Carlson, 2010; Marshall & Rossman, 2011).

### 4.8.6.3 Member Checking

Member checking is an important process for reducing researcher bias and improving credibility of the research (Tuckett, 2005c). Teddlie and Tashakkori (2009) posit this as “…perhaps the most important strategy for determining the credibility of the researcher’s interpretation of the participant’s perceptions” (p. 213). Member checking involves providing participants an opportunity to clarify data and interpretations (Carlson, 2010), providing opportunities for the researcher to determine if they have correctly understood participants (Morse, 2015).

Two specific strategies were used for member checking. During the semi-structured interview, and most specifically before concluding the interview, emergent ideas were paraphrased and communicated back to participants. This member checking at point of data collection provided an opportunity for participants to confirm if their ideas were being understood accurately and to correct misperceptions (Holloway & Wheeler, 2010). This was aided by the use of the reflective journal taking in-situ thematic notes, which were then brought back to participants as they emerged in real time. Additionally, follow up questions were asked during the telephone interviews to clarify any terminology or statements that were unclear to the researcher, a less formal but still valid approach (Polit & Beck, 2004).

### 4.8.6.4 Thick Description & Audit / Decision Trail

Thick description involves providing detailed descriptions of phenomena and the social context, with a view to enabling the reader to clearly comprehend the manner in which the researcher reached their conclusions (King & Horrocks, 2010). It does not seek to support transferability of data in the quantitative sense of telling truth to the reader (Cho & Trent, 2006, p. 329). The aim is to allow those reading the research findings to make sense of the findings (Tuckett, 2005c). Consequently thick description aids in improving the overall richness (Geertz, 1973; Patton, 2015) of the research.

If the intent of the research is to accurately reflect the experiences of the participants, then the interpretation of the accounts provided is of central importance (Cho & Trent, 2006). Thick description adds to the “vividness and creativity” (Polit & Beck, 2004, pp. 438-439) of
the data, and critically “...provides evidence for the transferability of interpretations and conclusions” (Teddlie & Tashakkori, 2009, p. 213). An additional benefit is that these thick descriptions provide an audit trail that evidences the development of ideas throughout the progression of the research (King & Horrocks, 2010).

4.8.6.5 Reflective (Researcher’s Field) Journal
Maintaining a reflective journal is a strategy that supports attainment of all four of Lincoln & Guba’s (1985) trustworthiness criteria (Teddlie & Tashakkori, 2009). Tuckett and Stewart (2003a) describe the approach originally developed by Schatzman and Strauss (1973), that involves recording observational notes, theoretical notes, and methodological notes. This approach has been used during this study to record key points or issues raised by participants (observational note – Appendix O), information pertaining to the researcher’s thoughts on emergent ideas (theoretical note – Appendix P), new or unusual concepts raised by participants (theoretical note – Appendix - P), and the process of interviewing including barriers and facilitators to effective interviewing (methodological note – Appendix Q).

Observational notes were documented during the interview to record key points presented by participants. Recording participant responses verbatim (that is with as little interpretation as possible) is necessary (Tuckett & Stewart, 2003b). These notes were important reference points that allowed the Investigator to further probe participants for deeper description (aiding thick description) and clarification of ideas (member checking). Additionally, this method supported the identification of specific words and phrases emerging from different participants that were introduced in later telephone interviews as an additional strategy in the member checking process.

To facilitate the capacity to provide thick description in this study, theoretical notes were developed during the interview process (as an adjunct to digital voice recordings). Theoretical notes are “…self-conscious, controlled attempts to derive meaning…” (Schatzman & Strauss, 1973, p. 101), which in time can be used to form the substance of the researcher’s final understandings (Tuckett & Stewart, 2003a). Theoretical notes were documented on immediate completion of each interview, and included the researcher’s immediate thoughts on important themes or key issues raised by the participant. The theoretical notes facilitated the constant comparison of data, developed into a clear audit trail, supported the researcher in reflecting on the research process, and contributed
significantly to the credibility and dependability of the outcomes (Tuckett, 2005). An example of a theoretical note is attached (Appendix P).

Methodological notes were also used in our study. A methodological note is concerned with the act of research, and the methods used by the researcher (Schatzman & Strauss, 1973, p. 101). Similarly to Tuckett & Stewart (2003b), methodological notes were used to record process related thoughts (for example “hard to focus on the interview content when mind wants to start unpacking and understanding”) and analysis related thoughts (for example “some clear similarities between first two interviews”). An example of a theoretical note is attached (Appendix Q).

4.8.7 Phase 2 - Data Storage

Digital voice recordings were stored in two geographically separate locations and were password protected. Hand written field notes and interview transcriptions were stored in a locked filing cabinet, within a secure office facility. The Investigator had sole access to these documents. Access to the raw data is limited to the Investigator and the Principal Advisor. This differs slightly from Phase 1 where the Investigator had sole access; the purpose of including the Primary Advisor in Phase 2 was to facilitate independent analysis of the data by two investigators.
4.9 Conclusion

In Chapter 4 the aims, objective, research questions, methodology and methods were described. An explanatory sequential mixed methods approach has been used, and for clarity the study was conducted in two phases with two stages in each phase. Phase 1 (Stage 1) entailed a review of the literature to identify existing instruments measuring moral distress; with selection and amendment of the Moral Distress Scale – Revised (Hamric & Blackhall, 2007) completed. In Phase 1 (Stage 2) the Moral Distress Scale – Revised (aged care) (Burston et al., 2016) was pilot tested with Australian aged care workers.

Phase 2 involved exploration of the experience of moral distress with these workers, through the use of telephone interviews (Stage 1) and case study scenarios (Stage 2). Data from the telephone interviews (Stage 1) was used to inform the development of case study scenarios (Stage 2) targeting the moral distress experiences identified by participants. Analysis of the case study scenarios (Stage 2) was used to inform the final findings. Thematic analysis relying on constant comparison of data was used to analyse textual data from both stages.

Chapter 5 reports the results from Phase 1 of the study; the amendment and validation of the Moral Distress Scale – Revised (aged care) (Burston et al., 2016). Psychometric testing of the instrument, with a view to determining construct validity and internal reliability is described
Chapter 5  Results Phase 1

5.1 Introduction
Chapter 4 outlined the methodological basis and methods used for this study exploring the experience of moral distress for Australian aged care workers. The aims, objectives, research questions and methods were identified, with justification for the use of a mixed methods approach presented. This mixed methods study is divided into two phases. Phase 1 (quantitative) involved the amendment and pilot testing of the Moral Distress Scale – Revised (aged care) (Burston et al., 2016). Phase 2 (qualitative) utilised telephone interviews and case study scenarios to explore workers experience of moral distress.

Chapter 5 presents results from Phase 1 (instrument modification and testing) of the study, with Phase 2 (telephone interviews and case study scenarios) results presented separately in Chapter 6. In Chapter 7 discussion of the findings from both Phase 1 and Phase 2 is presented.

Chapter 5 commences with a description of the sample populations and the results of psychometric evaluation of the Moral Distress Scale – Revised (aged care). Distribution of data was assessed, Exploratory Factor Analysis (EFA) was used to determine construct validity, and Cronbach’s alpha to determine reliability. Pilot testing demonstrated validity and reliability of the instrument, hence mean item scores are reported.

The findings of Phase 1 have been published in the peer-reviewed journal International Journal of Older People Nursing (Appendix C):

The aim of Phase 1 was to identify the degree to which Australian aged care workers experience (frequency and intensity) moral distress. Phase 1 (Stage 1) involved the identification and amendment of an instrument to measure moral distress. In Phase 1 (Stage 2) this amended instrument was pilot tested. Specifically research question 1 was addressed:

RQ 1. Do Australian aged care workers in residential and community aged care experience moral distress?

The review of the literature (described in Chapter 2) led to the identification of five instruments measuring moral distress. As detailed in Chapter 4 (Methodology) an existing instrument was selected and then amended for use in the Australian aged care setting: resulting in the Moral Distress Scale – Revised (aged care).

5.2 Phase 1 – Results

The following describes the use of the pilot data collected using both an electronic platform and paper surveys from; April 2013-April 2014 (Sample One), October 2013 (Sample Two), June 2014 – August 2014 (Sample Three) and August 2014 (Sample Four) for the purpose of developing the Moral Distress Scale – Revised (aged care). Chapter 7 presents a discussion of the findings detailed herein.

5.2.1 Sample description

The following section provides an overview of the sample population. Aged care workers from Queensland and Victoria (Australia) participated in the study. Additionally participant demographic characteristics of the participants are described.

5.2.1.1 Sample One

As previously described in Chapter 4 (refer section 4.7.8.1), a convenience sample of aged care workers from one state-wide organisation were approached for inclusion, with electronic distribution of survey. Forty-five respondents accessed the survey electronically, of these three declined to participate. Of the remaining 42 participants, 32 completed the survey entirely.

Participants ranged in age from 28 to 64 years, with an average age of 53 years. Four (12.5%) identified as male, and 28 (87.5%) as female. Thirty (93.8%) participants identified working in Queensland, with two (6.2%) participants indicated working in New South
Wales* (refer footnote\(^1\)). Nineteen (59.4%) participants worked in residential aged care, and 10 (31.3%) in community care. The remaining three (3.8%) worked in; hospital aged care, as a researcher, and in acute care (aged).

Two (6.25%) respondents worked as a Personal Carer /Assistant in Nursing, two (6.25%) as an Enrolled Nurse, and 24 (75%) worked as a Registered Nurse. Four participants (12.5%) identified their occupation as “other” [one service manager, three did not provide further information]. Length of time working in nursing varied in range from 2 to 41 years, with a mean time of 29 years. Length of time working in current facility ranged from less than one month up to 20 years, with a mean time of 7.6 years.

5.2.1.2 Sample Two
First described in Chapter 4, section 4.7.8.2, a second convenience sample was identified through a local residential aged care provider (part of the state-wide organisation for the Sample One population). A further 18 responses were obtained from this source.

Participants ranged in age from 22 to 64 years, with an average age of 49 years. Two (11%) identified as male, and 16 (89%) as female. All participants identified working in Queensland. Thirteen (72.2%) participants identified working in residential aged care and five (27.8%) in community care.

Eleven (61.2%) respondents worked as a Personal Carer/Assistant in Nursing, one (5.5%) as an Enrolled Nurse, and five (27.8%) as a Registered Nurse. One (5.5%) participant identified their occupation as “other” (Service Manager). Length of time working in nursing varied in range from two to 38 years, with a mean time of 15.6 years. Length of time working in current facility ranged from 1 year to 20 years, with a mean time of 6.5 years.

5.2.1.3 Sample Three
Again as described in Chapter 4 (refer section 4.7.8.3), sample three was accessed via an interstate colleague. An additional 58 responses were obtained, and of those returned surveys 52 contained sufficient data for analysis.

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\(^1\) Footnote: "Information and the electronic link to the study were advertised in the organisations electronic newsletter. The organisation operates a number of facilities in Northern New South Wales."
Participants ranged in age from 21 to 73 years, with an average age of 46.9 years. Six (11.5%) identified as male, and 46 (88.5%) as female. All participants worked in Victoria. Fifty-one participants (98.1%) worked in residential aged care. One participant (1.9%) worked across both residential aged care and acute care (Director of Nursing).

Eight (15.4%) respondents worked as a Personal Carer/Assistant in Nursing, 26 (50%) as an Enrolled Nurse, and 17 (32.7%) as a Registered Nurse. One participant (1.9%) did not answer the question. Length of time working in nursing varied in range from 1 to 55 years, with a mean time of 17.9 years. Length of time working in current facility ranged from four months to 46 years, with a mean time of 8.25 years.

5.2.1.4 Sample Four
As detailed in Chapter 4, section 4.7.8.4, another industry colleague provided contact with a fourth sample population. An additional four (4) responses were obtained from this population.

Participants were aged 57, 57, 59 & 61 years of age. One (25%) identified as male and three (75%) as female. All participants worked in residential aged care in Queensland. Two (50%) respondents worked as a Personal Carer/Assistant in Nursing, one (25%) as an Enrolled Nurse, and one (25%) as a Registered Nurse.

Length of time working in nursing (1 non-response) varied in range from one to four years, with a mean time of 2.5 years. Length of time working in current facility ranged from three months to four years, with a mean time of 1.5 years.

5.2.1.5 Complete Sample- Workplace, Role and Demographics
Of the 125 surveys commenced or returned, three (3) surveys were unusable because they did not contain any data, and a further sixteen (16) were discarded as only demographic data were provided. In total 106 completed the surveys were obtained. Participants ranged in age from 21 to 73 years, with an average age of 51 years. Thirteen (12.3%) identified as male, 93 (87.7%) as female. Forty-nine (46.3%) participants worked in Queensland, 51 (48.2%) in Victoria, two (1.8%) in New South Wales, and four (3.7%)
respondents did not answer this question. An overview of the sample is provided earlier in Chapter 4 (refer Figure 4-2).

Seventy nine (74.5%) participants worked in residential aged care and 23 (21.7%) in community care. The remaining four (3.8%) worked in; hospital aged care, as a researcher, in acute care (aged), and as a Director of Nursing (Table 5-1 below).

Table 5-1 Workplace setting of survey respondents

<table>
<thead>
<tr>
<th>Workplace Setting</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Aged Care</td>
<td>79 (74.5)</td>
</tr>
<tr>
<td>Community Care</td>
<td>23 (21.7)</td>
</tr>
<tr>
<td>Other*</td>
<td>4 (3.8)</td>
</tr>
</tbody>
</table>

*hospital aged care, researcher, acute care (aged), Director of Nursing

Twenty three (21.7%) respondents worked as a Personal Carer/Assistant in Nursing, 30 (28.3%) as an Enrolled Nurse, and 47 (44.4%) worked as a Registered Nurse. Six participants (5.6%) identified their occupation as “other” (2 service managers, 4 did not provide further information) (Table 5-2 below).

Table 5-2 Role designation of survey respondents

<table>
<thead>
<tr>
<th>Role Designation</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Carer / Assistant in Nursing</td>
<td>23(21.7)</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>30 (28.3)</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>47 (44.4)</td>
</tr>
<tr>
<td>Other**</td>
<td>6 (5.6)</td>
</tr>
</tbody>
</table>

**2 service managers, 4 did not provide further information

Length of time working in nursing varied in range from one year to 55 years, with a mean time of 20.6 years and a median of 21.0 years (Table 5-3 below).
Table 5-3 Years participants had worked in nursing

<table>
<thead>
<tr>
<th>Years nursing</th>
<th>Number of workers</th>
<th>Percentage of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 10 years</td>
<td>37</td>
<td>34.9</td>
</tr>
<tr>
<td>11 – 20 years</td>
<td>16</td>
<td>15.1</td>
</tr>
<tr>
<td>21 – 30 years</td>
<td>23</td>
<td>21.7</td>
</tr>
<tr>
<td>31 – 40 years</td>
<td>18</td>
<td>17.0</td>
</tr>
<tr>
<td>&gt; 40 years</td>
<td>10</td>
<td>9.2</td>
</tr>
<tr>
<td>Blank</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>106</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

(mean 20.6, median 21.0)

Length of time working in current facility ranged from less than one month up to 46 years, with a mean length of 7.6 years and a median of 5.7 years (Table 5-4 below).

Table 5-4 Years participants had worked at current facility

<table>
<thead>
<tr>
<th>Years Current Facility</th>
<th>Number of workers</th>
<th>Percentage of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 5 years</td>
<td>50</td>
<td>47.2</td>
</tr>
<tr>
<td>6 – 10 years</td>
<td>30</td>
<td>28.3</td>
</tr>
<tr>
<td>11 – 15 years</td>
<td>14</td>
<td>13.2</td>
</tr>
<tr>
<td>&gt; 15 years</td>
<td>10</td>
<td>9.4</td>
</tr>
<tr>
<td>Blank</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>106</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

(mean 7.6, median 5.7)

The majority of participants (86.8%) reported currency of clinical exposure, having worked at some stage within the preceding two weeks, six (5.7%) reported not having worked for more than two weeks; with one participant (0.9%) having last worked nine months previously. Five responses (4.8%) were blank and two responses (1.8%) were unable to be read.
Participants were asked if they had ever left, considered leaving a position, or taken a break from nursing because of moral distress. One third of participants had considered leaving a position and almost one quarter have left a position because of moral distress (Table 5-5 below).

**Table 5-5 Number of participants who had left or considered leaving a position**

<table>
<thead>
<tr>
<th>Have you ever left or considered leaving a position because of your moral distress with the way patient care was handled at your institution?</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, I’ve never considered quitting or left a position</td>
<td>46 (43.4)</td>
</tr>
<tr>
<td>Yes, I considered quitting but did not leave</td>
<td>35 (33.0)</td>
</tr>
<tr>
<td>Yes, I left a position</td>
<td>23 (21.7)</td>
</tr>
<tr>
<td>Blank</td>
<td>2 (1.9)</td>
</tr>
</tbody>
</table>

Additionally, one third also identified having taken a break from nursing because of this distress (refer Table 5-6 below).

**Table 5-6 Number of participants who had taken a break from nursing**

<table>
<thead>
<tr>
<th>Have you ever taken a break from nursing because of moral distress?</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>36 (34.0)</td>
</tr>
<tr>
<td>No</td>
<td>67 (63.2)</td>
</tr>
<tr>
<td>Blank</td>
<td>3 (2.8)</td>
</tr>
</tbody>
</table>

One quarter of respondents stated they had participated in some form of professional development related to moral distress, whilst the vast majority (75.5%) had not (refer Table 5-7 below).

**Table 5-7 Education on moral distress**

<table>
<thead>
<tr>
<th>Have you ever participated in any formal education, courses, or professional development related to moral distress?</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>24 (22.6)</td>
</tr>
<tr>
<td>No</td>
<td>80 (75.5)</td>
</tr>
<tr>
<td>Blank</td>
<td>2 (1.9)</td>
</tr>
</tbody>
</table>
The question asking participants to identify their contracted hours of work per week garnered incorrect responses. Nine participants (8.4%) identified working greater than 40 hours per week (with the highest response listed as 72 hours per week). The median score for this question was 31 hours per week (refer Figure 5-1 below).

![Figure 5-1 Identified hours worked per week](image)

A demographic question asking respondents to identify which cultural origin or background they most identified with was included. This open-ended question produced an array of responses as detailed in Table 5-8 below.
### Table 5-8 Participant response to cultural origin or background question

<table>
<thead>
<tr>
<th>Participant Response</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglo-Saxon</td>
<td>6</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
</tr>
<tr>
<td>Australian</td>
<td>67</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
</tr>
<tr>
<td>English / U.K. / English Australian</td>
<td>10</td>
</tr>
<tr>
<td>European</td>
<td>2</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2</td>
</tr>
<tr>
<td>Non-Australian</td>
<td>1</td>
</tr>
<tr>
<td>Philippines</td>
<td>1</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>3</td>
</tr>
<tr>
<td>No answer</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
</tbody>
</table>

### 5.3 Instrument Psychometrics

As detailed in Chapter 4 (refer section 4.7.9) expert review was used to ensure face and content validity of the instrument. This section describes the psychometric testing of the Moral Distress Scale – Revised (aged care). Data were cleaned and distribution of data (normality) assessed. Exploratory factor analysis (EFA) was used to determine construct validity, with internal reliability examined using Cronbach’s alpha (α). Finally, mean item scores of this 20 item instrument are presented.

The Moral Distress Scale – Revised (aged care) is a 20 item instrument measuring both the frequency and the intensity of moral distress. Respondents use a 0-4 Likert scale to rate the frequency of each item (never – very frequently), and intensity (none – great extent) of their experiences. This instrument was adapted from Hamric, Borchers and Epstein (2012) Moral Distress Scale – Revised, an instrument that demonstrated good internal consistency (α 0.83).
5.3.1 Data Analysis

Data obtained from the surveys were cleaned then analysed using IBM Statistics SPSS 21 (IBM Corporation, 2012). Missing data were evident in 3.65% of the response options. This constituted 13 respondents, of which eight were assessed as missing completely at random and imputed means were used to replace these data. Data from the remaining five was assessed as missing not at random. These data were used in the analysis however imputed means were not used to replace missing data. Methods for dealing with missing data were described in Chapter 4 (refer section 4.7.9.2).

5.3.2 Distribution of data

Normality was assessed using histograms and measures of shape (kurtosis and skew). Statistical testing of data to determine internal consistency [reliability] and construct validity of the amended instrument was undertaken. Most (17) items on the Frequency component identified as normally distributed. Three items had a statistically significant positive skew (>1.96 at p<.05). All data from the Intensity component of the scale was normally distributed. Kaiser-Meyer-Olkin measure of sampling adequacy (Frequency .844: Intensity .923) and Bartlett’s test for sphericity (Frequency \( \chi^2 \) 827.318; df 190; p<0.001: Intensity \( \chi^2 \) 1460.503; df 190; p<0.001) were conducted and indicated measures of sampling adequacy. The sample size (n=106) provided data from greater than five participants per item which is sufficient to allow validation (Hair et al., 1998).

5.3.3 Construct Validity - Factor Analysis

As detailed in Chapter 4 (section 4.7.9.4) exploratory factor analysis was undertaken to assess construct validity of the amended instrument. The intent is to determine how well the items within the instrument represent the conceptual structure (Jones & Rattray, 2010, p. 372). Principal axis factoring with orthogonal rotation of extracted factors by varimax rotation (Kaiser normalisation) was conducted to identify underlying components of the Moral Distress Scale – Revised (aged care). The intensity and frequency elements of the scale were analysed separately. Eigenvalues greater than 1.0 were used as general criteria. Factor loadings greater than 0.5 were identified as demonstrating a good fit for that factor (Hair et al., 2010).
The initial solution for the frequency component identified a five factor solution, with 51% of the variance explained. The Scree plot identified one primary factor and levelled out after five (refer Figure 5-2 below).

![Scree Plot](image)

*Figure 5-2 Scree Plot of Eigenvalues - Frequency component*

Factor loadings greater than 0.5 were identified as demonstrating a good fit for that factor (Hair et al., 2010). Factors 1 & 2 were loaded with six and four items respectively; however Factors 3, 4 & 5 were loaded with only one or two items. Six items did not specifically weight towards any given factor. Individual item weightings are detailed in Table 5-9 below - highlighted weights identify which factor an item loaded to.
<table>
<thead>
<tr>
<th>MDS-R (aged care) Instrument item</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
<th>Factor 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to participate in care for a hopelessly ill person who is being sustained by medical treatments, when no one will make a decision to withdraw support.</td>
<td>.728</td>
<td>.276</td>
<td>.254</td>
<td>.128</td>
<td></td>
</tr>
<tr>
<td>Carry out doctor’s orders for what I consider to be unnecessary tests and treatments.</td>
<td>.642</td>
<td>.235</td>
<td>.162</td>
<td>.102</td>
<td></td>
</tr>
<tr>
<td>Initiate life-saving actions when I think they only prolong death.</td>
<td>.632</td>
<td>.141</td>
<td>.314</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow the family’s wishes to delay palliative measures, even though I believe it is not in the best interest of the client.</td>
<td>.597</td>
<td>.272</td>
<td>.294</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assist a doctor who, in my opinion, is providing incompetent care.</td>
<td>.558</td>
<td>.222</td>
<td>.312</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide care that does not relieve the client’s suffering because the doctor fears that increasing the dose of pain medication will cause death.</td>
<td>.540</td>
<td>.292</td>
<td>.173</td>
<td>.127</td>
<td></td>
</tr>
<tr>
<td>Witness healthcare providers giving “false hope” to a client or family.</td>
<td>.434</td>
<td>.202</td>
<td>.143</td>
<td>.262</td>
<td>.109</td>
</tr>
<tr>
<td>Witness diminished client care quality due to poor team communication.</td>
<td>.841</td>
<td>.260</td>
<td>.157</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with nurses or other healthcare providers who are not as competent as the client care requires.</td>
<td>.315</td>
<td>.728</td>
<td>.110</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with levels of nurse or other care provider staffing that I consider unsafe.</td>
<td>.350</td>
<td>.661</td>
<td>.294</td>
<td>.167</td>
<td></td>
</tr>
<tr>
<td>Watch client care suffer because of a lack of provider continuity.</td>
<td>.134</td>
<td>.564</td>
<td>.206</td>
<td>.303</td>
<td>.369</td>
</tr>
<tr>
<td>Follow the doctor’s request not to discuss the patient’s prognosis with the client or family.</td>
<td>.130</td>
<td>.213</td>
<td>.691</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow the family’s request not to discuss death with a dying client who asks about dying.</td>
<td>.220</td>
<td>.685</td>
<td>.234</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow the family’s wishes for the client’s care when I do not agree with them, but do so because of fears of a lawsuit.</td>
<td>.197</td>
<td>.451</td>
<td>.445</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid taking action when I learn that a doctor or nurse colleague has made a medical error and does not report it.</td>
<td>.276</td>
<td>.359</td>
<td>.156</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the dose of sedatives/opiates for an unconscious client that I believe could hasten the client’s death.</td>
<td>.196</td>
<td>.129</td>
<td>.554</td>
<td>-.125</td>
<td></td>
</tr>
<tr>
<td>Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.</td>
<td>.164</td>
<td>.195</td>
<td>.493</td>
<td>.155</td>
<td></td>
</tr>
<tr>
<td>Ignore situations in which clients have not been given adequate information to insure informed consent.</td>
<td>.134</td>
<td>.183</td>
<td>.130</td>
<td>.449</td>
<td>.375</td>
</tr>
<tr>
<td>Be required to care for clients I don’t feel qualified to care for.</td>
<td>.212</td>
<td>.132</td>
<td>.752</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide less than optimal care due to pressures from administrators / supervisors to reduce costs.</td>
<td>.284</td>
<td>.269</td>
<td>.451</td>
<td>.494</td>
<td></td>
</tr>
</tbody>
</table>

Extraction Method: Principal Axis Factoring.
Rotation Method: Varimax with Kaiser Normalization.
Rotation converged in 7 iterations.
The initial solution for the intensity component identified a three factor solution, with 67% of the variance explained. The Scree plot identified one primary factor and levelled out after three (refer Figure 5-3 below).

![Scree Plot](image)

*Figure 5-3 Scree plot of Eigenvalues - Intensity component*

Factor loadings greater than 0.5 were identified as demonstrating a good fit for that factor (Hair et al., 2010). Factor 1 accounted for 55% of the variance and loaded with seven items. Factors 2 & 3 loaded with six and four items respectively. Three items did not specifically weight towards any given factor. Individual item weightings are detailed in Table 5-10 below - highlighted weights identify which factor an item loaded to.
Table 5-10 Factor weightings per item – Intensity component

<table>
<thead>
<tr>
<th>MDS-R (aged care) Instrument item</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide care that does not relieve the client’s suffering because the doctor fears that increasing the dose of pain medication will cause death.</td>
<td>0.759 .348 .131</td>
</tr>
<tr>
<td>Initiate life-saving actions when I think they only prolong death.</td>
<td>0.684 .223 .341</td>
</tr>
<tr>
<td>Continue to participate in care for a hopelessly ill person who is being sustained by medical treatments, when no one will make a decision to withdraw support.</td>
<td>0.682 .280 .323</td>
</tr>
<tr>
<td>Carry out doctor’s orders for what I consider to be unnecessary tests and treatments.</td>
<td>0.648 .296 .241</td>
</tr>
<tr>
<td>Assist a doctor who, in my opinion, is providing incompetent care.</td>
<td>0.609 .479 .391</td>
</tr>
<tr>
<td>Follow the family’s wishes to delay palliative measures, even though I believe it is not in the best interest of the client.</td>
<td>0.580 .382 .241</td>
</tr>
<tr>
<td>Provide less than optimal care due to pressures from administrators / supervisors to reduce costs.</td>
<td>0.554 .504</td>
</tr>
<tr>
<td>Follow the family’s wishes for the client’s care when I do not agree with them, but do so because of fears of a lawsuit.</td>
<td>0.492 .434 .332</td>
</tr>
<tr>
<td>Witness healthcare providers giving “false hope” to a client or family.</td>
<td>0.471 .217 .395</td>
</tr>
<tr>
<td>Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.</td>
<td>0.227 .766 .292</td>
</tr>
<tr>
<td>Increase the dose of sedatives/opiates for an unconscious client that I believe could hasten the client’s death.</td>
<td>0.195 .723 .144</td>
</tr>
<tr>
<td>Ignore situations in which clients have not been given adequate information to insure informed consent.</td>
<td>0.211 .673 .461</td>
</tr>
<tr>
<td>Follow the doctor’s request not to discuss the patient’s prognosis with the client or family.</td>
<td>0.426 .623 .232</td>
</tr>
<tr>
<td>Avoid taking action when I learn that a doctor or nurse colleague has made a medical error and does not report it.</td>
<td>0.417 .620 .311</td>
</tr>
<tr>
<td>Follow the family’s request not to discuss death with a dying client who asks about dying.</td>
<td>0.498 .520 .165</td>
</tr>
<tr>
<td>Be required to care for clients I don’t feel qualified to care for.</td>
<td>0.401 .483 .359</td>
</tr>
<tr>
<td>Witness diminished client care quality due to poor team communication.</td>
<td>0.177 .305 .824</td>
</tr>
<tr>
<td>Watch client care suffer because of a lack of provider continuity.</td>
<td>0.380 .313 .656</td>
</tr>
<tr>
<td>Work with levels of nurse or other care provider staffing that I consider unsafe.</td>
<td>0.386 .362 .606</td>
</tr>
<tr>
<td>Work with nurses or other healthcare providers who are not as competent as the client care requires.</td>
<td>0.353 .360 .575</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Axis Factoring.  
Rotation Method: Varimax with Kaiser Normalization.  
Rotation converged in 8 iterations.
Factors were examined for cross-factor loadings. The Frequency component included one item that loaded closely to factors 1 & 3. This item (assist a doctor who, in my opinion, is providing incompetent care) loaded most strongly to factor 1 (0.431) and conceptually most closely matched other items loaded to this factor – hence it was assigned to factor 1. The Intensity component of the scale revealed three items loading closely to more than one factor. Each of these clearly loaded more strongly and conceptually matched one factor over another, and hence was assigned to that factor.

Analysis of items loaded to each individual factor of each component (Frequency and Intensity), identified clear similarities. Frequency factor 1 and Intensity factor 1 identified issues related to direct care delivery. The first factor derived from the amended instrument was labelled Quality of Care, and centred on issues of unnecessary (futile) or inappropriate care being provided. Commonly this occurred through the participation, delay or omission of care, but also included participation in unnecessary or ineffective care.

Frequency factor 2 and Intensity factor 3 loaded items exploring the ability of the healthcare team to deliver care. This second factor derived from the amended instrument was labelled Capacity of Team, and specifically included items related to issues of communication and competence within the healthcare team. Staffing levels, skill-mix, communication within the team and continuity of care issues are evident in this factor.

Frequency factor 3 and Intensity factor 2 centred upon actions required of the individual worker to function professionally. This third factor derived from the amended instrument was labelled as Professional Practice. Situations in which the nurse felt a perceived restriction on autonomy or inability to fulfil expected professional behaviours were evident within this factor. Items primarily involved non-disclosure of information, and ignoring, or avoiding actions or situations; often this was due to requests of others involved in the situation (doctors, family members).

5.3.4 Reliability (Internal Consistency)
Reliability of the instrument was assessed using Cronbach’s alpha ($\alpha$), with a score of 0.70 used to determine reliability. The frequency component of the instrument demonstrated an $\alpha$ of 0.89, the intensity component of the instrument 0.95, and the instrument as a whole
0.94. Three factors were identified in the frequency component of the instrument, returning \( \alpha \) scores of 0.82, 0.84, and 0.73, respectively. Three factors were identified in the intensity component and these returned \( \alpha \) scores of 0.92, 0.91, and 0.89 respectively (Table 5-11 below).

**Table 5-11 Factor descriptions of MDS-R (aged care)**

<table>
<thead>
<tr>
<th>MDS-R (aged care)</th>
<th>Factor number</th>
<th>Factor name</th>
<th>( \alpha )</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td>Factor 1</td>
<td>Quality of Care</td>
<td>0.82</td>
<td>1.20</td>
<td>0.107</td>
</tr>
<tr>
<td></td>
<td>Factor 2</td>
<td>Capacity of Team</td>
<td>0.84</td>
<td>1.40</td>
<td>0.149</td>
</tr>
<tr>
<td></td>
<td>Factor 3</td>
<td>Professional Practice</td>
<td>0.73</td>
<td>0.61</td>
<td>0.061</td>
</tr>
<tr>
<td><strong>Intensity</strong></td>
<td>Factor 1</td>
<td>Quality of Care</td>
<td>0.92</td>
<td>2.58</td>
<td>0.034</td>
</tr>
<tr>
<td></td>
<td>Factor 2</td>
<td>Professional Practice</td>
<td>0.91</td>
<td>2.14</td>
<td>0.075</td>
</tr>
<tr>
<td></td>
<td>Factor 3</td>
<td>Capacity of Team</td>
<td>0.89</td>
<td>0.89</td>
<td>0.013</td>
</tr>
</tbody>
</table>

Items analysis to test for redundancy identified no statistically significant difference to the instrument as a whole, the frequency component, or the intensity component of the scale. Similarly no statistically significant difference to the three intensity component factors nor the three frequency component factors, was identified when weakly loaded items were removed.

### 5.3.5 Mean Item Scores

The five point Likert type scale used in this instrument allowed for scores ranging from zero to four. Mean scores for “frequency” ranged from 0.36 to 1.73, indicating a relatively low occurrence of moral distress. Mean scores for “intensity” ranged from 1.66 to 2.93 indicating moral distress was experienced at a moderate level. Mean scores for all individual items, as well as the items ranked by means in relation to other items, are detailed in Table 5-12 below. Of particular note are the three items occurring most frequently also accounting for the three highest intensity scores.

The items with the highest mean score for “frequency” were: **work with nurses or other healthcare providers who are not as competent as the client care requires** (1.71); and **witness diminished client care quality due to poor team communication** (1.63). Items with the lowest mean score for “frequency” were: **take no action about an observed ethical**
issue because the involved staff member or someone in a position of authority requested that I do nothing (0.38); and ignore situations in which clients have not been given adequate information to insure informed consent (0.42).

Items with the highest mean score for “intensity” were: work with nurses or other healthcare providers who are not as competent as the client care requires (2.90); and witness diminished client care quality due to poor team communication (2.79). Items with the lowest mean score for “intensity” were: increase the dose of sedatives/opiates for an unconscious client I believe that could hasten the client’s death (1.64); and follow the doctor’s request not to discuss the patient’s prognosis with the client or family (1.89).
### Table 5-12 Ranked item mean scores

<table>
<thead>
<tr>
<th>MDS-R (aged care) Instrument item</th>
<th>Frequency Mean</th>
<th>Frequency SD</th>
<th>Frequency Rank</th>
<th>Intensity Mean</th>
<th>Intensity SD</th>
<th>Intensity Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with nurses or other healthcare providers who are not as competent as the client care requires.</td>
<td>1.71</td>
<td>1.316</td>
<td>1</td>
<td>2.90</td>
<td>1.407</td>
<td>1</td>
</tr>
<tr>
<td>Witness diminished client care quality due to poor team communication.</td>
<td>1.63</td>
<td>1.213</td>
<td>2</td>
<td>2.79</td>
<td>1.338</td>
<td>2</td>
</tr>
<tr>
<td>Follow the family’s wishes to delay palliative measures, even though I believe it is not in the best interest of the client.</td>
<td>1.60</td>
<td>1.258</td>
<td>3</td>
<td>2.75</td>
<td>1.296</td>
<td>3</td>
</tr>
<tr>
<td>Provide less than optimal care due to pressures from administrators / supervisors to reduce costs.</td>
<td>1.59</td>
<td>1.299</td>
<td>4</td>
<td>2.62</td>
<td>1.245</td>
<td>9</td>
</tr>
<tr>
<td>Provide care that does not relieve the client’s suffering because the doctor fears that increasing the dose of pain medication will cause death.</td>
<td>1.50</td>
<td>1.372</td>
<td>5</td>
<td>2.75</td>
<td>1.411</td>
<td>4</td>
</tr>
<tr>
<td>Work with levels of nurse or other care provider staffing that I consider unsafe.</td>
<td>1.50</td>
<td>1.401</td>
<td>6</td>
<td>2.68</td>
<td>1.570</td>
<td>7</td>
</tr>
<tr>
<td>Watch client care suffer because of a lack of provider continuity.</td>
<td>1.44</td>
<td>1.244</td>
<td>7</td>
<td>2.63</td>
<td>1.388</td>
<td>8</td>
</tr>
<tr>
<td>Continue to participate in care for a hopeless person who is being sustained by medical treatments, when no one will make a decision to withdraw support.</td>
<td>1.42</td>
<td>1.300</td>
<td>8</td>
<td>2.68</td>
<td>1.452</td>
<td>6</td>
</tr>
<tr>
<td>Carry out doctor’s orders for what I consider to be unnecessary tests and treatments.</td>
<td>1.40</td>
<td>1.250</td>
<td>9</td>
<td>2.33</td>
<td>1.422</td>
<td>12</td>
</tr>
<tr>
<td>Initiate life-saving actions when I think they only prolong death.</td>
<td>1.31</td>
<td>1.247</td>
<td>10</td>
<td>2.60</td>
<td>1.452</td>
<td>10</td>
</tr>
<tr>
<td>Witness healthcare providers giving &quot;false hope&quot; to a client or family.</td>
<td>1.03</td>
<td>1.040</td>
<td>11</td>
<td>2.30</td>
<td>1.426</td>
<td>15</td>
</tr>
<tr>
<td>Follow the family’s wishes for the client’s care when I do not agree with them, but do so because of fears of a lawsuit.</td>
<td>0.95</td>
<td>1.213</td>
<td>12</td>
<td>2.33</td>
<td>1.535</td>
<td>14</td>
</tr>
<tr>
<td>Follow the family’s request not to discuss death with a dying client who asks about dying.</td>
<td>0.93</td>
<td>0.955</td>
<td>13</td>
<td>2.29</td>
<td>1.508</td>
<td>16</td>
</tr>
<tr>
<td>Assist a doctor who, in my opinion, is providing incompetent care.</td>
<td>0.84</td>
<td>1.012</td>
<td>14</td>
<td>2.71</td>
<td>1.537</td>
<td>5</td>
</tr>
<tr>
<td>Increase the dose of sedatives/opiates for an unconscious client that I believe could hasten the client’s death.</td>
<td>0.68</td>
<td>1.001</td>
<td>15</td>
<td>1.64</td>
<td>1.567</td>
<td>20</td>
</tr>
<tr>
<td>Be required to care for clients I don’t feel qualified to care for.</td>
<td>0.65</td>
<td>0.921</td>
<td>16</td>
<td>2.10</td>
<td>1.564</td>
<td>17</td>
</tr>
<tr>
<td>Follow the doctor’s request not to discuss the patient’s prognosis with the client or family.</td>
<td>0.60</td>
<td>1.043</td>
<td>17</td>
<td>1.89</td>
<td>1.560</td>
<td>19</td>
</tr>
<tr>
<td>Avoid taking action when I learn that a doctor or nurse colleague has made a medical error and does not report it.</td>
<td>0.50</td>
<td>0.840</td>
<td>18</td>
<td>2.33</td>
<td>1.557</td>
<td>13</td>
</tr>
<tr>
<td>Ignore situations in which clients have not been given adequate information to insure informed consent.</td>
<td>0.42</td>
<td>0.772</td>
<td>19</td>
<td>2.08</td>
<td>1.579</td>
<td>18</td>
</tr>
<tr>
<td>Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.</td>
<td>0.38</td>
<td>0.739</td>
<td>20</td>
<td>2.45</td>
<td>1.734</td>
<td>11</td>
</tr>
</tbody>
</table>
5.4 Conclusion

Chapter 5 details Phase 1 of the study (instrument modification) leading to the development of the Moral Distress Scale – Revised (aged care) (Burston et al., 2016). A description of the sample population demographics and examined the psychometric evaluation of the Moral Distress Scale – Revised (aged care) was provided. The instrument demonstrated construct validity and reliability, and can be used to measure moral distress within the Australian aged care workforce. Three factors labelled as: Quality of Care, Professional Practice, and Capacity of Team were identified. A Cronbach’s alpha (α) of 0.94 demonstrated reliability of the instrument. Participants identified moral distress as occurring with low frequency but with a moderate level of intensity. Of the 106 participants; one-third had considered leaving a position because of moral distress, just over one-fifth had left a position, and over one-third had taken a break from nursing. Additionally, three-quarters of workers had never received any education or professional development related to moral distress.

Chapter 6 reports on Phase 2 of the study. Phase 2 used a combination of telephone interviews and written case study scenarios to further qualitatively examine the experience of moral distress for Australian aged care workers. Thematic analysis was used to analyse Phase 2 qualitative data.
Chapter 6  Results Phase 2

6.1 Introduction

Chapter 5 presented the results from Phase 1 (quantitative phase) of the study. Phase 1 involved amendment and testing of an instrument to measure moral distress within the Australian aged care setting. The Moral Distress Scale – Revised (aged care) demonstrated validity and reliability (Burston et al., 2016). Data collected in Phase 1 indicated Australian aged care workers’ experience moral distress with relatively low frequency, but when experienced it is felt with a moderate level of intensity. Moral distress caused many workers to either take a break from or leave nursing, and the majority had never received any education on moral distress. Chapter 7 presents a consolidated discussion of the findings from both Phase 1 and Phase 2.

This chapter, Chapter 6, reports on the results from Phase 2 of the study. The aim of Phase 2 was to explore qualitatively Australian aged care workers’ experience of moral distress. Telephone interviews and case study scenarios were used to collect data for Phase 2 of the study, from participants in Queensland and Victoria, Australia.

Specific research questions for this phase were:

RQ 2. What do Australian aged care workers understand about moral distress in residential and community care?

RQ 3. How does moral distress impact upon residential and community aged care workers and their workplace?

As detailed earlier in Chapter 4 (refer section 4.8.1) Phase 2 was undertaken in two stages. In Phase 2 (Stage 1) telephone interviews were used to collect data. Data were then analysed and reduced using thematic analysis relying also on constant comparison of data. This data informed the development of the case study scenarios used in Phase 2 (Stage 2).

In Phase 2 (Stage 2) data from both Phase 2 (Stage 1) and knowledge from contemporary literature informed the development of two (2) case study scenarios. These scenarios focussed on known causes of moral distress, and were used to collect additional data on
the experience of moral distress. Data were then analysed and reduced using thematic analysis relying also on constant comparison of data.

To preserve anonymity of participants in reporting of the data, pseudonyms have been used to represent individual participants. For Stage 1 (telephone interviews) participants were given female pseudonyms (for example Anjuna, Bella). In Stage 2 (case study scenarios) participants were given male pseudonyms (for example Andrew, Brad). For clarity and consistency of data display participants own words are displayed within quotation marks and are italicised (for example “….happy and content with their care”). On occasions were more than one participant has reported quite similar ideas or, one individual’s statements have been condensed, these ideas have been displayed as normal text with participants pseudonyms identified within parentheses. An example of this is - have higher workloads (Caleb, John). This style is consistent with others (Hallett et al., 2017; Hatala et al., 2017)

6.2 Phase 2 (Stage 1)

Nine telephone interviews were conducted with participants to; explore their understanding of moral distress, identify situations in which participants’ encountered this distress, and elicit the specific effects of moral distress on Australian aged care workers. Four participants were Registered Nurses, one was an Enrolled Nurse, and four were Personal Care Workers/Assistants in Nursing (refer Chapter 1, section 1.7 for details of these roles) (Appendix H).

Demographic details of participants interviewed in this manner are included in Table 6-1 below. Telephone interviews were conducted from September 2014 until March 2015. Interviews ranged from 10-16 minutes in length, were electronically recorded, and were conducted at a time suitable to the participant.
Thematic analysis relying also on constant comparison of data (Braun & Clarke, 2006; Sarantakos, 2013; Tuckett, 2005a) was used during the interview stage to identify common experiences emerging from participants’ experiences of moral distress. The telephone interviews were conducted in three rounds, with three interviews in each round. After each round data were transcribed verbatim, audited for accuracy, and subject to researcher triangulation to ensure rigour. A reflective journal recording observation, theoretical and methodological notes was kept during each interview (refer section 4.8.6.5). While all participants discussed workplace issues causing stress, commonly participants struggled to clearly distinguish between moral distress and distress from other causes (such as personal rostering issues or inter-personal relationships). Two key ideas known to relate to moral distress did emerge, inadequate resourcing impacting on care, and being forced to participate in un-necessary deliver care.

Resourcing issues were identified by a number of participants. Charlie identified the source of this conflict as “…budget and money…management run the budget and nurses do the work.” Similarly Anjuna identified the issue as depending upon “…numbers and
income…” A factor underpinning this resource related moral distress was a desire to deliver appropriate care, with Deepa identifying a conflict between “…your need for resources and your need for efficiency…”. Fahari explicitly stated “…it’s not meeting his (older persons) personal needs”, and Imogen “you know they can only have so many pads in the day…”.

Participating in care delivery believed to be inappropriate also emerged. In the context of providing palliative care, Hao described clear tension between the healthcare team. The tension in this situation arose from conflict between the options of providing acute (treatment) intervention or supportive (palliative) care. Charlie described a very similar situation to Hao, but compounding her distress Charlie explains being directly asked by the older person “…what do I do?” Imogen’s distress stemmed from the concept of dignity, expressing the belief that more proactive use of advanced care directives was needed to avoid these types of situations altogether.

Ultimately though data specifically related to moral distress lacked clarity and the sought after richness or thickness necessary (Geertz, 1973). In consultation with the Principle Advisor the decision was made to undertake an additional strategy to collect data (refer section 4.8.1). Data from Phase 2 (Stage 1) were kept and used to inform the development of the case study scenarios in Phase 2 (Stage 2).

6.3 Phase 2 (Stage 2)

Two ideas that did emerge from the Phase 2 (Stage 1) data centred on challenges emerging from insufficient resources to deliver care, and the futility of care provision in certain circumstances. Relying on the analysis steps previously described in Chapter 4 (refer section 4.8.4), preliminary themes from the nine telephone interviews, and with due consideration of the contemporary moral distress literature, two case study scenarios were written and then used to collect written responses (textual data) (Appendix I).

Case study scenarios were distributed to participants, with a total of 16 participants returning written responses to both case studies (four questions per case study). Demographic characteristics were not collected with the case study scenarios.
Of the 16 participants, one participant was known to have completed Stage 1 (telephone interviews) as they returned Stage 2 responses (case study scenarios) via email. This participant’s response was provided within 48 hours of receipt of the case study scenarios, with responses typed on the case study scenario form. Answer length for the eight questions (4 questions per case study) varied between 9 and 207 words.

The remaining 15 participants were accessed by re-visiting two aged care facilities that participated in Phase 1 (Stage 2) – instrument validation. It was not possible to track if these participants had completed the Phase 1 survey. These 15 participants were given a printed version of the case study scenarios, and asked to complete their responses whilst the Investigator waited in a separate area. No specific time limit was imposed on these participants, most completed their responses within 10 – 15 minutes. These participants provided handwritten responses with answer length varying between 1 and 57 words.

Scenario 1 asked participants to consider a situation of an older person frustrated by a lack of time being spent in meeting her care needs. Scenario 2 required participants to contemplate the transfer of an older person to an acute care facility for treatment. For each scenario, participants were asked to answer four questions (Appendix I). Analysis of this textual data was undertaken relying on the themes of contributing factors, outcomes and interventions identified in the literature review. This analysis process is detailed in Chapter 4 (refer section 4.8.4.1). Data from Phase 2 (Stage 2) informed the final findings of the study.

### 6.3.1 Scenario 1

In Scenario 1, participants identified the following factors contributing to moral distress: insufficient time (temporality), repetition and staffing. In addition, participants highlighted moral distress as having a range of negative and neutral outcomes on both staff and the older person. Lastly, participants offered solutions (interventions) to address the impacts of moral distress which centred on doing work and speaking with others. A representation of the links between Scenario 1 data and the moral distress literature is provided (refer Figure 6-1 below), and will be explicated in greater detail during Chapter 7.
6.3.2 Contributing Factors

6.3.2.1 Insufficient Time

A desire to provide the time needed for provision of care was described as contributing to moral distress. Temporality was expressed as a desire to have enough “quality time” (Caleb) for the older people to be “…happy and content with their care” or to provide “…above adequate care…” (Ranju). It (insufficient time) was identified as a “…common problem…” (Heath) that occurred “…across the board…” (Ranju). Staff were either simply not given enough time (Ranju), or although managing their time were too busy to complete all allocated tasks (Fabian). A desire to give older people sufficient time for care provision was highlighted by many (Caleb, Heath, Larry, Micah).

Participants also expressed workload concerns in the context of having insufficient time to provide care (Ranju, Fabian). Older people need to feel they are “…cared for…” beyond provision of basic tasks, and “keeping residents mentally active is a large part of their overall happiness…” (Neil). Staff were not providing the care required (Caleb, Dinesh), or were intentionally taking advantage of the older person’s capacity (to self-care) (Andrew). Specifically, “staff are not allowing for TLC for this resident” (Dinesh) and “…Mrs A needs more time spent on her” (Caleb). Older people who require “…extra care are often rushed – this is a problem due to change in nursing practice” (Dinesh).

Others expressed their responses in the context of things they felt unable to do. This was noted as an issue by Ken because “…I want to be able to ensure I was giving her the time she needs…” Only getting the basics done (Graham) and having to “…cram in daily tasks” (Micah) also contributed to moral distress. An inability to provide the care required was deemed “…unfair on residents and staff” (Brad), with Larry acknowledging “…staff do their best, but pushed at times to spend the time they want…”, and Ranju noting “…I am continually unable to” (provide above adequate care). Ken, whilst identifying this issue of insufficient time, still clearly pointed out that it is “…not an excuse for not giving this resident time she requires.”
6.3.2.2 Repetition
Participants also described the commonness of the experience as a contributing factor (Andrew, Ranju). That is, staff were frequently exposed to the circumstances described in the scenario and the repetitive nature of this exposure further contributed to moral distress. Participants felt the way they did, because they have “...seen this happen and been put in this situation” (Larry) or “…see it happen to a lot of mentally alert residents” (John). Coupled to their perception of the scenario’s commonness was attendant elements like “extreme workload” (Heath) and either “…lack of staff resources or need to improve work practices…” (Ian).

6.3.2.3 Staffing
Participants clearly identified a problem with the workload expectation placed upon staff, with one participant in particular stating “this situation often occurs in the Aged care area…” (Brad). Nurses have higher workloads (Caleb, John) and are “overworked” (Micah). This workload was commonly linked to an increase in both the physical and psychological care needs (acuity) of older people over time (Andrew, Brad, Ian, Ken, Neil). Inadequate provision of resources (notably staff) emerged. Either “…not enough staff…” (Ranju) or “…low/poor staff ratios…” (Heath) exist. A lack of control over staffing ratios was a cause of frustration for Heath, with Omar stating that “dependency of residents does not reflect nurses’ enterprise bargaining agreement (EBA)”.

6.3.3 Outcomes
6.3.3.1 On staff
Multiple participants expressed frustration as a clear effect of the situation described in the scenario (Andrew, Brad, Caleb, Graham, Heath, Ian, Neil, Omar). Whilst many did not expand on this answer or the specific cause of the frustration, Brad identified this situation as one which caused the most frustration, with Heath feeling frustrated and powerless. Andrew explained this frustration as existing both for staff and older people, with frustration stemming from unmet care requirements (Ian, Neil). This frustration “…increases stress, anxiety to get the job done, staff morale is poor…” (Brad).
Others expressed the psychological effects of moral distress to include unhappiness (Ethan), sadness (Caleb), and a feeling of being upset (Fabian). Brad and Ken said they felt sorry for the older person, with Larry simply stating “I feel for the resident….” The strongest response was provided by Ranju, who stated “it annoys the hell out of me”.

Continuing on, Ranju described the effect on staff, indicating “…you can find yourself just switching off and no longer caring”. In contrast, two participants offered different views. First, John described feeling “normal” about the situation and said nothing else. Elsewhere, Paul questioned the older person’s authenticity, wondering if the concerns were even genuine.

6.3.3.2 On Older person
The emotional effect for the older person also emerged. It was described as “frustrating” (Andrew), “disheartening” (Dinesh), and “upsetting and stressful” (Fabian) for the older person; resulting in them being “unhappy” (Ian). Others acknowledged the older person’s frustration, indicating it resulted from “feeling a level of neglect” (Ethan), “feeling let down” (Larry) or an “awareness of staff constraints” (Ian). This awareness of staff constraints was also interpreted to extend to an understanding by the older person of the increased needs of other aged care residents as well (Ian). In contrast, the dissenting voice of Paul questioned if the older person was “…not understanding that staff also have to spend time with others…”. It was Brad who encapsulated the general emotional tension by stating: “it isn’t their fault, it’s not right…”, with John suggesting the older person’s expressed behaviour was a result of her adjusting to a declining level of independence.

6.3.4 Interventions

6.3.4.1 Doing work
Participants expressed a need for staff to adjust work practices as a solution to the circumstances causing the psychological effects of moral distress. Many of these responses centred on the idea of doing more; however specific strategies to achieve this were commonly not included. Responses included “spending” (Fabian, Heath) or “giving” (Andrew) more time, a desire to “re-arrange workload” (Ian, Ken), and to “provide as much time and care as possible” (Larry). Omar concurred, identifying a need to spend more time with the older person but in addition identifying the need to bring in other resources (an activities coordinator) to discuss solutions. Attempting to “slow down” (John) or just “work harder” (Ethan) were also identified. Dinesh added to this, stating “….nurses need to slow
down – nurses need to take a more holistic care approach”. Like Omar’s suggestion, Micah believed “…at least one other staff member on per shift…” was needed.

6.3.4.2 Speaking with Others

Participants also clearly recognised the value of communicating with the older person, the healthcare team and others. This communication was aimed at reducing or removing contributing factors, and alleviating the extent of moral distress experienced. Solutions from an individualistic perspective involved speaking with or listening to the older person as a priority (Fabian, Graham, Ian, Paul, Ranju). Typically, Graham wanted to “explain that staff try and spend as much time as they can with residents”. Others like Caleb, Ian and Paul specifically expressed a desire to find out exactly what needs of the older person were not being met by the nursing staff. Also identified was a need to sit with the older person, “…listen to her complaints…” (Paul) and recognise “…her feelings are valid” (Ranju). To this end, Ken expressed a desire to explore “…why the resident has made this comment…”. Contrary Paul proposed his view that whilst the older person was being cared for and acknowledging he (participant) may be wrong, “…the resident may be the one that wants all the attention”. He identified a desire to encourage the older person to “…voice her concerns to each person as the concern arose”, whilst also wanting to “…tell the resident not to complain about not getting attention.”

Collaboratively, verbal communication of the issue within the health team was identified as a solution. Within the health team this involved the Nurse Unit Manager (Caleb, Omar), a “superior” (Fabian), “colleagues” (Heath) or “other staff” (Caleb, Ian, Larry). Commonly the intended purpose of this communication was not explained; however Caleb (“ask other staff what they have noticed”), Ian (“discuss options with staff”), and Larry (“make other staff aware”), did provide additional detail beyond a basic desire to communicate. Paul expressed a desire to “…ensure all staff are aware…” but did not explicitly state how this would be achieved. On the other hand, Ranju identified communication at “…the monthly staff meeting” as a strategy.

Some participants also identified written communication as part of the solution; identifying a need to “…document it…” (Fabian), “write the conversation in her progress notes…” (Caleb), update the care plan (Heath), or complete an “…individual needs form…” (Ranju). Ranju also said he would “…put in an official request for more time…” but did not expand
on how this would be achieved. Additionally Omar desired to “look into the Aged Care Funding Instrument (ACFI) scores of the resident”.

Additionally two participants identified, as a solution to factors in the scenario that contributed to the psychological effects of moral distress, a desire to communicate with others outside the healthcare team including third parties. For example, Andrew wanted to “…organise a volunteer to talk to her and give her more one-one time”. Encouraging family involvement and ensuring the older person interacted with other aged care residents were identified as strategies by Neil.
**FINDINGS - Scenario 1**

**Core Issue:** Resource Allocation

**Temporality**

**Repetition**

**Staffing**

**Outcomes**

On staff

On Older Person

**Interventions**

Doing Work

Speaking with Others

---

**LITERATURE REVIEW** - Moral Distress

**Contributing Factors**

Individual

Site Specific

Broader External Influences

---

**Outcomes**

Towards self "I would feel..."

Towards others "I would act..."

Towards the system "I would do..."

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**Interventions**

Individualistic Approach

Collaborative Approach

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**Figure 6-1 Interrelationship of Scenario 1 data as demonstrative of moral distress in the aged care setting**
6.3.5 Scenario 2

In Scenario 2, participants identified the following factors contributing to moral distress: the futility of the situation, internal (worker) crisis from a perceived lack of adequate consultation, and division of opinions about the actual decision. In addition, participants highlighted again moral distress as having a range of outcomes on staff stemming from their perceptions about the futility of the treatment, the correctness of the decision, and challenges to older person autonomy. As with Scenario 1, participants proposed solutions (interventions) – in scenario two these centred on doing work and speaking with others to clarify the older person’s wishes and provide advocacy. A representation of the links between Scenario 2 data and the moral distress literature is provided (refer Figure 6.2 below), and will be explicated in greater detail during Chapter 7.

6.3.6 Contributing Factors

6.3.6.1 Futility of the situation

The futility of the treatment option contributed to participant’s feelings, and was expressed both directly and indirectly. Fabian explicitly stated “…I feel that to prolong someone’s life for the sake of it without hope of recovery is futile”. Others like Heath, John and Paul felt that quality of life is the primary consideration, indicating that the chosen treatment option was not necessarily in accordance with this. Heath clearly identified the potential for the older person to experience “…trauma /distress which is not necessary”. Similarly, Neil identified issues of co-morbidities, elderly age and poor prognosis as contributing to feelings about the (futility of the) situation. Additionally, Graham stated that “…often the outcome results in death just prolonging it at a large cost”, with Dinesh indicating that “everyone should be able to die with dignity”.

6.3.6.2 Inadequate consultation

Participants also pondered the consultative inclusion/exclusion by the doctor of the older person and family in the decision-making process. Inadequate consultation was clearly highlighted as a factor contributing to moral distress. Caleb wondered if the “… Dr (had) spoken to family”. It was perceived the “doctors don’t always listen to what (the) resident or family want” (Caleb), while Andrew believed the “…doctor has gone against resident and family request”. Furthermore, Micah recognised the doctor as doing “…what he thinks best without consulting others”, with Larry concurring, stating “…the Dr has made the choice, without any discussion with Mr Smith.”
Although the autonomous decision-making capacity of the older person was not overtly articulated in Scenario 2, a need to facilitate this capacity was a significant finding. Brad recognised it as “a choice for Mr Smith, not me or other staff” and Fabian was happy with the transfer to hospital “…if it is what he (older person) wants…” Heath agreed (albeit not quite as directly) stating “…it needs to be clarified what the resident wants”. More forthrightly, Larry went further positing that “…Mr Smith might be receiving treatment he has (sic) don’t want…”. Poignantly, Ian identified his frustration based on his view of a “…deluded sense of doing…” things in the interests of the older person.

Others extended this further. For example, Heath indicated “…plus/minus the family may have indicated they wanted the transfer…” but this was ambiguous. Concurring, Ken wondered if “…the family…had much input…”, but also stated the “…family/resident need to have more input…”. Both Ethan and John also indicated the family should have been included more in the decision-making process. Micah summed this up: the “…family need to be consulted before (the older persons) being transferred because it hasn’t been discussed with anyone…”.

### 6.3.6.3 Decision division

Contributing also to the psychological effects of moral distress experienced in this scenario, a number of participants identified issues related to the decision-making process and the correctness of the decision itself. A clear tension exists with some expressing that the decision was suitable (Brad, Paul, Ranju) whilst others felt it was inappropriate (Fabian, Graham, Heath, Neil). Andrew simply stated “(I) disagree with doctor’s advanced treatment.” Agreeing with this sentiment, Dinesh felt the “…resident’s treatment should be ceased…for comfort measures only” and Graham expressing treatment at the nursing home as a “…better option…”.

The futility of advanced interventions was suggested as contra-indicating a transfer to hospital (Heath). Graham expressed concerns about the chosen option, indicating it “…may prolong his life but at what quality of life and for how long and at what cost”. The option of palliation rather than advanced treatment (Neil) and care at the residential facility rather than an acute hospital (Fabian) where deemed more appropriate. One participant, whilst not disagreeing outright, acknowledged “he (the older person) won’t necessarily be better off in hospital” (Caleb).
Participants identified failures with the nursing process as another contributor to the emergent psychological effects of moral distress. Ken described a communication breakdown, stating: “...request for transfer has been overlooked and other staff have not been informed...”, with Neil and Omar describing failures in care planning. Specifically Neil felt that “advance care planning “...is either a) not realistic, b) not done, c) not followed” against which Omar also identified a need to “...check end of life choices...”.

In contrast to these views, Paul expressed the belief that the transfer to hospital for other treatment was in fact “…the best thing for him (the older person)…”. Others agreed, with Ranju of the opinion that “the nurse and doctor have taken the appropriate actions” and Brad accepting that “it’s ok if that’s what he wants”. Despite not agreeing with the decision Heath recognised that ultimately “…it is not my choice”.

6.3.7 Outcomes

6.3.7.1 On staff
The range of psychological effects experienced by staff varied. Some were “sad for family and resident” (Andrew), “saddened that a doctor is trying to save an 84yo with no quality of life” (Dinesh), or sad for the older person who was excluded from the decision-making process (Larry). Internalising the emotional effect, Ethan felt a sense of distress from being “…powerless to help” as did Ian who expressed anger at the lack of autonomy afforded the older person and his own feeling of powerlessness.

Conversely, others felt “fine” (Omar), did “not feel a lot” (Ranju), or that they did not have “…enough information to feel anything, maybe curious” (Caleb). Although Ethan did not express a clear opinion one way or the other, he did acknowledge the situation “…may cause a lot of conflicting emotions…” for nurses.

6.3.8 Interventions

6.3.8.1 Doing work
The act of doing work with a view to providing appropriate care in-situ, was proposed for addressing the situation and alleviating the psychological effects of moral distress. How this was described varied. On occasions this involved provision of curative measures in-situ, for others - palliative measures. Graham specified he would ensure “…the family and Mr Smith’s wishes are
met”. In the context of doing more, Ethan wanted extra time to care for the older person in-situ, indicating he would also explore physiotherapy treatments for the older person. Similarly, Paul would organise the transfer to hospital but also “question why he can’t have IV therapy in the facility”. Fabian described implementing palliative measures expressing a desire to “keep him (the older person) pain free, comfortable and give him his dignity”.

In contrast, two participants stated their “doing work” would be to simply follow the status quo. Omar indicated quite clearly that he would “follow medical directives”. Even less active than this, Ranju’s assessment was that “there is nothing for me to do”.

6.3.8.2 Speaking with others
Participants identified a desire to communicate with others, with a view to seeking clarification and resolving the situation. However, who this communication should involve varied. John simply wanted to “consult” echoing Caleb who wanted to “check for further information before transferring him”. Less vaguely, Ken identified consultation with the Nurse Unit Manager (NUM) as the appropriate approach, with Heath, Neil and Fabian stating they would consult with the older person and family. The purpose of involving the older person and family was to seek clarification before speaking with the doctor (Heath) and to check for an advance care plan (Neil, Fabian). Graham and Neil bypassed the older person and family wanting to immediately “discuss with the doctor”.

Additionally, advocacy through communication as a professional responsibility of nursing staff was also described. Ian saw this as a “…delicate situation…” and specifically expressed the “…need to be an advocate…” Heath identified a responsibility to discuss the pending transfer with medical staff, “…if it is documented that they (older person) do not wish transfer…”. Also within this sphere of acting as an advocate, Andrew, Dinesh and Ethan indicated they would directly advocate for a change in the decision to transfer to hospital. They all expressed a desire to change the decision, but identified different strategies to achieve this. Andrew sought to speak with the family first in a bid to reverse the decision, Dinesh wanted to ask the doctor to re-evaluate the decision, and Ethan wanted to speak directly with the NUM about alternative options. Ethan also wanted staff consultation in the process, with a goal of providing care for the older person “…in his familiar surroundings”.
Furthermore, Ian, Larry and Micah indicated they would actively initiate communication with the doctor in advocating for the older person; with Larry also including the family in this dialogue. While not explicitly stating a desire to change the decision, Micah identified a desire to “confront the doctor and ask him to discuss it with the family and the resident first”. Both Ian and Larry stated they would discuss the situation directly with the doctor, with a view to being an advocate (Ian, Larry) and ensuring “…wishes and advanced treatment directives were upheld” (Ian). A belief this advocacy would occur “…in the face of fierce opposition” was clearly defined (Ian).

Finally, Brad and Paul indicated support for the decision. Brad identified a desire to “support him in his decision”, however whether the term “him” refers to the older person or the doctor is not clear. Paul expressed an explicit desire to support the older person in his decision, identifying a need to “find out what Mr Smith wants to do…”

A representation of the links between Scenario 2 data and the moral distress literature is provided (refer Figure 6-2 below). A representation of the consolidated findings from Phase 2 (Scenario 1 and Scenario 2), and the links between these data and the contributing factors, effects and interventions identified in the literature review (Burston & Tuckett, 2013), is provided (refer Figure 6-3 below). These links will be explicated in greater detail during Chapter 7. Data from Phase 2 was structured under this framework with a view to enhancing trustworthiness of the data (as detailed in Chapter 4 Methodology), and facilitating later discussion of findings.
Figure 6-2: Interrelationship of Scenario 2 data as demonstrative of moral distress in the aged care setting

**FINDINGS** - Scenario 2
Core Issue: Futile Treatment

**Contributing Factors**
- Individual
- Site Specific
- Broader External Influences

**Contributing Factors**
- Futility
- Inadequate Consultation
- Decision Division

**Outcomes**
- Towards self “I would feel…”
- Towards others “I would act”
- Towards the system “I would do”

**Outcomes**
- On Staff
- Decision Division

**Interventions**
- Individualistic Approach
- Collaborative Approach

**Interventions**
- Doing Work
- Speaking with Others

Figure 6-3 Interrelationship of Phase 2 data as demonstrative of moral distress in the aged care setting

FINDINGS - Scenario 1
Core Issue: Resource Allocation

- Temporality
- Repetition
- Staffing

Outcomes
- On Staff
- On Older Person

Interventions
- Doing Work
- Speaking with Others

Contributing Factors
- Individual
- Site Specific
- Broader External Influences

Outcomes
- Towards self "I would feel…"
- Towards others "I would..."
- Towards the system "I would..."

Interventions
- Individualistic Approach
- Collaborative Approach

Contributing Factors
- Futility
- Inadequate Consultation
- Decision Division

FINDINGS - Scenario 2
Core Issue: Futile Treatment

Outcomes
- On Staff

Interventions
- Doing Work
- Speaking with Others

Contributing Factors
- Individual
- Site Specific
- Broader External Influences

Outcomes
- Towards self "I would feel…"
- Towards others "I would..."
- Towards the system "I would..."

Interventions
- Individualistic Approach
- Collaborative Approach

Contributing Factors
- Futility
- Inadequate Consultation
- Decision Division

LITERATURE REVIEW* - Moral Distress

Contributing Factors
- Temporality
- Repetition
- Staffing

Outcomes
- On Staff
- On Older Person

Interventions
- Doing Work
- Speaking with Others

6.4 Conclusion

Chapter 6 reported the findings from Phase 2 of our study. Qualitative methods to explore the experience of moral distress were used. Telephone interviews and case study scenarios (textual data) were used to collect data. Thematic analysis relying on constant comparison of data was used to analyse both Stage 1 and Stage 2 data.

An inductive approach was used in the analysis of Stage 1 (interview) data (section 4.8.4). Additionally the contributing factors, outcomes and interventions identified in the Literature Review (Chapter 2) were re-visited, with both used to underpin the case study scenarios developed for Stage 2. Data from Phase 2 were structured under this framework with a view to enhancing trustworthiness of the data (refer Chapter 4, section 4.8.6). A deductive-inductive approach was used in the analysis of Stage 2 data (refer section 4.8.4).

Participants described a range of contributing factors to moral distress that were clearly contextually specific. For Scenario 1 the issue of insufficient time (Temporality), the commonness of the situation (Repetition), and inadequate resourcing (Staffing) were explicated as contributing factors. In Scenario 2 contributing factors were the futility of the situation (Futility), a lack of consultation (Inadequate Consultation), and division about the correctness of the decision (Decision Division). Contrary to the clear impact of contextual differences in precipitating contributing factors, clear similarities across the range of outcomes from both Scenario 1 and Scenario 2 were evident. Primarily only the outcomes of moral distress on staff (On Staff) were described, with some identification of effects for the older person (On Older Person) emerging from Scenario 1 only. A range of individual and collaborative interventions to reduce the occurrence and/or the effects of moral distress were elicited by participants. For both scenarios these interventions involved either actively undertaking or not undertaking specific tasks (Doing Work), or, engaging in communication with others within and outside of the healthcare team (Speaking with Others).

A detailed discussion of the key points identified in both Phase 1 and Phase 2 of the study is provided in Chapter 7. Explication of links between these data and the contributing factors, outcomes and interventions identified in the literature review (Burston & Tuckett, 2013) are detailed. Following this, links between the Job Demand-Control-Support model (Johnson & Hall, 1988) and moral distress will be described.
Chapter 7  Discussion

7.1 Introduction

Chapter 5 (Study Phase 1) outlined the processes undertaken to pilot test the new Moral Distress Scale – Revised (aged care) developed in this study. The psychometric evaluation of the Moral Distress Scale – Revised (aged care) (Burston et al., 2016) demonstrated validity/reliability for measuring moral distress in aged care in Australia, and identified moral distress occurring with low frequency and moderate intensity.

Chapter 6 (Study Phase 2) described the range of contributing factors, outcomes and proposed interventions (solutions) for the experience of moral distress, as conveyed by participants in telephone interviews and through completion of case study scenarios. In Australian residential and community aged care contributing factors leading to moral distress are insufficient time (Temporality), the commonness of the situation (Repetition), inadequate resourcing (Staffing), futility of the situation (Futility), a lack of consultation (Inadequate Consultation), and division about the correctness of the decision (Decision Division). The outcomes of moral distress included staff feeling frustration, stress, anxiety and powerlessness. Interventions towards resolving moral distress in aged care as proposed by these participants involved either actively undertaking or not undertaking specific tasks (Doing Work), or engaging in communication with others within and outside of the healthcare team (Speaking with Others).

Chapter 7 provides an integrated discussion of findings from Phase 1 and Phase 2 of this study. It begins with discussion of the amendment and psychometric testing of the Moral Distress Scale – Revised (aged care) (Burston et al., 2016) conducted in Phase 1. Following this, qualitative data from Phase 2 is discussed within the context of the contributing factors, outcomes and interventions identified in the Chapter 2 literature review (Burston & Tuckett, 2013). Finally, the strengths and limitations of framing moral distress within the Job Demand Control Support model, and the limitations of our study are discussed.
7.2 Phase 1: Amendment and pilot testing of the instrument

Research question 1 sought to determine if Australian aged care workers in residential and community aged care settings experienced moral distress. Despite moral distress occurring in acute and other specialist care contexts, little evidence exploring this phenomenon in aged care and specifically the Australian context exists. To measure exposure to moral distress a valid instrument was required and none existed for the aged care sector.

In order to fill this gap the Moral Distress Scale – Revised (MDS-R) (Hamric et al., 2012) was amended and pilot tested resulting in the new Moral Distress Scale – Revised (aged care) (Burston et al., 2016). Previous iterations of the Moral Distress Scale / Moral Distress Scale - Revised have undergone only preliminary (Corley, 1995; Corley et al, 2001) or no factor analysis (Hamric & Blackhall, 2007; Hamric et al., 2012). To fill this gap, exploratory factor analysis was undertaken (Burns & Grove, 2009).

To suit the aged care setting for this study, minor amendments were made to the Moral Distress Scale – Revised (MDS-R) (Hamric et al., 2012). Amendments for contextual relevance are appropriate and recommended (Corley et al., 2001; Hamric et al., 2012), and were necessary. Care was taken during the instrument amendment phase to ensure it would be clearly relatable to previous versions of the instrument. Primarily, amendments focussed on accommodating terminology, changing physician to doctor and patient to client. These changes did not alter the conceptual underpinning of instrument items.

Careful consideration was also given when adjusting the original instrument with its acute care focus to suit the aged care environment. To this end, a primary focus was maintaining the conceptual basis of the instrument. As an example, Item 7 of the Moral Distress Scale – Revised (MDS-R) (Hamric et al., 2012) focuses on continued ventilation support for a patient who is hopelessly ill, a treatment option that simply does not exist in the Australian aged care settings. As the core premise of this item is inquiry into the provision of care in a situation deemed hopeless, this item was amended to better suit aged care to read “…participate in care for a hopelessly ill person...”. Item 11 was deemed redundant for use in this study, as the item inquired into the practices of medical students, a situation that is not common in the Australian aged care environment. A comparable aged care specific
alternative was not identified, and consequently it was removed from the amended instrument entirely.

To allow validation of an amended instrument, complete data from between five (Hair et al., 1998) and ten participants per item (Polit, 2010) is needed. The sample size in this study (n=106) provided greater than five responses per item (20 item instrument). Given the Moral Distress Scale – Revised (MDS-R) (Hamric et al., 2012) was an existing instrument has been used extensively (Burston & Tuckett, 2013) and the amendments made for this study were minor, the sample size for this study is sufficient, indicating the MDS-R (aged care) (Burston et al., 2016) as suitable for use with the Australian aged care workforce.

Our exploratory factor analysis identified three factors, labelled as Quality of Care (inappropriate or futile care), Capacity of Team (communication and competence of workers) and Professional Practice (inability to fulfil professional responsibilities).

These factors demonstrate some alignment with those identified by Corley (1995). Corley identified three factors labelled as: action response (participating in care not agreed with or ignoring actions one should take); aggressive care (providing aggressive care for the hopelessly ill); and honesty (not addressing impending death honestly) (Corley, 1995). Professional Practice (inability to fulfil professional responsibilities) and action response (participating in care not agreed with or ignoring actions one should take) show alignment. Quality of Care (inappropriate or futile care) and aggressive care (providing aggressive care for the hopelessly ill) also demonstrate clear synergy. However, Capacity of Team (communication and competence of workers) and honesty (not addressing impending death honestly) do not directly align.

Eizenberg, Desivilya and Hirschfield’s (2009) moral distress questionnaire displayed three indirectly related factors, labelled as: problems caused by time pressure, problems due to lack of resources, and problems caused by work relationships among staff. Whilst these later factors do not align directly with the factors identified in our study, relationships can be posited. For example in our study Quality of Care (inappropriate or futile care) was commonly driven by problems caused by time pressure and problems due to lack of
resources. Similarly, Capacity of Team (communication and competence of workers) included problems caused by work relationships among staff.

The new instrument as a whole demonstrated high reliability (α 0.94), with results comparing favourably to Eizenberg, Desivilya and Hirschfeld (2009) α 0.79, Corley (1995) α 0.93, and Hamric and Blackhall (2007) α 0.83. Analysis for redundancy indicated that Cronbach’s alpha would not increase if items were removed. As such, further use of our Moral Distress Scale – Revised (aged care) (Burston et al., 2016) in the aged care environment with a view to solidifying reliability is well supported.

7.3 Phase 1: Measuring Moral Distress

As reported in Chapter 5 (refer section 5.3) and discussed immediately above, psychometric testing of the Moral Distress Scale – Revised (aged care) (Burston et al., 2016) demonstrated reliability and validity. Additionally, no research measuring moral distress in the Australian aged care environment was identified in the Chapter 2 Literature Review (Burston & Tuckett, 2013). Consequently the data collected during the pilot test were kept and analysed further. Using pilot study data in this type of circumstance is acceptable (Taylor et al., 2007). Specifically in our study, mean item scores for each of the 20 items were analysed.

The Moral Distress Scale – Revised (aged care) is a twenty (20) item instrument using a five point (0-4) Likert scale to measure both the frequency and the intensity of the moral distress experience. Respondents use the scale to rate the frequency (0 never – 4 very frequently), and intensity (0 none – 4 great extent) of moral distress. A mean score of two or below would therefore be considered a low to moderate frequency or intensity of moral distress. A mean score greater than two indicates a moderate to high frequency or intensity of moral distress.

The mean frequency scores which were all below two indicated a relatively low occurrence of moral distress. However scores for intensity, which were consistently higher, indicated that when moral distress was experienced it was experienced at a moderate level. Findings of this current study are similar to that of Corley et al. (2001) who identified moderately high levels (intensity) of moral distress in a population of critical care nurses.
Of note in this first iteration of Corley et al.’s scale (2001) the frequency of each item was not requested. Similarly to our study, Silen et al. (2011) identified low frequency with moderate intensity; with an attendant explanation that a more positive ethical climate correlated with a lower frequency of moral distress. Whilst there is complementarity here between all three studies, we do recognise variations across different types of clinical units have been identified by others (Sirilla, Thompson, Yamokoski, Risser, & Chipps, 2017).

In our study, the three items occurring most frequently also caused the highest intensity, and spoke directly to quality of care issues. These items in ranked order were: (1) work with nurses or other healthcare providers who are not as competent as the client care requires; (2) witness diminished client care quality due to poor team communication; and, (3) follow the family’s wishes to delay palliative measures, even though I believe it is not in the best interest of the client. There is some alignment here with a recent study by Woods, Rodgers, Towers and Grow (2014). In that study (1) work with nurses who are less than competent was identified as their third most frequent cause of moral distress, and (2) witness diminished client care quality due to poor team communication emerged as causing the second highest level of intensity of moral distress. However, in contrast to our study they identified provide less than optimal care due to pressure from management to reduce costs as their highest cause of moral distress.

Our study differs from Hamric and Blackhall (2007) who identified issues of continued aggressive treatment as a primary source of moral distress in intensive care units (ICU). These differences are likely due to the contextual nature of the care environments, namely aged care (in our study) with a focus on providing quality of life while ageing, as opposed to acute (intensive) care with a clear and distinct curative focus. Differences such as this in the appearance of moral distress across clinical contexts, are evident in the literature (Burston & Tuckett, 2013; Sirilla et al., 2017). Understanding moral distress within specific clinical environments facilitates understanding of its uniqueness and the development of targeted interventions suitable for specific clinical contexts. Interventions proposed from our (aged care) study are forthcoming in Chapter 8.

On the frequency component of the scale, three items (follow the doctor’s request not to discuss the patient’s progress…; ignore situations in which clients have not been given adequate information…; and take no action about an observed ethical issue…)
demonstrated a statistically significant positive skew (>1.96 at p<.05). This non-symmetrical distribution of data indicates the data from these items may be non-representative, consequently impacting on the generalisability of findings. Additionally, mean scores for these items were low (respectively 0.60; 0.42; 0.38), with over 83% of respondents indicating these situations either never occurred (respectively 58.5%; 66.0%; 68.9%) or occurred very infrequently (respectively 24.5%; 17.9%; 15.1%). Additionally, all three items loaded onto the same factor, that of *Professional Practice*.

This finding interprets in three ways: (1) these situations do not occur frequently within the aged care workforce, (2) the results are an aberration and not truly representative of the broader aged care workforce, or (3) they occur infrequently in this specific population (that is the context or environment this population operates within). For the first two points noted further exploration with larger samples will provide clarity. If the third point is correct, then some other underlying organisational element is at play (that is the context impacting on the experience) ameliorating moral distress from these sources for these workers. The context or environment in which workers operate has been unequivocally demonstrated to influence moral distress (Austin, 2012; Deady & McCarthy, 2010; Kain et al., 2009; Ohnishi et al., 2010). Uncovering the constituent elements at play in specific contexts such as this, is key in addressing moral distress.

A survey question asked participants if they had “ever left a position, considered leaving a position, or taken a break from nursing because of moral distress”. Although just under half had never considered quitting or leaving a position, one third of participants had considered leaving a position and almost one quarter stated that they had left a position because of moral distress. This is similar to Woods et al. (2014) who reported 48% of their participants as having considered leaving nursing (across a range of general care settings), but higher than Silen et al. (2011) who found 20% of participants had considered leaving (hospital care setting). So while findings in our study are not as high as some, one third of participants having considered leaving a position because of moral distress is significant. Clearly our findings support the need for interventions to reduce moral distress in order to retain staff in the aged care workplace. Situating moral distress within a known workforce model of stress such as the Job Demand-Control-Support model (Johnson & Hall, 1988) (discussed in section 7.5) supports development of these interventions.
One participant returned a survey indicating they had never experienced moral distress, and did not believe that any of the situations described in the survey would cause it. In the absence of a follow-up on this atypical response, two speculative reasons are offered. One possibility is that the response was genuine and accurate. Therefore, this worker is claiming either a moral void or moral harmony in the context of moral obligation. Either way, this is different to the moral obligation (evidenced as moral distress) expressed by the remaining 105 participants. Typically, those providing nursing care believe they have a strong moral commitment (Traynor, Boland, & Buus, 2010) and obligation to practice with moral integrity (Laabs, 2011), and as such challenges to moral agency at some point during a workers career are expected.

A second possibility is that the survey was misread. That is, the participant may have inadvertently reversed the Likert scoring system. A reversal of this kind means the participant actually experienced moral distress with very high frequency and feeling distressed to a great extent, from all 20 items in the instrument. This explanation is no less perplexing than the first.

Additionally, participants were specifically instructed (on the instrument) to provide a scored response from 0-4, to all items on the intensity side of the scale even if they had not experienced the situation. Therefore the intensity side of the scale is expected to include some variation in response scores (i.e. some degree of distress for at least one item) unless the participant truly believes that none of the 20 items described would ever cause feelings of moral distress.

7.4 Phase 2: Understanding the Moral Distress of Australian aged care workers

Research questions two and three of this study targeted the qualitative experiences, understanding and the impact of moral distress for the aged care worker. Without prior qualitative findings about this phenomenon in the Australian aged care context, our outcomes demonstrated close alignment with that known in the moral distress literature (refer Chapter 6, Figure 6.3). Stemming from their understanding of moral distress, participants proposed a range of individual and collaborative interventions in dealing with it in their workplace.
7.4.1 Contributing Factors

7.4.1.1 Insufficient time

Insufficient resources (time and people) were commonly described. Participants clearly described an issue of insufficient time for care delivery, describing a mismatch with their desire to have sufficient time to ensure the older person was content with the quality of care and a perceived inability to do so. Of interest here is whether this desire to provide quality care was a desire borne of the older person’s expectation, borne of the worker’s self-expectations, or borne of the employers’ expectations. Data was not definitive, but suggested the desire was borne of the workers themselves based in their interpretation of what was required. This desire may be grounded in a realistic understanding of the situation or simply be an idealistic hope. Regardless of this, it is believed that a lack of time for direct care activities negatively effects retention (Duffield, Gardner, & Catling-Paull, 2008), and as such confronting the time poor/moral distress nexus is necessary (Tuckett et al., 2009).

The Moral Distress Scale – Revised (aged care) (Burston et al., 2016) used in Phase 1 of the study (instrument amendment and pilot testing) does not have items specifically targeting time or a lack of time. The item “provide less than optimal care due to pressures from administrators / supervisors to reduce costs” most closely links to insufficient time. In Phase 1 this item was the fourth highest frequency item, and generated the ninth highest level of distress.

7.4.1.2 Repetition and Staffing

Workers identified the commonness of the clinical situation described in Scenario 1 (inadequate resourcing). As an example participants felt the way they did, because they have “…seen this happen and been put in this situation” (Larry). This repetitive exposure was a key factor in the frustration and unhappiness experienced by workers. Repeated exposure to moral distress over time has been demonstrated to build a moral residue (Epstein & Hamric, 2009). Over time this residual effect creates a new baseline level for an individual’s moral distress, and in turn increases the intensity of subsequent incidents. With the known challenges of an ageing workforce and an ageing population (Access Economics, 2009; Productivity Commission, 2005) increasing demand, this is concerning.
Contributing to moral distress from this source, the repetitive nature of this exposure was linked to extreme workload and lack of staff resources.

Many participants describing this in the context of time, that is, things they were unable to do. The interpretive challenge here is twofold: either a realistic or an un-realistic (idealistic) expectation by the worker exists; or there are legitimate and definitive resourcing issues (in the sense of lack of human resources i.e. staffing) apparent. Excessive workload adversely affects workers (Eley et al., 2007), contributes to staff shortages (Kingma, 2009), and contributes to moral distress (Hamaideh, 2014; Karanikola et al., 2014; Papathanassoglou et al., 2012). Clear recognition of excessive workload was evident, and understanding this with greater clarity is needed if the frequency of moral distress is to be reduced. In the context of Phase 1 of our study, the item “work with levels of nurse or other care provider staffing…” was the sixth most frequent item, generating the ninth highest level of distress.

### 7.4.1.3 Futility

The provision of overly aggressive or futile treatment is a concept that emerges strongly as one causing moral distress (Brazil et al., 2010; Epstein, 2010; Ferrell, 2006; Kain et al., 2009; Oberle & Hughes, 2001). Futility emerged strongly in Phase 1 of this study, with a delay in implementing palliative care identified as the third highest cause (frequency) of moral distress and causing the third highest intensity level of moral distress. Our Phase 2, Scenario 2 provided an understanding about futility and participants’ perceptions of futile treatment with many participants judging the decision to provide an acute intervention as futile. Their determination of futility was grounded in their understandings about the lack of hope of recovery, anticipated quality of life, and a desire to avoid un-necessary trauma or distress. The care workers’ judgements about futile treatment and its contribution to their moral distress were dependent on the older person’s pre-existing conditions and co-morbidities, as well as the workers’ previous experiences in similar situations.

Provision of care perceived to be futile occurs often, with over 84% of acute care nurses in one study reporting having provided futile care (Kadooka, Asai, Fukuyama, & Bito, 2014). Provision of futile care negatively affects morale, creating indifference and decreasing care sensitivity (Aghabarary & Nayeri, 2016), and commonly emerges from a values difference between medical (curative) and nursing (caring) professions (Broom, Kirby, Good, & Lwin,
2016). Although much of the literature discusses futility in the context of being detrimental and negative, Mohammed and Peter (2009) in the intensive care context argue that treatment perceived as medically futile can also provide important social value in the support of rituals around death and dying. Of importance is the opportunity this (bio-medically futile) care provides for family and staff to “…dissipate the sense of ambiguity between life and death, establish a social script for letting go, and realize a space where the grieving process can begin” (Mohammed & Peter, 2009, p. 301). Time and space is allowed for people to address the pending (physical) death.

Given this study was conducted in an aged care environment, in which older people commonly reside until the end of their life, this latter counter claim is important. Provision of holistic support focused on all needs of the older people (as opposed to purely medical needs) is important to workers, and an environment that recognises and supports this will have a useful impact on the alleviation of moral distress. Although the needs of the older person must always be placed first, the social needs of the broader aged care community should also be considered.

The Moral Distress Scale – Revised (aged care) (Burston et al., 2016) contains a number of items targeting futile treatment. These items generally ranked quite highly. The item “Follow the family’s wishes to delay palliative…” scored the third highest cause and third highest intensity of moral distress. “Provide care that does not relieve the client’s suffering…” ranked fifth highest frequency and fourth highest intensity”. A third item, “continue to participate in care for the hopelessly ill…” was the eighth highest cause and sixth highest intensity item. Consequently a case study based in a futile situation was used in Phase 2 of our study.

7.4.1.1 Inadequate Consultation and Decision Division
The hierarchical nature of the nurse / doctor relationship also intensifies issues of moral distress, and does stem from the differing philosophical approaches to healthcare delivery (i.e. curative versus care) (Malloy et al., 2009; Redman & Fry, 2000). The dichotomy between medical curative and nursing care is a point of difference between professions (Aghabarary & Nayeri, 2016). As a consequence, conflict in professional relationships is a common contributor to moral distress (Solum & Schaffer, 2003).
Broom, Kirby, Good and Lwin (2016) identify both the proximity of nurses to patients and nursing values as placing them in a precarious position when managing the collaboration required for decisions between active intervention and palliation. Similarly, evidence of this emerged in our study with participants clearly identifying a desire to advocate for patients within and outside of the healthcare team. Some were very specific in expressing the “…need to be an advocate…” Others more indirect, for example wanting to ensure “…wishes and advanced treatment directives were upheld”.

This interaction was described both in collaborative (consult, discuss), and adversarial (confront) manners. Advocacy in this situation was presented as a contributing factor in the sense of it occurring “…in the face of fierce opposition”. Similarly the moral distress literature identifies a belief that often opinions are not accepted” (Malloy et al., 2009). Advocacy as a solution was also apparent, with participants clearly wanting to engage in advocacy (through communication) as a resolution to the situation. This contradicts the literature which indicates that workers often feel they lack the power to speak in these situations (Malloy et al., 2009). In our study most participants clearly expressed a desire to speak openly with other/s about the issues raised. Recognition by participants of the need to communicate effectively in a bid to facilitate resolution of ethical challenges is encouraging. It also speaks to many participants desire to actively advocate on behalf of their clients as part of their moral responsibility.

An obvious divergence does exist, with some participants expressing the decisions made in Scenario 2 were suitable, while others felt the decision was inappropriate. Disagreement with the decision was expressed with the belief that palliative measures where more appropriate, for example “…resident’s treatment should be ceased…for comfort measures only”. Contrasting this others saw this acute intervention as the best option and entirely appropriate. What emerged most strongly was recognition of the older person’s autonomy of choice.

In the context of Phase 1 of our study, items related to consultation / decision-making only ranked moderately. The item “continue care…when no-one will make a decision to withdraw support” was the eighth most frequent item, generating the sixth highest level of distress. “Follow the family’s request not to discuss death…” ranked thirteenth (frequency) and sixteenth (intensity).
7.4.1.2 What didn’t show up clearly in this study

The data in our study revealed a variety of contributing factors to moral distress consistent with the literature, with the exception of some components of the Contributing Factors – Site Specific and Broader External (recall Chapter 2 Literature Review, Figure 2-1) categories. In the literature reviewed, the Site Specific categorisation described (among others) allocation of resources (Green & Jeffers, 2006), cost containment (Kälvemark et al., 2004), unsafe staffing levels (Corley et al., 2005), inappropriate environment for the provision of palliative care (Kain et al., 2009), and ‘futile’ care situations (Rice, et al., 2008) as contributing to moral distress. In the context of Broader External Influences, broader healthcare regulations (Pendry, 2007), organizational policy and procedures (Silén et al., 2008; Solum & Schaffer, 2003), and tension caused between hospital practice and evolving evidence-based best practice (Godfrey & Smith, 2002) were evidenced. Our data added a new insight about contributing factors when considered against the review of literature.

Unlike the literature (refer Chapter 2, section 2.4.1.2) our findings indicate that worker skill mix and worker numbers provided to deliver care was not a moral distress differential. That is, participants did identify inadequate numbers of staff and poor staff ratios as a problem, but did not directly identify skill mix (that is the right staff with the right knowledge to deliver care) as a contributing factor. By comparison, during Phase 1 of the study (instrument amendment and pilot testing) an item on the Moral Distress Scale – Revised (aged care) (Burston et al., 2016) specifically targeted skill mix, and when analysed that item ranked fifth highest in frequency and seventh highest in intensity.

Elsewhere, this distinction between skill mix and staff numbers is an important one. The knowledge level (Laabs, 2007) and the perceived skill level (Pauly et al., 2009; E. Rice et al., 2008) of the care worker has been previously identified as contributing to moral distress. Skill mix issues are linked to inadequate education, inability or difficulty in employing appropriately skilled workers, lack of recognition at the management level of the skill mix required, or funding structures that do not allow employment of an appropriate skill mix (Goryakin, Griffiths, & Maben, 2011; E. Jacob, McKenna, & D'Amore, 2015; D Twigg, Duffield, Bremner, Rapley, & Finn, 2012). Worker numbers are an effect of either funding models which require direct financial input to redress, or retention issues which would require quite different strategies to alleviate (Graham & Duffield, 2010; Welton,
Identifying the root cause of both of these problems is therefore critical. Further clarification of the worker’s experience of these two related elements is important for the development of tailored interventions to address moral distress in aged care.

Additionally, unlike our review of the literature, little mention of broader external influences as a contributing factor to moral distress were evident in our study. For Scenario 1, a single participant indicated the failing enterprise bargaining agreement related to workload contributing to the problem of insufficient time to deliver care and ultimately moral distress. We know that broader healthcare regulations (Torjuul & Sortie, 2006), organizational policy and procedures (Silen et al., 2008; Solum & Schaffer, 2003), and macro-economic factors (Silen et al., 2008) impacting access to care (Brazil et al., 2010) are known contributors to moral distress. At no other stage did participants mention an external contributor to their experience of moral distress. However, it is surprising that no mention of broader social contributors, such as State or Federal funding for aged care services were identified, particularly given the emergent demand on aged care services and the financial resources needed to support this (Productivity Commission, 2011a).

Issues of resource allocation in the form of cost containment (Kälvemark et al., 2004; Tiedje, 2000) and financial constraints (Oberle & Hughes, 2001), leading to a lack of resources (Kain et al., 2009; Nordam et al., 2005) directly contributes to moral distress. Therefore in the context of future recommendations, implementation of facilitated ethical discussions for staff related to the interface between organisational expectations and direct service provision is warranted.

A final point needs to be made. Methodologically we acknowledge the possibility that the case study scenarios did not prompt generation of thought on these broader external issues (refer forthcoming Section 7.6 Limitations).
7.4.2 Outcomes

7.4.2.1 On Staff
Consistent with the literature, a range of psychological effects such as unhappiness, sadness, being upset and feeling annoyed all emerged in our study (Burston & Tuckett, 2013). These effects were demonstrated across both case study scenarios. Most dominant in the literature and in our study were feelings of frustration (Ferrell, 2006; Green & Jeffers, 2006; Krishnasamy, 1999; Laabs, 2005; Nordam et al., 2005; Tiedje, 2000), and powerlessness (Ferrell, 2006; Krishnasamy, 1999; Laabs, 2007; Montagnino & Ethier, 2007; Nordam et al., 2005; Wilkinson, 1989).

The frustration described in our study was specifically linked to an increase in stress and anxiety levels, ultimately decreasing morale and leading one participant to “switch off and no longer care” or simply “not feel a lot”. This may stem from a diminished sense of purpose (Nelson, 2009), personal and professional disillusionment (Krishnasamy, 1999), and a sense of resignation (Hanna, 2005). Personal integrity and values are challenged and over time eroded (Krishnasamy, 1999), leading to emotional exhaustion (Pendry, 2007) and emotional detachment (Laabs, 2007). These effects of moral distress are known to contribute to workers leaving the workforce (Burston & Tuckett, 2013).

In contrast to the views above signifying resignation, detachment or exhaustion, one participant in this study identified feeling quite “normal” when faced with the frustrated older person in Scenario 1. This participant may not have felt there was an issue at all, hence not feeling ethically challenged and neither experiencing any subsequent moral distress. Scenario 2 generated similar conflicting views, with one participant feeling “fine” while another did “not feel a lot”. It has been noted that not all ethically challenging events invoke a heightened moral distress nor are evaluated negatively (Garel et al., 2007; Green & Jeffers, 2006; Meaney, 2002a), but others propose that some may experience moral distress yet fail to recognize it (Solum and Schaffer, 2003).

An additional outlying opinion warrants mention here. For Scenario 1 one participant questioned the authenticity of the older person’s claims. It maybe that the participant’s statement stemmed from a genuine openness to explore the situation further, rather than react emotionally. It may indicate that either intentionally (deception) or unintentionally, the older person’s claims are not always legitimate and need verification. Worse case and
requiring attention for any intervention to address moral distress, the statement may also be a reaction grounded in the callousness (Meaney, 2002a) and cynicism (Ohnishi et al., 2010) known to emerge in some morally distressing situations.

### 7.4.2.2 On Older Person

A number of participants responding to Scenario 1 in our study were concerned about the perceived effect on the older person. Whilst our focus was on seeking to understand and find meaning about moral distress as experienced by the aged care worker, its effects on the older person were described as frustration, feeling disheartened, being upset, being stressful and inducing unhappiness. It is important to remember that the data collection involved participants reading an inductively derived scenario, so we propose that these described effects stem from either witnessed effects in similar situations or are a projection of what participants imagined how the older person would respond in a like situation.

The overarching statement clearly summarising participants’ feelings on this issue was one of “it is not right”. This speaks directly to the moral obligation to practise with commitment and integrity (Laabs, 2011; Traynor et al., 2010) which is needed to deliver care that is appropriate for the needs of the older person. This simple statement speaks to the core of the moral distress experience – a feeling that what is or is not occurring is not right (Jameton, 1984), and is a threat to the objective good (Hanna, 2005). In direct contrast though, one participant dissented, believing the older person was “…not understanding that staff also have to spend time with others…”.

### 7.4.2.3 What didn’t show up clearly in this study

The data in our study did not reveal anything about Outcomes - *Towards the system “I would do”* (recall Chapter 2 Literature Review, Figure 2-1). In the literature reviewed, this categorisation described not discussing the situation, taking no direct action (Cohen & Erickson, 2006), avoiding the patient (Wilkinson, 1989), avoiding conflict (Laabs, 2007), ending care delivery (Kirk, 2007), and over-compensating with extra care (Wilkinson, 1989) as the impact or consequences of moral distress. Again, method(ologically) we acknowledge the possibility that the telephone interviews and the scenarios limited the data grounded in our questioning or triggers (refer forthcoming Section 7.6 Limitations).
7.4.3 Interventions

Interventions to both scenarios were proposed by participants and have been categorised under two key headings: Doing Work, and Speaking with Others. The act of Doing Work involved either wanting to do more or to reorganise workloads to alleviate factors contributing to moral distress. A clear desire to speak with those involved in the care situations with a view to resolving the distressing situation was expressed as Speaking with Others.

7.4.3.1 Doing Work

The primary desire from Scenario 1 was the idea of “doing work”, but how best to achieve this varied. Wanting to spend or give more time, slow down, or just work harder was a common desire of workers. However, unless participants were acknowledging they were not actually working to their capacity (which given the earlier identification of excessive workloads is unlikely), the way in which workers could realistically achieve this as a solution is unclear. The only tangible solution proposed was for the individual to “re-arrange workload”. Aged care workers are time poor and generally function at high capacity, hence in practice simply “doing more” is often not physically possible. A worker in this situation may find themselves becoming detached from caring or experiencing burnout, and executive management have a clear obligation to proactively manage these manifestations of moral distress (Corley et al., 2005) with a view to meeting their responsibility to improve job satisfaction (Moyle et al., 2003).

In Scenario 2 the act of doing work with a view to providing appropriate care in-situ was proposed. However what was classified as “appropriate care” varied between providing curative measure or providing palliative measures, a situation highlighted in the range of responses regarding the workers role as an advocate for the older person in this situation. Despite these two conflicting goals, most participants wanted to be actively engaged in care provision for the older person as a solution to the problem, and did not want to see the older person moved elsewhere.

In contrast two participants wanted to maintain the status quo supporting the transfer for acute intervention, with one further participant believing there was nothing more to be done. Although deeper exploration of this with participants is not possible, potential reasons can be proffered. These findings may be indicative of an emotional maturity demonstrated as a pragmatic acceptance of reality; that is, evidence of a worker who has
experienced this or similar situations previously and has developed a resilience that can alleviate the effects of workplace stress (Grafton, Gillespie, & Henderson, 2010). Alternatively, it could evidence an abrogation of the workers role as an advocate for the older person, not dis-similar to the emotional detachment (Laabs, 2007) professional disillusionment and erosion of personal integrity (Krishnasamy, 1999) evidenced in the moral distress literature.

A further observation can be made about our findings in Phase 2. In our research only two participants specifically discussed the inclusion of other members of the healthcare team. In Scenario 1 the inclusion of an activities co-ordinator was suggested as important in addressing the older person’s perception of inadequate time being spent with her; whilst in Scenario 2 the inclusion of a physiotherapist was proposed. The multi-disciplinary involvement in care delivery is an important approach to providing quality care (A. Jacob, Roe, Merrigan, & Brown, 2013; Ndoro, 2014), so our observation is surprising given the known benefits from multi-disciplinary involvement in planning and implementing care.

This finding may be explained as follows. It may be that the aged care workers in our study simply saw a lack of need for multi-disciplinary involvement, or a lack of existence of the available expertise. Though, the automatic inclusion of the multi-disciplinary approach as a solution to moral distress is not necessarily a panacea, as the genesis of moral distress is not always consistently acknowledge or addressed in multi-disciplinary teams either (Deady & McCarthy, 2010). Moral distress experienced by different team members can generate from different elements within the situation (Sturm, 2007). So while the involvement of additional professions in care delivery may reduce the moral distress experience for one worker, it may also be the genesis of moral distress for another (Deady & McCarthy, 2010).

7.4.3.2 Speaking with Others
For both Scenario 1 and Scenario 2, most evident in participant responses was the importance of communication as a solution mitigating moral distress. However, who this consultation should involve varied, and included the older person, other health-care workers, family members, or combinations of each. This is consistent with the literature that clearly identifies communication around these types of ethical issues as integral to reducing the occurrence and effects of moral distress (Burston & Tuckett, 2013).
At times the nature of this desired communication was collaborative and inclusive, while on occasions a more confrontational approach was proposed. Typically, collaboration was sought between the aged care worker and the older person, between aged care workers and family, or within the healthcare team. Effectiveness and openness of communication have been demonstrated to reduce turnover in aged care (R. Anderson, Corazzini, & McDaniel, 2004) and improve job satisfaction (Choi et al., 2013). Attention to supporting effective communication with the organisation is necessary (Batch, Barnard, & Windsor, 2009; Gao, Tilse, Wilson, Tuckett, & Newcombe, 2015).

Advocacy as a solution emerged. Although a delicate situation the professional responsibility to advocate was described clearly and repeatedly. This role as an advocate was described directly as a need of the worker, and usually with a collaborative tone, for example as a liaison between the older person and the doctor in supporting older person autonomy. The alternate preference for a more confrontational approach expressed by one participant was grounded in the belief of the participant that the older person and their family had not been included appropriately in the decision-making process. However the level of discussion between the doctor and older person/family was not explicitly identified in the scenario. The reasons why the participant has assumed inadequate communication occurred is not clear. Reasons may include the wording of the scenario (discussed further in forthcoming Limitations section 7.6) or the participant drawing on previous experiences in a like situation. Previous exposure to distressing situations can generate a moral residue over time, with subsequent exposures to similar situations prompting more intense reactions (Epstein & Hamric, 2009). Clearer understanding of all of this at any individual’s level is important in addressing the moral distress experience.
7.5 Making sense of the Job Demand Control Support model and our moral distress study

Models such as the Job Demand-Control-Support (JDCS) model (Johnson & Hall, 1988) are useful tools for exploring relationships between the (aged care) worker, worker stress and their world of work. Models like the JDCS facilitate better understanding of the contributing or causative factors of moral distress and their effects, but must be used with some caution. The nature of human dynamics, the way we act within, interact with and experience work, is situational and at face value can appear inconsistent (Arnold & Randall, 2010).

Moral distress as a workforce issue is clearly evidenced in the literature (Burston & Tuckett, 2013). As detailed in Chapter 2, issues like organisational structures, policies and the nature of the work environment are known contributors to moral distress. A goal for situating the experience of moral distress within a recognised model of occupational stress is to provide a tangible workforce/workplace basis for developing sound interventions to reduce the exposure to or improve the experience of workplace stress (i.e. moral distress). Stress related issues such as moral distress are known to decrease job satisfaction and lead to turnover of staff (Coomber & Barriball, 2006). The three components of the JDCS; job control, job demands and social support, clearly encompass both the organisational and the ethical climate factors at play in the manifestation of moral distress.

The use of the JDCS model in our study has provided important understandings. The JDCS model is well recognised as a valid and influential model (Luchman & González-Morales, 2013) and its use in nursing workforce studies is recognised (Y. Chiu, R. Chung, C. Wu, & C. Ho, 2009; Gao et al., 2014; Peterson et al., 2011). The use of the JDCS in this study within the unique context of moral distress ‘advances the science’ for the use of the JDCS in nursing, moral distress and workforce study.

Our research is the first time that conceptual links between the JDCS model and moral distress have been explored. The Chapter 3 discussion demonstrates that the individual components of the JDCS, that is job demands, job control, and social support, have clear links to the experience of moral distress. Job demands speaks to the necessity for aged care workers to function within the often competing demands for resourcing and care delivery in a collaborative multi-disciplinary workplace. Job demands are subject to the
constraints laid out by legal parameters, ethical obligations, regulatory frameworks, organisational structures, and a workplace culture (Karasek, 1979). Moral distress has been demonstrated repeatedly in the literature to emanate from constraints placed on the workers by elements such as these (Burston & Tuckett, 2013).

Job control speaks to the capacity of the worker to do her/his work with autonomy - the less autonomy afforded the worker the less job control available. The idea of responsibility without authority has been identified in the both moral distress (Meaney, 2002a; Pendry, 2007) and job strain (Karasek, 1979) literature. Executive decisions on resource allocation (Green & Jeffers, 2006), cost containment (Kälvemark et al., 2004) and staffing levels (Ohnishi et al., 2010) all contribute to moral distress. These decisions have a direct impact on the worker and are decisions over which the aged care worker has little direct control.

The third component of the JDCS, added by Johnson and Hall (1988) to Karasek’s original JDC model (1979) is that of co-worker social support. Johnson & Hall (1988) investigated social support by exploring both communication and interaction levels with co-workers at work, and the level of socialisation with co-workers outside of work. They determined a low level of work related social support as heightening the impact of job strain on the worker.

The ethical climate of the workplace can be positively influenced by aged care workers. Although somewhat tied to organisational structure and culture, facilitating workers to take ownership of the culture of their workplace, to become invested in how they ‘do nursing’, will empower gradual but sustainable change (Darbyshire, 2010; Kennerly et al., 2012). A bottom up approach to change can be generated by them; driving cultural change that is owned by the aged care worker. As an example, this may manifest as facilitated ethical discussions on specific challenges within the individual workplace, allowing aged care workers the opportunity to voice concerns and consider differing perspectives. Ultimately, these discussions would promote openness between workers and improve the social support network within the workplace. It would also support workers in re-framing the outcome of moral distress from one of powerlessness and despair (Rodney, 2017) to one of moral resilience.
The social support afforded the worker is inextricably linked to the moral or ethical climate of the workplace, and the moral climate relates to the moral distress experience (Lützén et al., 2010). Necessary in addressing moral distress is a safe environment that facilitates the moral agency of the worker (Austin, 2012). To this end, some refer to the workplace as a ‘moral community’ (Austin, 2007; Storch, 2007) as an important approach towards reducing ethical constraints (Austin, 2007), naming and thus identifying moral problems and improving safety in care delivery (Storch, 2007). By interpreting the workplace as a ‘moral community’ not only can the safety of patients be improved, but also that of healthcare providers (Rodney, Doane, Storch, & Varcoe, 2006). Oppressive work environments have been clearly demonstrated to reduce the moral habitability of the work environment (Peter, Macfarlane, & O’Brien-Pallas, 2004). Building quality relationships (Galletta et al., 2013; Han & Jekel, 2011) and nurturing a suitable ethical climate (Wang & Hsieh, 2013) will counter this oppressiveness, temper or lessen experiences of moral distress (Pauly et al., 2009; Silén et al., 2011), enhance social support, and improve job satisfaction and retention.

Two limitations in the use of the JDCS model exist. First, moral distress is a complex experience driven by a range of individual, site specific and broader external influences (Burston & Tuckett, 2013). Any single experience of moral distress generates from a number of contributing factors, with variable attendant effects and is also influenced by the individuals’ previous experiences of moral distress. The interconnectedness of the contributing factors and effects, within different workplace contexts challenges the capacity to fit moral distress cleanly into a pre-existing framework. So while the JDCS model is valuable for providing tangible recognition of the moral distress experience within a ‘set’ of known workplace stress parameters, the model must be used with some caution.

Second, aged care workers are primarily focussed on the direct delivery of care. As many of the contributing factors for moral distress stem from organisational and broader external influences beyond their direct control, there is a risk of overburdening aged care workers with information and change strategies that they may see as beyond their capacity to influence. This could cause workers to become disillusioned or disengaged. So while situating moral distress within the JDCS is useful in providing a template for any proposed change strategies, a cautious approach with how this is communicated to workers is warranted. It must be done in a manner that empowers aged care workers to take
ownership of factors within the workplace they can control, while also incorporating strategies to facilitate clear communication about issues over which they have limited direct decision-making capacity.

7.6 Limitations

7.6.1 Phase 1

The inability to conduct test–retest for reliability over time was a limitation of our study. An original criterion of 0.5 for factor loadings was set. However, this criterion was relaxed slightly to fit the model that emerged. Removal of the weaker loaded items from each sub-scale did not significantly change the reliability of the identified factors. Consequently, these items were retained. Larger datasets in future testing will facilitate a clearer picture of the inclusion of these items within the Moral Distress Scale – Revised (aged care) (Burston et al., 2016).

While the sample size for Phase 1 (n=106) was sufficient to validate the Moral Distress Scale – Revised (aged care) (Burston et al., 2016), generalizability of the findings is limited. This is a challenge with convenience sampling (Coolican, 2009). Findings from this study may not directly equate to the situation or experiences of aged care or care workers in other geographic or organisational contexts.

Moral distress is known to cause workers to leave healthcare jobs and also to leave the profession. Participants in this study were asked if they had ever left a job, or intended to leave their current job because of moral distress. However workers not currently employed in aged care delivery were excluded from the study. Inclusion in future studies of aged care workers not working at the time of study would be beneficial in providing more robust understandings.

A cross-sectional design was used in this study to collect data at one point in time. Whilst this provided insight into the occurrence, intensity and experience of moral distress for this sample of aged care workers, it is not possible to ascertain causal relationships. Further research using a longitudinal design would be beneficial in determining if experiences of moral distress change over time, particularly in light of Epstein and Hamric’s (2009) finding that frequent exposure to moral distress causes development of a moral residue (i.e.
lingering residual feelings that continue after the moral challenge has passed). Additionally, a longitudinal design would provide opportunities to identify specific triggering events, for example, implementation of new approaches to care delivery or changes in funding structures occurring within specific workplaces that may be responsible for generating increases or ‘spikes’ in moral distress.

7.6.2 Phase 2
Telephone interviews were used for the first stage of Phase 2. A positive benefit of this approach was that it facilitated access to a geographically disperse sample population. They are an appropriate means of collecting data, even for potentially sensitive ethical topics (Mealer & Jones, 2014). The use of telephone interviews allowed collection of data from participants working in different states of Australia, and subsequently practicing in organisations subject to different funding structures. Given that provision of resources was an identified contributor to moral distress in this study, and is a known and consistently identified contributor in the literature (Kain et al., 2009; Kälvemark et al., 2004; Pendry, 2007; Tiedje, 2000), using this method to access different sample populations was worthwhile.

However, the use of the telephone interviews is also challenging as it removes many of the important non-verbal components of communication (O'Toole, 2016). This was particularly evident in our study which required supporting participants to discuss a topic inherently grounded in feelings of distress, a situation that is more natural to avoid. As such, the inability to read and use the non-verbal cues may have reduced the capacity of the Investigator to draw out pertinent information from participants. Despite this, the use of the telephone interview method is a valuable tool for collecting information on sensitive topics (Mealer & Jones, 2014; Trier-Bieniek, 2012), that does not affect the quality of the data (Nandi & Platt, 2017).

The case study scenarios distributed in Phase 2 described two known causes of moral distress; lack of resources and futile treatment. Both scenarios described a very specific direct care episode, and as such provided a clear focal point for consideration. As detailed in Chapter 2 moral distress is initiated by a much broader range of factors including personal values, role perceptions, previous experiences, hierarchical relationships, and the moral climate of the health care setting (Burston & Tuckett, 2013). So, we recognise that
whilst we rely on two known causes of moral distress, we accept our study did not canvass understanding and meaning making about the broader range of factors found in the literature. Use of scenarios that introduce moral distress and more specifically target these broader external influences would be beneficial in future research.

For practical reasons our case study scenarios used an outlined box as a space for answers. The benefits of this were a reduction in the number of ambiguous responses and clearer identification of answers for each individual question. The use of an outline box to frame answers risked participants restricting the length of response so compromising a deeper understanding of the experience of moral distress. No discussion on the appropriateness of outlined response boxes, or the scale of these boxes is evident in the literature.

One final limitation warrants mention here. For Scenario 1, one participant questioned the authenticity of the older person’s claims. It may be that the participant’s statement stemmed from a genuine openness to explore the situation further, rather than react emotionally. It may indicate a belief that either intentionally (deception) or unintentionally, the older person’s claims are not always legitimate and need verification. Also in contrast to the views signifying resignation, detachment or exhaustion in Scenario 1, one additional participant identified feeling quite “normal” when faced with the frustrated older person. The inability to use probing techniques to unpack these responses in more detail, is a limitation of the use of the written scenarios as a data collection tool.

7.7 Methodological Challenges
The most significant challenge encountered in this time constrained PhD study was the access and recruitment of an appropriate sample population. A number of strategies were initiated throughout the study to continually boost participant numbers. Ultimately four separate sample populations were accessed.

In Phase 1 of the study aged care workers completed a survey instrument measuring moral distress. The instrument is relatively short, including eleven basic demographic questions, a 20 item Likert type scale (two responses per item), and three additional questions related to moral distress requiring check box answers. Estimated completion
time for an individual survey was between 15-20 minutes. Ultimately four separate populations of aged care workers were accessed to obtain a sufficient sample size (n=106). Access to these populations involved human research ethics applications to two organisations, meetings with two primary gatekeepers plus further discussions with gatekeepers at individual aged care facilities. Collection of data in Phase 1 occurred over a 17 month period of time.

Initially the survey instrument was distributed in an electronic format to facilitate access for aged care workers. Primarily this was because the organisations targeted for inclusion specified that an electronic link to the survey could be distributed through their monthly electronic newsletter, and that the Investigator was not able to visit individual facilities within the organisation. The rationale provided for this was that staff within the organisation were balancing many competing demands and additional pressure in the form of direct requests to participate in research was not appropriate. Only 32 completed surveys (from a potential workforce in excess of 1500 workers) were collected in this manner.

A Facility Manager from within this organisation who completed the on-line survey contacted the Investigator directly. The Manager indicate that many of the targeted sample would not have consistent access to a computer workstation while at work, and suggested the use of printed surveys as an alternative. Permission to access her facility directly was provided by the Manager. A further 18 completed surveys were collected in this manner.

Discussions with an interstate work colleague led to an introduction to an interstate sample population. Negotiations with the relevant gatekeeper allowed entrée. Another 52 completed printed surveys (from three separate facilities within the one organisation) were collected in this manner.

Following this, a second industry colleague supported entry to a fourth population. The Investigator visited the facility and spoke to workers during the afternoon shift changeover. The scope of the study was explained and surveys distributed directly to workers, with many expressing direct interest in participation. Despite this personal approach, only a further 4 completed surveys were collected. This disconnect between stated intent and action is interesting. Potential participants at the time recognised the research as relevant.
In our study there was no direct incentive offered to participants which may have contributed to the low participation rate. One worker explicitly stated to the researcher “I’m not paid enough to do research”. Consequently, this extensive process of recruitment only resulted in 106 participants.

Recruitment for Phase 2 of the study was no less challenging. In Phase 1, participants were asked if they would participate in a follow up interview. Only 26 of the 106 Phase 1 participants indicated a desire to participate in an interview, and of these only nine resulted in completed telephone interviews. As the data from the telephone interviews lacked clarity and the sought after richness or thickness (Geertz, 1973) (refer Chapter 6) case study scenarios were developed and distributed to the nine interview participants, resulting in one completed response. Additional follow up at two previously visited facilities was also undertaken, providing an additional 15 responses to the scenarios (resulting in 16) written responses for analysis).

As a PhD Candidate and emerging researcher many lessons have been learnt. First intentional and comprehensive consideration of the benefits and limitations of particular research methods must be undertaken prior to commencing a study. While the methods used need to be suitable to answer the research question or questions, clear recognition of what can and cannot be achieved within a short timeframe is necessary. Not only is this important in ultimately discussing any findings, clear understanding of any methodological challenges provides a tangible framework or parameter within which to function during the data collection phase.

The second lesson is the difficulty that can be encountered in accessing and collecting valid data from what at the outset appears to be a suitable population. The chosen population is directly tied to the type of data that is needed to answer the research questions. However, there is also benefit in carefully considering the ability to access appropriate populations while concurrently framing the early research questions. This aids in ameliorating access difficulties, or at the least allows the researcher to carefully consider approaches to accessing populations, either via human research ethics committees or organisation specific gatekeepers. Importantly though any perceived or real difficulty in accessing sample populations should not be used as an excuse to ignore important research questions and populations with legitimate research needs. Incentives for
participation were not used in this research. Often participants are given some sort of recompense for participating, and the use of incentives may have improved participation. However incentives alone do not always increase response rates (Harris, Khoo, Young, Solomon, & Rae, 2008).

A third key lesson learnt is that as a researcher one must be persistent, resilient and willing to make legitimate adjustments to the research methods as need arises. A cautious and considered approach to fluidity is necessary, as the integrity of the research process and the validity of the study must not be compromised. However, a persistent, resilient approach will ensure difficult research projects can be completed successfully. The capacity to remain flexible and make legitimate adjustments when required ensures valuable resources are not wasted on incomplete projects.

7.8 Conclusion

Chapter 7 discussed the findings from our study. The Moral Distress Scale – Revised (aged care) was shown to be a valid and reliable instrument for use within the Australian aged care environment. Moral distress does occur within the aged care workforce causing a variety of detrimental effects on the worker and older people. Similarly to other studies (refer Chapter 2 Literature Review) the moral distress of Australian aged care workers generated from issues of futility and insufficient resourcing. A clear desire to engage the issue through communication with others and by actively doing more was discussed, but what this specifically entailed was not always clearly elicited by participants.

Commonalities between the Job Demand Control Support (JDCS) model and moral distress exist, and using the JDCS model to frame moral distress can provide a valid foundational structure for interventions.

Chapter 8 provides a summative discussion of the key themes emerging from the research, including recommendations for addressing moral distress and future research.
Chapter 8  Recommendations and Conclusion

8.1 Introduction
Chapter 7 provided an integrated discussion of findings, assimilating outcomes from Phase 1 (Chapter 5) and Phase 2 (Chapter 6). Chapter 7 also bridges the conceptual sidelines of the theoretical framework (Chapter 3) and the phenomenon under investigation, moral distress (Chapter 2). Assimilating the discussion in this way is wholly consistent with the explanatory sequential mixed methods approach outlined in Chapter 4. In essence, Chapter 7 is a discussion of the whole.

Chapter 8 provides a number of recommendations - first, to address moral distress in aged care; and second, for future moral distress research. The recommendations for addressing moral distress are mapped against the factors contributing to moral distress detailed in Chapter 2, namely individual, site specific and broader external. This approach ensures the recommendations are applicable and useful for care workers and interested others in aged care.

8.2 Recommendations to address moral distress in aged care

8.2.1 Individual

8.2.1.1 Critical self-reflection
Building moral resilience within the individual is an important strategy to address moral distress (Carse, 2013). Not only will this aid aged care workers in negotiating the moral landscape of residential and community aged care work, it will improve their capacity to manage exposure to inevitable moral challenges. At an individual level, it is important that aged care workers understand workplace stress, understand and recognise moral distress and its contributing factors and effects, and develop skills in managing occupational stress. A clear opportunity for this is to engage aged care workers in critical self-reflection (Hanna, 2005). That is, to allow them an opportunity to reflect on morally challenging situations, the way in which they manage these situations, and formulate coping strategies to use to deal with the effects. This would support them in reducing the internalization of moral distress, give them a greater sense of control and change the narrative of powerlessness and despair described by Rodney (2017).
Critical self-reflection addresses both desires expressed by participants in Phase 2, of “Doing Work” and of “Speaking with Others”. Commonly participants struggled to clearly elicit what constituted “Doing Work”, and opportunities for structured reflection support the workers consolidation of concerns and clarity of thought, on what realistically can and cannot be done. Additionally this self-reflection provides opportunities for workers to clarify thoughts on their moral distress, aiding clearer elicitation of their concerns in forums such as those proposed below (“Speaking with Others”).

Typically, this critical self-reflection would be at the workplace, at the bedside, during purposefully designed ‘ethics rounds’ or as part of the routine residential aged and community care staff development (Caldwell & Grobbel, 2013; Svantesson, Lofmark, Thorson, Kallenberg, & Ahlstrom, 2008). However, the individual aged care worker practices within an organisation, and the organisation is a community of individual workers. As such both individual and site specific interventions are fundamentally linked. The onus to effect change cannot reside solely at the individual level (see below).

**8.2.2 Site Specific**

Recommendations at the site specific level consistently sit within the broader notion of an ethically safe environment or what has also been called the moral habitability of the workplace (Peter et al., 2004). Fostering a workplace of moral safety is crucial to addressing moral distress (Vanderheide et al., 2013). Strategies to meet this need include ethics education and collaborative discussion forums.

**8.2.2.1 Ethics education**

The moral distress literature clearly identifies ethics education as a relevant mechanism to address moral distress (Burston & Tuckett, 2013). This aligns closely with the findings from our study in two ways: a question in the Phase 1 survey identified only 22% of participants having been involved in education related to moral distress; and the Investigator’s field note during the telephone interviews, that participants had difficulty in clearly distinguishing moral distress from other types of workplace and personal stress. Participants in Phase 2 clearly identified a desire to engage in collaborative solutions and ethics education supports this.
Educational opportunities must be multi-faceted. From a content perspective, any education programme must incorporate the definitions and known experiences of moral distress, contributing factors and outcomes. Discussions on moral distress should also focus on distinguishing moral distress from other forms of occupational and personal stress, and explore strategies to build moral resilience (Rodney, 2017). Additionally exploration of the constituents for a sound ethical practice environment should be included (Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014). Education would be tailored to suit the unique clinical environments’ of individual aged care workers; accounting for variations in organisational structures, approaches to care delivery, the inherent workplace culture and potentially different policies and funding mechanisms.

Pedagogically, this education is designed and delivered from two perspectives. From the perspective of the learner, facilitated workshop sessions in which participants are exposed to theoretical knowledge and then afforded opportunities to openly discuss and explore the practical application of this new theory are appropriate. These workshops would also provide opportunities for participants to be supported with the guided self-reflection (see above). Implementation of these workshops must be conducted in a manner that promotes ethical safety of participants (Sağnak, 2017).

From the perspective of the educator the development of a moral distress toolbox is proposed. Development of a moral distress toolbox (MDT) would guide individual educators and also provide a sound base for recommended interventional research (see below). It is envisaged that the MDT should be designed in such a manner that it could be portable and used by a nurse educator with minimal effort but maximal effect. Resources in the toolbox would include a series of lesson plans with accompanying facilitator guides, and incorporate a range of activities and supplemental resources for participants using a series of video vignettes as trigger points for facilitated activities. A user guide outlining the content of the MDT, the range of resources, and the advised sequence of activities would also be included.

8.2.2.2 Collaborative discussion forums
In conjunction with the MDT, an organisational commitment to the consistent provision of a forum for aged care workers to discuss moral challenges is needed. These forums would be used to discuss ethical issues in a general sense, for example related to care delivery or resource allocation, but also used for more targeted case study type discussion of
individual situations as they arise. These forums address the explicit desire of the aged care workers from Phase 2 of the study: ‘Speaking with Others’.

Importantly, these discussion must be collaborative (Silén et al., 2011). One element of this is discussions between and amongst all health workers involved in the front-end of care delivery in aged care; for example the nurses, unregulated carers like personal care assistants/assistants-in-nursing, doctors, allied health staff. Whilst there are logistical difficulties in bringing together this cohort, it can be done and it can be planned (Tuckett et al., 2014; Tuckett et al., 2015) (REF). Secondly, discussion between aged care workers and higher levels of management must be actively facilitated. Lastly, at all times this communication must be bi-directional; workers in residential and community aged care must feel that their experiences are valid and that solutions they offer are fully considered (Shelby-James, Butow, Davison, & Currow, 2012; Tuckett et al., 2015).

8.2.3 Broader External

On a broader scale, action needs to be directed at the increasing demands of an ageing population on the ageing nursing workforce in Australia (Australian Institute of Health and Welfare, 2011b; Productivity Commission, 2005). A concerted approach from representative organisations such as regulating authorities, professional nursing bodies and unions should target discussion about approaches to dealing with workplace stress generally (and moral distress as a component of this) for the purpose of finding tangible solutions. Whilst there are logistical difficulties in bringing together this cohort, it can be done and it can be planned (Burke & Greenglass, 2001; McVicar, Munn-Giddings, & Seebohm, 2013). Nursing is by nature a moral endeavour and hence moral challenges will always exist. Collaboratively designed appropriately targeted action can go a long way to ameliorating the adverse effects of moral distress (Burston & Tuckett, 2013).
8.3 Recommendations for future moral distress research

8.3.1 Exploratory

Due to the nature of the research questions for our study, data collection was bounded – i.e. it was not collected to facilitate consideration of the moral distress experience for specific subsets of the aged care workforce (for example by role description, age of worker, or years nursing). This limitation impacts the overall generalisability of the data and also limits consideration of elements unique to specific subsets. A key variable is that of nursing experience. As discussed in Chapter 2 (Literature Review), varying views about the impact of nursing work on experiences of moral distress abound. These views range from: more nursing experience equating to higher frequency and intensity of moral distress (Rice et al., 2008); less experience with ethical challenges equating to increased risk of moral distress (Meaney, 2002a); more experience nursing equating to fewer instances of moral distress (Wilkinson, 1989); and, no correlation between experience and moral distress (Pauly et al., 2009). A recommendation for future moral distress research is for collecting data from either a larger sample size or for the more specific targeting of identified subsets of workers within the Australian aged care workforce.

8.3.2 Intervention-based

Intervention-based moral distress research has long been proposed in the literature (Burston & Tuckett, 2013; Hamric, 2012) but limited interventional studies have been conducted. Interventional moral distress research would explore the outcomes of for example, the ethics education and the collaborative discussion forums proposed earlier. Data on the efficacy of interventions is needed to progress the situation from one of the powerless suffering to one of resilient action (Rodney, 2017). Ideally, longitudinal studies that are able to explore not only the effect of interventions, but the ongoing benefits as they relate to moral resilience and moral residue are needed (Epstein & Hamric, 2009).

8.3.3 Consolidation

Our study developed and pilot tested the Moral Distress Scale – Revised (aged care) (Burston et al., 2016). Whilst sufficient participants were obtained to validate the instrument, larger samples would further consolidate this initial validation. Additionally, the use of the instrument with a larger sample would provide a clearer picture of moral distress across the aged care workforce in Australia. A clearer picture of the reality of moral
distress in residential and community aged care would provide more substantive evidence to support the funding, development and implementation of the moral distress toolkit (MDT), workplace ethics education and collaborative discussion forums.

Moral distress is one component of stress that workers experience. While there is value in exploring it as a unique entity, understanding moral distress and proposing interventions to address it need to be tested within the broader scope of occupational stress. For example, the use of a known occupational stress model, such as the Job-Demand-Control-Support (JDCS) model used in our study has extended the science of moral distress and the JDCS, respectively. Studies that explore moral distress and other workplace and personal stressors concurrently will facilitate a better understanding of workplace and worker stress.

8.4 Thesis Conclusion

Moral distress is detrimental to the Australian aged care worker; reducing job satisfaction, and negatively impacting the way in which workers interact and work within the workplace. Workers leave the workplace or leave the profession entirely. Additionally, quality of care suffers as workers become detached, cynical and switch off from older people. The demands of an ageing population on this workforce will continue to increase, and as such building a resilient and robust workforce is paramount. Workers clearly express a desire to confront morally distressing situations and engage pro-actively to ameliorate the effects of moral distress and reduce its occurrence.

The aim of this mixed methods study was to explore the effect of moral distress on Australian aged care workers in residential and community aged care. The amendment and validation process of the Moral Distress Scale – Revised (aged care) (Burston et al., 2016) proved instrument validity, and demonstrated aged care workers experiencing moral distress. One-third of workers had considered leaving a position because of moral distress, and over one-fifth had left. The most frequent and distressing situations identified were those in which quality of care was compromised or care was seen to be futile.

Qualitative exploration through the use of telephone interviews and written case studies identified psychological effects on the worker consistent with the literature and the quantitative findings. Somewhat unanticipated, workers also clearly described negative effects on the older person as evident. Additionally, workers described a strong desire to
engage in collaborative strategies to address the situation. Evident through both the telephone interviews and the written case study responses, was that workers either struggled to conceptualise moral distress, or did not easily distinguish (either unintentionally or by design) moral distress from other forms of stress and workplace stress.

Moral distress is a key component of workplace stress evident in the aged care workforce. Situating moral distress within the Job Demand-Control-Support model (Johnson & Hall, 1988), provides a solid foundation for building valid interventions to improve the work life of these workers. Recommendations of our study include ethics education, collaborative discussion forums, and future research targeted at better understanding, identifying and addressing moral distress. Addressing moral distress will improve the situation of workers, positively impacting job satisfaction and quality of care.
Reference List


Austin, W., Bergum, V., & Goldberg, L. (2003a). Unable to answer the call of our patients: mental health nurses’ experience of moral distress. *Nursing Inquiry, 10*(3), 177-183.


Browning, A. M. (2013). Moral Distress and Psychological Empowerment In Critical Care Nurses Caring for Adults at End of Life. *American Journal of Critical Care, 22*(2), 143-152. doi:10.4037/ajcc2013437


Ford, S. (2013). RCN Warns of a Hidden Crisis, as 20 000 Nursing Posts are Unfilled *Nursing Times*


Grealish, L., Lucas, N., Neill, J., McQuellin, C., Bacon, R., & Trede, F. (2013). Promoting student learning and increasing organizational capacity to host students in


Among Canadian Indigenous Youth. *Qualitative Health Research*, 27(9), 1330-1344. doi:10.1177/1049732317712489


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Publication 1

Appendix B – Moral Distress Scale – Revised (aged care)

Demographic Information

Please complete the following questions. It is important to the quality of the research that all questions are answered as accurately as possible.

My year of birth is... ___________________________ I identify as:  Female □  Male □

The cultural origin or background I most identify with is... ___________________________.

I am contracted to work ... ____________ hours per week (insert number of hours).

The last time I worked a clinical shift was _____________________________ ago. (e.g. 6 days, 3 months)

I currently work in ...  Residential Aged Care □  Community Care □  Other □ Please specify:

The postcode of my current workplace is... ___________________________.

I am employed as:

Personal Carer /Assistant in Nursing □

Enrolled Nurse □  Registered Nurse Level 3 □

Registered Nurse Level 1 □  Registered Nurse Level 4 □

Registered Nurse Level 2 □  Registered Nurse Level 5 □

Other (please specify): ___________________________.

I have been working in nursing for ____________ years (insert number of years).

I have been working in my current facility/service for ____________ years (insert number of years).

Would you like the opportunity to participate in a follow up interview to discuss moral distress further?

Yes □  No □

If yes please identify a preferred contact method:

Phone Number: ___________________________.

E-mail address: ___________________________.
Appendix B – Moral Distress Scale – Revised (aged care)

MDS-R
Nurse Questionnaire [Aged Care]

Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints. The following situations occur in clinical practice. If you have experienced these situations they may or may not have been morally distressing to you. Please indicate how frequently you experience each item described and how disturbing the experience is for you. If you have never experienced a particular situation, select “0” (never) for frequency. Even if you have not experienced a situation, please indicate how disturbed you would be if it occurred in your practice.

**Note:** you will respond to each item by checking the appropriate column for two dimensions: Frequency and Level of Disturbance.

<table>
<thead>
<tr>
<th>Frequency (number of times)</th>
<th>Level of Disturbance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Very frequently</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

1. Provide less than optimal care due to pressures from administrators/supervisors to reduce costs.

2. Witness healthcare providers giving “false hope” to a client or family.

3. Follow the family’s wishes to delay palliative measures, even though I believe it is not in the best interest of the client.

4. Initiate life-saving actions when I think they only prolong death.

5. Follow the family’s request not to discuss death with a dying client who asks about dying.

6. Carry out doctor’s orders for what I consider to be unnecessary tests and treatments.

7. Continue to participate in care for a hopelessly ill person who is being sustained by medical treatments, when no one will make a decision to withdraw support.

8. Avoid taking action when I learn that a doctor or nurse colleague has made a medical error and does not report it.

9. Assist a doctor who, in my opinion, is providing incompetent care.

10. Be required to care for clients I don’t feel qualified to care for.

11. Provide care that does not relieve the client’s suffering because the doctor fears that increasing the dose of pain medication will cause death.
## Appendix B – Moral Distress Scale – Revised (aged care)

<table>
<thead>
<tr>
<th>Frequency (number of times)</th>
<th>Level of Disturbance</th>
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</thead>
<tbody>
<tr>
<td>Never</td>
<td>Very frequently</td>
</tr>
<tr>
<td></td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

12. Follow the doctor’s request not to discuss the patient’s prognosis with the client or family.

13. Increase the dose of sedatives/ opiates for an unconscious client that I believe could hasten the client’s death.

14. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.

15. Follow the family’s wishes for the client’s care when I do not agree with them, but do so because of fears of a lawsuit.

16. Work with nurses or other healthcare providers who are not as competent as the client care requires.

17. Witness diminished client care quality due to poor team communication.

18. Ignore situations in which clients have not been given adequate information to make informed consent.

19. Watch client care suffer because of a lack of provider continuity.

20. Work with levels of nurse or other care provider staffing that I consider unsafe.

If there are other situations in which you have felt moral distress, please write them and score them here.

---

Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

- No, I’ve never considered quitting or left a position ☐
- Yes, I considered quitting but did not leave ☐
- Yes, I left a position ☐

Have you ever participated in any formal education, courses, or professional development related to moral distress? Yes ☐ No ☐

Have you ever taken a break from nursing because of moral distress? Yes ☐ No ☐

*Thank you for completing the survey. Please place the survey in the reply paid envelope for return.*
Publication 2

### Institutional Human Research Ethics Approval

**Project Title:** The Australian Aged Care Nurse: Improving Workplace Satisfaction And Staff Retention - 20/12/2013 - AMENDMENT

**Chief Investigator:** Mr Adam Burston

**Supervisor:** Dr Anthony Tuckett, A/Prof Deborah Parker, Dr Robert Eley

**Co-Investigator(s):** None

**School(s):** School of Nursing and Midwifery, Faculty of Health Sciences

**Approval Number:** 2012000659

**Granting Agency/Degree:** Master of Philosophy

**Duration:** 31st December 2017

**Comments/Conditions:** Expedited Review - low risk.

*Note: If this approval is for amendments to an already approved protocol for which a UQ Clinical Trials Protection/Insurance Form was originally submitted, then the researchers must directly notify the UQ Insurance Office of any changes to that Form and Participant Information Sheets & Consent Forms as a result of the amendments, before action.*

**Name of responsible Committee:** Behavioural & Social Sciences Ethical Review Committee

This project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research and complies with the regulations governing experimentation on humans.

**Name of Ethics Committee representative:**
Associate Professor John McLean  
Chairperson  
Behavioural & Social Sciences Ethical Review Committee

**Signature:**  
**Date:** 21/11/2014
28 September 2012

Mr Adam Burston
The University of Queensland
School of Nursing & Midwifery
Mater Hospital Clinical School
SOUTH BRISBANE QLD 4101

UNITINGCARE QUEENSLAND HUMAN RESEARCH ETHICS COMMITTEE
Reference Number: Burston 12912
Study Title: The Australian Aged-Care Nurse: Improving workplace satisfaction and staff retention

Dear Adam
Thank you for your responses to the issues raised in our Outcome letter to you dated 17 July 2012.

The Committee has granted approval for you to proceed with the study and would like to wish you well with this important work.

If you have any further questions, please contact: Ms Pat Patterson, UCQ HREC Coordinator on 07 3025-2000 or (patricia.patterson@ucareqld.com.au).

Yours sincerely

[Signature]

Ms Colleen Geyer
Chair, UnitingCare Queensland Human Research Ethics Committee
Appendix F - Phase 1 Participant Information Sheet

PROJECT TITLE
The Australian Aged Care Nurse: Improving workplace satisfaction and staff retention.

Principal Investigator
Mr Adam Burston
Research Higher Degree Candidate,
The University of Queensland, School of Nursing & Midwifery
P: 07 3623 7556  E: adam.burston@uq.net.au

Research Supervisors
Dr Anthony Tuckett
Deputy Director, The University of Queensland / Blue Care Research & Practice Development Centre
Associate Professor Deborah Parker
Director, The University of Queensland / Blue Care Research & Practice Development Centre
Dr Robert Ely
Academic Research Manager, The University of Queensland - Princess Alexandra Hospital, Emergency Department Research Program

Aim of the Research
The aim of this research is to explore the experience of moral distress for Aged Care nurses in Queensland, Australia. Moral distress is a situation that arises when a nurse has made a choice on a particular course of moral action, but then finds she/he is restricted from pursuing that chosen course. Minimal research exploring moral distress in either the Australian or the Aged Care contexts exists.

Your Involvement in the Project
If you wish to participate, you will be asked to participate in a semi-structured interview exploring moral distress. The interview should take approximately 30 - 40 minutes to complete.

Your Voluntary Participation
Participation in the research is voluntary. You may withdraw from the research at any time without penalty. Withdrawal from the study will in no way affect your relationship with either the investigators or your employer.

Benefits of the Research
The relevance resides in the implications moral distress has on you, the nurse, and the nursing workforce more broadly. An ageing population, an ageing nursing workforce and increasing demands for service efficiency all impact on the quality of care you can deliver. Data from the interviews will inform the development of interventions specifically targeted to improving the quality of your working environment.

Risks
It is acknowledged that you will be asked to consider situations you may have found distressing. If you experience any unresolved issues and feel you would benefit from some additional support, Blue Care’s Employee Assistance Program (EAP) offers confidential counselling through an independent organisation. This service can be accessed by calling 1800 172 069.
Appendix F - Phase 1 Participant Information Sheet

Chaplaincy Support
Blue Care also offers chaplaincy support for employees. The following chaplains can be contacted for support:

**Metro North**
- Gary Ayre Deagon Yallambee 5499 6025; Wendy Kevble Nazarene / Girraween / Pilgrim / Redcliffe Community Services 0414 816 660; Jill McNeely, Pinewoods 3881 1626; Lynne Gibson Jona Nursing Centre / Tarry Brae / Henderson Respite 0419 650 468; Brian Murphy Northside Centre 0410 608 674.

**Metro South**
- Peter Hobson Wirunya / Springwood, Burremah Place / Bethania 0410 596 125; Merv Brooks Redland Community Services / Nandeebie / Yarrabee / Yurana 0405 327 411; Trevor Gibson Pleasantville Wynnum/Mt Gravatt & West End Respite 0416 186 459; Dennis Harth Southside Community Care 0410 578 792; Harold Kilah Salvin Park / Carramar 0404 831 254.

**Ipswich**
- Kelly Braun Ipswich Community Care 0431 794 785; Lyn Favelle Ipswich Community / Ipswich Respite 0404 801 373; Kaitlyn Gordon Ipswich Community / Ipswich Respite 3281 8444.

**South Coast**
- Barbara Jones 0435 824 474; Helen Dick 0419 787 242; Nanette Bicket 0419 744 801.

Confidentiality
No specific identifying information will be requested during the interview. All collected data including written and recorded transcripts will be stored in a secure manner. Data will not be shared with third parties.

Storage of Data & Data Sharing
Written documentation and the electronic recording device related to the interviews will be stored in a locked filing cabinet within a secure office facility. Electronic data will be stored on a university server and the Principal Investigator’s computer hard drive. All electronic data will be password protected.

Feedback Available to You
If you feel you would like to discuss the research further or access a report of the findings from this study, you may contact the Principal Investigator adam.burston@uq.net.au directly.

This study has been cleared by a human research ethics committee of The University of Queensland in accordance with the National Health and Medical Research Council’s guidelines. If you would like to speak to an officer of the University not involved in the study, you may contact the UQ Ethics Officer on 3365 3924. You are of course free to discuss your participation in this study with project staff (Primary Supervisor Dr Anthony Tuckett, 07-3720 5405, a.tuckett@uq.edu.au).

Ethics approval for the study from the UnitingCare Queensland Human Research Ethics Committee (UCQHREC) has also been obtained. If you would like to discuss the study with a representative of Uniting Care not associated with the project, the committee can be contacted via the HREC Coordinator Patricia Patterson at HREC@unicareqld.com.au.
<table>
<thead>
<tr>
<th>Root Cause</th>
<th>MDS-R</th>
<th>Proposed MDS – R (Aged Care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2, 3</td>
<td>1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.</td>
<td>1. Provide less than optimal care due to pressures from administrators / supervisors to reduce costs.</td>
</tr>
<tr>
<td>1</td>
<td>2. Witness healthcare providers giving “false hope” to a patient or family.</td>
<td>2. Witness healthcare providers giving “false hope” to a client or family.</td>
</tr>
<tr>
<td>2, 3</td>
<td>3. Follow the family’s wishes to continue life support even though I believe it is not in the best interest of the patient.</td>
<td>3. Follow the family’s wishes to delay palliative measures, even though I believe it is not in the best interest of the client.</td>
</tr>
<tr>
<td>1, 2</td>
<td>4. Initiate extensive life-saving actions when I think they only prolong death.</td>
<td>4. Initiate life-saving actions when I think they only prolong death.</td>
</tr>
<tr>
<td>1, 2</td>
<td>5. Follow the family’s request not to discuss death with a dying patient who asks about dying.</td>
<td>5. Follow the family’s request not to discuss death with a dying client who asks about dying.</td>
</tr>
<tr>
<td>1, 2, 3</td>
<td>6. Carry out the physician’s orders for what I consider to be unnecessary tests and treatments.</td>
<td>6. Carry out doctor’s orders for what I consider to be unnecessary tests and treatments.</td>
</tr>
<tr>
<td>1, 2</td>
<td>7. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.</td>
<td>7. Continue to participate in care for a hopelessly ill person who is being sustained by medical treatments, when no one will make a decision to withdraw support.</td>
</tr>
<tr>
<td>2, 3</td>
<td>8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.</td>
<td>8. Avoid taking action when I learn that a doctor or nurse colleague has made a medical error and does not report it.</td>
</tr>
<tr>
<td>2, 3</td>
<td>9. Assist a physician who, in my opinion, is providing incompetent care.</td>
<td>9. Assist a doctor who, in my opinion, is providing incompetent care.</td>
</tr>
<tr>
<td>2, 3</td>
<td>10. Be required to care for patients I don’t feel qualified to care for.</td>
<td>10. Be required to care for clients I don’t feel qualified to care for.</td>
</tr>
<tr>
<td>1, 3</td>
<td>11. Witness medical students perform painful procedures on patients solely to increase their skill.</td>
<td>Deleted from instrument.</td>
</tr>
<tr>
<td>1, 2, 3</td>
<td>12. Provide care that does not relieve the patient’s suffering because the physician fears that increasing the dose of pain medication will cause death.</td>
<td>12. Provide care that does not relieve the client’s suffering because the doctor fears that increasing the dose of pain medication will cause death.</td>
</tr>
<tr>
<td>1, 2</td>
<td>13. Follow the physician’s request not to discuss the patient’s prognosis with the patient or family.</td>
<td>13. Follow the doctor’s request not to discuss the patient’s prognosis with the client or family.</td>
</tr>
</tbody>
</table>
14. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient’s death.

14. Increase the dose of sedatives/opiates for an unconscious client that I believe could hasten the client’s death.

15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.

15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.

16. Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit.

16. Follow the family’s wishes for the client’s care when I do not agree with them, but do so because of fears of a lawsuit.

17. Work with nurses or other healthcare providers who are not as competent as the patient care requires.

17. Work with nurses or other healthcare providers who are not as competent as the client care requires.

18. Witness diminished patient care quality due to poor team communication.

18. Witness diminished client care quality due to poor team communication.

19. Ignore situations in which patients have not been given adequate information to insure informed consent.

19. Ignore situations in which clients have not been given adequate information to insure informed consent.

20. Watch patient care suffer because of a lack of provider continuity.

20. Watch client care suffer because of a lack of provider continuity.

21. Work with levels of nurse or other care provider staffing that I consider unsafe.

21. Work with levels of nurse or other care provider staffing that I consider unsafe.

If there are other situations in which you have felt moral distress, please write them and score them here:

Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

No, I’ve never considered quitting or left a position ______
Yes, I considered quitting but did not leave ______
Yes, I left a position ______

Are you considering leaving your position now? Yes  No
Appendix G - Phase 1 Instrument Amendments

**Amendments**

Physician changed to doctor in all relevant items.

Patient changed to client in all relevant items.

Item 1 – insurer removed, supervisor added as believed AIN particularly may not have much interaction with ‘executive’ level staffs.

Item 2 – no change.

Item 3 – “continue life support” changed to “delay palliative measures” to better reflect the reality of aged care.

Item 4 – ‘extensive’ removed to better reflect the reality of aged care.

Item 5 – no change.

Item 6 – no change.

Item 7 – “sustained on a ventilator” changed to “sustained by medical treatments” to better reflect the reality of aged care.

Item 8 – no change.

Item 9 – no change.

Item 10 - no change.

Item 11 – deleted as not deemed relevant to aged care.

Item 12 – no change.

Item 13 – no change.
Appendix G - Phase 1 Instrument Amendments

Item 14 – no change.

Item 15 – no change.

Item 16 – no change.

Item 17 – no change.

Item 18 – no change.

Item 19 – no change.

Item 20 – no change.

Item 21 – no change.

Final Question – no change.
Questions for Qualitative Phase of Study

1. Consent
   a) Have you read and understood the participant sheet?
   b) I will then read through the questions on the consent form and ask you to answer them.

2. Demographic Information
   a) Year of birth: _______________________
   b) I am employed as (RN/EN/PCA): _________________________
   c) Years working in nursing: ______________________________
   d) Years working in my current facility / service: __________________________

3. Focus questions for Semi-structured interview
   a) Can you tell me what you think moral distress is?
   b) In what ways do you think moral distress affects your work or you?
   c) If people are experiencing moral distress in your workplace how do you think this affects you and others?
   d) Is there anything that can be done in your workplace that might limit the moral distress that you or other people experience?
   e) Is there anything else you would like to share with me about moral distress?
### Scenario 1

You currently work in the East wing of a Residential Aged Care facility, and have worked there for just over 3 years. You know the residents quite well and over the last 3 years have noticed an increase in the level of care they need. Mrs Anastas is a 72 year old who, due to rheumatoid arthritis, increasingly needs assistance with hygiene, toileting and dressing. She is mentally alert and participates in activities such as arts and crafts, board games and group exercise classes. Today she told you that she is “frustrated because nurses aren’t spending enough time with me to meet my needs”. She complains that “everyone used to have more time”.

<table>
<thead>
<tr>
<th>1. What does this situation mean to you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. What do you feel about this situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Why do you feel this way?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. What would you do in this situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response:</td>
</tr>
</tbody>
</table>
**Scenario 2**

Mr Smith is an 84 year old man who has been a resident at your facility for the last 11 ½ years. Initially he only required low level assistance with care however over time his care needs have increased significantly. He has a medical history including Type 2 diabetes mellitus, a left below knee amputation, and inoperable lung cancer. He requires full assistance with activities of daily living and is doubly incontinent. One week ago he became unwell with a chest infection, for which he was started on oral antibiotics. Despite this treatment the infection has become worse, with Mr Smith coughing up large amounts of purulent green sputum. A member of the nursing team has just noticed in the medical record that Mr Smith’s doctor has been in to see him and has requested Mr Smith be transferred to hospital for more advanced treatment.

<table>
<thead>
<tr>
<th>1. What does this situation mean to you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. What do you feel about this situation?</th>
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<tbody>
<tr>
<td>Response:</td>
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<tr>
<td></td>
</tr>
</tbody>
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<th>3. Why do you feel this way?</th>
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<tr>
<td>Response:</td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. What would you do in this situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Institutional Human Research Ethics Approval

**Project Title:** The Australian Aged Care Nurse: Improving Workplace Satisfaction And Staff Retention - 23/12/2015 - AMENDMENT

**Chief Investigator:** Mr Adam Burston

**Supervisor:** Dr Anthony Tuckett, A/Prof Deborah Parker, Dr Robert Eley

**Co-Investigator(s):** None

**School(s):** School of Nursing and Midwifery, Faculty of Health Sciences

**Approval Number:** 2012000659

**Granting Agency/Degree:** Doctor of Philosophy

**Duration:** 31st December 2017

**Comments/Conditions:**

---

**Note:** If this approval is for amendments to an already approved protocol for which a UQ Clinical Trials Protection/Inclusion Form was originally submitted, then the researcher must directly notify the UQ Insurance Office of any changes to that Form and Participant Information Sheet(s) & Consent Forms as a result of the amendments, before action.

**Name of responsible Committee:** Behavioural & Social Sciences Ethical Review Committee

This project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research and complies with the regulations governing experimentation on humans.

**Name of Ethics Committee representative:** Associate Professor John McLean

**Chairperson:** Behavioural & Social Sciences Ethical Review Committee

---

**Signature**  

**Date** 12/11/2016
Appendix K - Phase 2 Participant Information Sheet

PROJECT TITLE
The Australian Aged Care Nurse: improving workplace satisfaction and staff retention.

Principal Investigator
Mr Adam Burston
Research Higher Degree Candidate,
The University of Queensland, School of Nursing & Midwifery
P: 07 3623 7556 E: adam.burston@uq.edu.au

Research Supervisors
Dr Anthony Tuckett
Deputy Director, The University of Queensland / Blue Care Research & Practice Development Centre

Associate Professor Deborah Parker
Director, The University of Queensland / Blue Care Research & Practice Development Centre

Dr Robert Ely
Academic Research Manager, The University of Queensland - Princess Alexandra Hospital, Emergency Department Research Program

Aim of the Research
The aim of this study is to adapt and pilot test a survey instrument to measure the intensity and frequency of the moral distress experience for Aged Care nurses in Queensland, Australia. Moral distress is a situation that arises when a nurse has made a choice on a particular course of moral action, but then finds she/he is restricted from pursuing that chosen course. Minimal research exploring moral distress in either the Australian or the Aged Care contexts exists.

Your Involvement in the Project
If you wish to participate, you will be asked to complete a survey investigating moral distress. Completing the paper-based survey will be taken as implied consent to participate. The survey should take approximately 20 minutes to complete.

Your Voluntary Participation
Participation in the research is voluntary. You may withdraw from the research at any time without penalty, simply by not completing the survey. Withdrawal from the study will in no way affect your relationship with either the investigators or your employer.

Benefits of the Research
The relevance resides in the implications moral distress has on you, the nurse, and the nursing workforce more broadly. An ageing population, an ageing nursing workforce and increasing demands for service efficiency all impact on the quality of care you can deliver. This initial study will provide a platform for future research designed to provide significant and tangible data on the intensity and frequency of moral distress in the Australian Aged Care workforce; which will inform the development of interventions specifically targeted to improving the quality of your working environment.
Appendix K - Phase 2 Participant Information Sheet

Risks

While the structure of the questionnaire will not allow you to clearly identify any specific state of moral distress, we do recognize that engaging in the survey requires you to consider situations you may have experienced as distressing. If you experience any unresolved issues and feel you would benefit from some additional support, Blue Care’s Employee Assistance Program (EAP) offers confidential counselling through an independent organisation. This service can be accessed by calling 1800 172 069.

Confidentiality

The questionnaire is designed in such a way that information provided cannot be traced back to any individual participant. No specific identifying information will be requested. All collected data will be stored in a secure manner.

Storage of Data & Data Sharing

Paper-based surveys will be stored in a locked filing cabinet within a secure office. Paper-based surveys will also be scanned for electronic storage. Electronic data will be stored on a university server and the Principal Investigator’s computer hard drive. All electronic data will be password protected.

Dr Ann Hamric, who is both a Professor in the School of Nursing & Associate Dean of Academic Programs at Virginia Commonwealth University, has been heavily involved in recent years with the development and testing of the survey instrument. Dr Hamric has requested that any data collected be shared with her to assist in further validating the quality of the survey instrument. All data shared will be thoroughly de-identified and will in no way be able to be traced back to an individual survey respondent.

Feedback Available to You

There will be no direct feedback given to individual participants after completion of the survey, however if you feel you would like to discuss the research further or access a report of the findings from this study, you may contact the Principal Investigator adam.burston@uq.net.au directly.

This study has been cleared by one of the human ethics committees of the University of Queensland in accordance with the National Health and Medical Research Council’s guidelines. If you would like to speak to an officer of the University not involved in the study, you may contact the UQ Ethics Officer on 3365 3924. You are of course free to discuss your participation in this study with project staff (Primary Supervisor contactable on 07-3720 5405, a.tuckett@uq.edu.au).
### Appendix L - Example of coding

#### Scenario 2, Question 1 – What does this situation mean to you?

<table>
<thead>
<tr>
<th>Participant</th>
<th>Verbatim Response</th>
<th>Initial thoughts / key words</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Disagree with doctors advanced treatment.</td>
<td>error in treatment decision</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>It’s a choice for Mr Smith, not me or other staff.</td>
<td>Pt choice (autonomy)</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Is he NFR, has Dr spoken to family He won’t necessarily be better off in hospital</td>
<td>incorrect option, ?consultative decision</td>
<td>1,3</td>
</tr>
<tr>
<td>4</td>
<td>This residents treatment should be ceased + NFR order be put in place for comfort measures only.</td>
<td>wrong treatment option</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Whilst I understand the Doctor has the patients physical best health in mind transferring him to hospital it may cause a lot of conflicting emotions i.e. Nurses get very fond of their patients and understand their needs as individuals</td>
<td>?</td>
<td>71</td>
</tr>
<tr>
<td>6</td>
<td>Fine if it is what he wants and the family wants. Not fine if he does not want advanced treatment.</td>
<td>Pt choice (autonomy)</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>At this stage in his life and with expected outcome better to be treated at nursing home.</td>
<td>wrong treatment option</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Firstly, it needs to be clarified what the resident wants. The resident plus/minus the family may have indicated that they wanted transfer in the event of deterioration. If it is documented that they do not wish transfer I would contact Mr Smiths Doctor to discuss further.</td>
<td>Pt choice (autonomy)</td>
<td>1,3,4</td>
</tr>
<tr>
<td>9</td>
<td>Need to be an advocate for the patient – delicate situation between pt, nursing &amp; medical staff. Need diplomacy. Difficult once again to be in the middle.</td>
<td>Advocacy role, difficult situation</td>
<td>4</td>
</tr>
</tbody>
</table>
## Appendix M - Example of categories

<table>
<thead>
<tr>
<th>Category Number</th>
<th>Category Heading</th>
<th>Participant Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Correctness of</td>
<td>#1 &quot;Disagre with doctors advanced treatment.&quot; #3 &quot;He won't necessarily be better off in hospital&quot; #4 &quot;This residents treatment should be ceased + NFR order be put in place for comfort measures only.&quot; #7 &quot;At this stage in his life and with expected outcome better to be treated at nursing home.&quot; #16 &quot;If he is not getting better it would be the best thing for him to go to hospital for other treatment&quot; #5 &quot;Whilst I understand the Doctor has the patients physical best health in mind transferring him to hospital it may cause a lot of conflicting emotions i.e. Nurses get very fond of their patients and understand their needs as individuals&quot;.</td>
</tr>
<tr>
<td>2</td>
<td>Autonomy</td>
<td>#2 &quot;It's a choice for Mr Smith, not me or other staff.&quot; #6 &quot;Fine if it is what he wants and the family wants. Not fine if he does not want advanced treatment.&quot; #8 &quot;Firstly, it needs to be clarified what the resident wants.&quot; #12 &quot;I think that Mr Smith might be receiving treatment he doesn't want, considering his age and other health issues.&quot;</td>
</tr>
<tr>
<td>3</td>
<td>Consultation</td>
<td>#3 &quot;Is he NFR, has Dr spoken to family?&quot; #8 &quot;The resident plus/minus the family may have indicated that they wanted transfer in the event of deterioration.&quot; #13 &quot;The resident and his family need to be consulted before being transferred.&quot;</td>
</tr>
<tr>
<td>4</td>
<td>Advocacy</td>
<td>#8 &quot;If it is documented that they do not wish transfer I would contact Mr Smith's Doctor to discuss further.&quot; #9 &quot;Need to be an advocate for the patient – delicate situation between pt, nursing &amp; medical staff.&quot;</td>
</tr>
</tbody>
</table>
## Appendix N - Example of themes

<table>
<thead>
<tr>
<th>Categories (Question 1 data only)</th>
<th>PHASE 2 (Stage 2) Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>no data on futility in response to question 1</td>
<td>Futility</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Consultation</td>
</tr>
<tr>
<td>Consultation Crisis</td>
<td></td>
</tr>
<tr>
<td>Correctness of decision</td>
<td>Decision Division</td>
</tr>
</tbody>
</table>
Appendix O - Example Observational Note

3C) "All you hear is bitching," same concerns specifically
dolled up, no one cares
(dolled up, getting out).

3D) Debrief sessions, staff meetings - not useful in dry run.
"Rush up to McDonald's" and quiet talk.
Feel alone & un-supported as community
Discord office vs road staff
Rostering - teams + regular care

(DN) "They talk about it" - much changed, "gotten worse."

3. Upper management need to be approachable "feel like you
would lose job."

(DN) Had "focus group" - only "yes men" invited. Token BS.
Not aware of discussion before rostering, but only works PT.
Appendix P - Example Theoretical Note

Theoretical Notes

"Family"

Resourcing
Task focus vs. Patient focus
All about money.
Family vs. resident needs.
Brief - unnecessary treatments (overuse, medication).

Frustrated, disempowered, distressed for client.
Cynical - as older doesn't see with new nurses.
"I've done the best I can." Coping mechanism.

6 quality of care
1. Stimulation for residents
2. Staff "short" with residents - thinks residents pick up on this.

De-personalised service.
Methodological Notes

- Someone who wanted to talk, how to keep focused without restricting it challenging
- Already some clear similarities between first two interviews (also some differences)
- Hard to focus on the interview content when mind want to start unpicking & understanding what it has heard
  
  Distressed, frustrated, angry