ATHABASCA UNIVERSITY

MORAL DISTRESS IN AN OVERCROWDED EMERGENCY DEPARTMENT: UNDERSTANDING THE NURSES' EXPERIENCE

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Approval of Thesis

The undersigned certify that they have read the thesis entitled

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The thesis examination committee certifies that the thesis
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Like a small boat
On the ocean
Sending big waves
Into motion
Like how a single word
Can make a heart open
I might only have one match
But I can make an explosion
This is my fight song
Take back my life song
Prove I'm alright song
My power's turned on
Starting right now I'll be strong
I'll play my fight song
And I don't really care if nobody else believes
'Cause I've still got a lot of fight left in me
Know I've still got a lot of fight left in me

Rachel Platten

Dedication

This work is dedicated to the seven nurses who participated in this study. Telling your stories was the constant motivation I held onto in my darkest times. Your truth needs to be heard. I hope that I have honoured you and that by staying the course, your voices will bring awareness and shed light on one of our darkest and worst kept secrets.

This work is also dedicated to the countless other emergency department nurses with similar stories of moral distress in overcrowded emergency departments. Your struggles are real and your feelings are valid. You all deserve to be heard.

To my friends and colleagues who live this life with me every day, we are bonded in the joys, and in the traumas of what we see and do every day. While I did not share your stories within this work, I have heard them, I have felt them, and this belongs to you.

Finally, this work is dedicated to JP. I will never forget where this work started. Your daughter was right; this is wrong, and no one should ever have to do this.

Acknowledgement

Completing this journey would not have been possible without the support I have received from a number of people over the last several years. I must begin with acknowledging my supervisor, Dr. Beth Perry. You have shown me nothing but kindness and grace with an insurmountable amount of patience. You have helped support my journey during some of my darkest and weakest moments and I will forever be grateful for the time that you allowed me to heal. You were always ready with everything that I have needed at exactly the right time. I would not be here today without you.

I also respectfully acknowledge committee member Rose Schroeder. I am grateful for your continued support and commitment to my work. I cannot imagine that I would be able to finish this work without you.

To Dr. Janet Storch, I am deeply appreciative and honoured to have met you. Having the opportunity to connect and share my work with you is humbling and I look forward to working together in the future.

To my family, you have given me the time and space that was needed to complete this work whether you wanted to or not. You have all given up as much as I have to allow me the privilege in completing my Master of Nursing.

Abstract

Nursing in the Emergency Department (ED) is a rewarding and dynamic challenge. ED nurses face challenges on the job every day and moral distress is one such example. Moral distress is a phenomenon that has been described in over 30 years of nursing literature but infrequently focuses on the challenges specific to the ED. In the ED environment nurses can face challenges related to overcrowding and are being forced to take care of their patients in hallways and other inappropriate care spaces, while other patients wait for extended periods in waiting rooms without treatment or assessment. This study employs a qualitative descriptive approach to examine the experience of moral distress in nurses who are working in overcrowded EDs. This thesis describes the ED nurses' experiences of moral distress when working in an overcrowded ED.

Keywords: emergency nursing, emergency department, moral distress, overcrowding, hallway nursing, qualitative descriptive research

Preface

I chose this research topic in part as a result of an experience I had when working as a nurse in an ED. To help set the context for this study, and to help make my positionality transparent, I begin with that story. A version of this reflection was published in *The Canadian Journal of Emergency Nursing,* Fall 2018.

I am Broken

On February 27, 2018 I worked what I would consider to be the worst shift ever in the Emergency Room. I am a nurse, and I love my job. I think I'm a pretty good nurse, certainly not the best, but rest assured, if you are my patient, I've got your back. I take pride in my credentials and abilities. I have tried to better myself by taking as many courses as I can. I try to stay up to date on things, I try to meet the standards that I am sure I have set way too high. I have been an RN for over 11 years, and an LPN for 2 years before that and never have I witnessed anything as heartbreaking as I did during this particular shift. To give that perspective, I have seen countless people die, of natural causes, old age, heart attacks and strokes. I have seen trauma. I have seen unspeakable things. Things most people cringe to hear about. I have asked for the organs, tissues and eyes of the dying and recently deceased before the bodies are even cold. I have watched parents collapse as they learn that we will be stopping CPR and resuscitation efforts of their child, I have placed the bodies of dead infants back into their mothers arms for the last time. I have handed still born babies to their mothers for the first and only time. I have seen bodies ripped apart, missing limbs, crushed and broken. I have seen abuse in all forms. I have carried the body of an infant in my arms to the morgue after she had her head crushed by a caregiver who threw her into a wall. I have seen what drugs and

alcohol do, not just to the person who did it one time, but also to the person who is dying from a lifetime of addiction. I have been part of many conversations where patients learn they will never be going home. I have explained diseases and disease processes to patients so they understand that their time on this earth is now limited. I have held the hands of those same patients and their families while the priest blesses them with Last Rights. I have been assaulted, by patients and their families, verbally and physically so many times I have lost count. I have found concealed weapons on patients who had intent to harm anyone in their way in order to escape police custody. I have done these things day after day, year after year, because it's been my job. I am a nurse and this is what I do, it is who I am. I have managed to separate the emotional baggage of these things from my life. They are horrible and unspeakable, but they happen... and when they do, I will be there with as much compassion and knowledge and experience as I can muster. Until last night... now I am unsure.

Our hospital is in crisis. I cannot see how anyone can dispute this. We run at or above capacity most days. With the rising population and lack of primary care for so many this will not end anytime soon. This causes a backlog of patients waiting in the ER. It causes patients to receive care in hallways and other inappropriate care areas throughout our hospital. This is simply undignified. Lack of safety aside, imagine feeling sick and miserable laying on a hospital stretcher, in a hospital gown, in the middle of the hallway. You are on display for everyone. Everything you do is seen and heard. Every question that is asked of you is heard. Every time you vomit, everyone sees it. Every time you go to the bathroom, everyone will know. There is rarely even the semblance of privacy. There are not half curtains or rolling screens in the ER, there are only open halls.

Last night, as is typical of most nights lately in the ER, the hallway was lined with patients. As I walked up the hall I passed a man who looked like he was struggling. His IV was stretched to the limit, he was half out of the bed, he appeared someone agitated and confused, he had a urinal bottle in one hand and a family member on each side of him. I quickly jumped in and rescued and secured his IV site and then asked about his obvious need to use the bathroom. His family were sure that given his current state he would not be able to walk the 20 feet down the hall to the bathroom, but he was desperate to go. The patient stood, in the hall, next to his stretcher while his family created a curtain around him with a flannel sheet. The patient then attempted to use the urinal. I am sure that due to his level of unwellness coupled with the awkwardness of the makeshift curtain, he was unable to use the urinal successfully. He urinated all over the floor, himself and my shoes. I lied and told him he was doing a great job, and looked to his daughter to see tears overflowing in her eyes. All she could say was "this is so wrong, no one should have to do this". I can only imagine how humiliated and embarrassed she felt, for herself and her father. I cannot imagine how angry I would have been if that had been my father. All I could think about was that this level of care is substandard. This is the level of care provided in third world countries. This should not be accepted in Canada, Island Health, the Victoria General Hospital or the ER. Of all the horrible things I have witnessed, this is it, this is what has broken me.

I was reviewing our Standards of Practice when doing my license renewal.

> 1-4. Takes action to promote the provision of safe, appropriate and ethical care to clients.
>
> 4-2. Provides care in a manner that preserves and protects client dignity.

Every time we put a patient in the hallway we fail on these standards. The patient is stripped of their dignity, confidentiality, safety and they are left exposed and vulnerable. Not one single staff member would be satisfied to have a member of their own family treated in this manner, why have we become so complacent as to continually accept it when it is someone else's family? I challenge you to explain why this is allowed to continue on a daily basis.

I do not know where to go from here. I do know that there needs to be a change. Soon. No more patients deserve to be treated like this. No more patients should be treated like we are in the third world. I have spent the last 24 hours questioning if I want to go back to work. I certainly don't want to, but I feel like I need to. I need to be part of the change, part of the solution. I don't have the answers, but I want to find them.

Until we all acknowledge the problem, report the problem and demand a change, there will be no change. This will become the status quo and complacency will rule. To my colleagues I ask that you push back and report the unsafe patient care. Report that you are not able to meet your standards. Force the change. To the management I ask that you listen, and act to support your staff and the patients. Would anyone of you really be happy to be treated this way?

Laura MacKinnon RN BSN ENC(c) CEN CPEN

Staff Nurse, Victoria General Hospital Emergency

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List of Abbreviations

RN – Registered Nurse

ED – Emergency Department

Chapter 1. Introduction

Introduction

Emergency department (ED) overcrowding in Canadian hospitals is not a new phenomenon. For more than 25 years there have been numerous news reports and scholarly literature documenting this reality (Affleck, et al., 2013). ED overcrowding is a "situation where the demand for emergency services exceeds the ability of an emergency ED to provide quality care within appropriate time frames" (Affleck, et al., 2013, p. 359).

ED overcrowding has negative effects on health care professionals as they may experience burnout resulting in reduced quality of care and even more strain on the caregivers and on the system. Varner (2023) reports that ED departments in Canada have staffing shortages and longer ED stays in part because patients remain in the ED since even after admission they cannot be moved to inpatient units as no beds are available. Varner predicts this situation will not change in the near future and the outcome is exhausted care providers (2023).

Background

The idea for this study arose from experiences I had as a registered nurse (RN) working in a very busy ED in a larger tertiary care hospital in an urban center in Canada. I experienced firsthand the effects of overcrowding on nurses and patients. As detailed in the Preface, the experience of working in such a challenging situation had negative effects on me and led to what I came to know as moral distress. I wanted to learn more about the experiences of other nurses working in a similar environment. My ultimate goal

was to conduct research that described the phenomena to be able to encourage and support change to improved nurse and patient well-being.

While the literature concludes that overcrowding in ED has many negative effects on nurses I am most interested in the outcome of moral distress (Hamilton-Houghtaling, 2012). To that end, the RNs experience of moral distress became the focus for my study.

Statement of Problem

Moral distress is a term being used more commonly today in the literature and is often referenced as one of the causes of burnout and nursing attrition (Hamilton-Houghtaling, 2012; Morley et al., 2019; Morley et al., 2020; Unruh, 2010). Moral distress in nursing literature pertains to the feelings experienced when the nurse knows the right thing to do but is unable to do it due to organizational constraints (Whitehead et al., 2014). There are several well-documented causes of moral distress including being involved with prolonged and aggressive resuscitation attempts and being compelled to follow doctors' orders that the nurse believes to be against patient wishes (Whitehead et al., 2014). The symptoms associated with moral distress are both emotional and physical and can be devastating to a nursing career. Nurses can be left feeling angry, frustrated, anxious, isolated, belittled, and embarrassed, all potentially contributing to job dissatisfaction and to the intent to leave the profession (CNA, 2017; Epstein & Delgado, 2010; Hamilton-Houghtaling, 2012 & Unruh, 2010).

Within the context of moral distress 'organizational constraints' can include a broad variety of situations. One area often overlooked in the literature is the overcrowded and over burdened medical system. In the ED overcrowding is caused when demand exceeds supply. That is, overcrowding happens when the number of patients and their

needs outweigh the resources available to safely manage their care (Yarmohammadian et al., 2017). Today's EDs are challenged with a variety of input, throughput, and output problems all contributing to a backlog of patients in the ED (Salehi et al., 2018). This backlog results in longer wait times to see physicians, longer wait times for a bed on an inpatient unit, and an increase in nursing workload (Affleck et al., 2013; Salehi et al., 2018). ED overcrowding has also been shown to lead to negative patient outcomes, including delayed treatments, delayed administration of pain medication, decreased patient satisfaction, and increased patient mortality (Johnson & Winkleman, 2011).

Purpose

The purpose of this study is to learn how ED nurses describe their experience of moral distress and how overcrowding impacts that experience.

Delimitations

While there are many health care providers working in EDs (i.e., physicians, respiratory technologists, licensed practical nurses), only the experiences of RNs are explored in this study.

Research Question

The purpose of this proposed qualitative research study is to examine how ED nurses describe their experience of moral distress while taking care of patients in overcrowded working conditions. The research question is: How do ED nurses describe their experience of moral distress when working in an overcrowded ED? Participants were asked to describe their experience with moral distress and how ED overcrowding in particular played a role in that experience.

Definition of Terms

There are several adaptations and variations to the original concept of moral distress presented by Jameton in 1984. Morely et al. (2019) reviewed and analyzed several definitions of moral distress. Jameton originally claimed that "moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (as cited in Morely et al., 2019, p. 652). From his original work, the concept of moral distress in nursing was born and research continues today to gain a deeper understanding of moral distress and of the impacts on health care providers.

Moral Distress

Several prominent definitions have been presented since Jameton's original publication. In their review, Morely et al. (2019) present several trends unique to many of the definitions provided of moral distress. Their review reveals that most definitions include some type of constraint, usually institutional, often there are psychological or even physical effects felt, and some type of moral compromise has taken place. Epstein and Hamric (2009) provide a definition encompassing all of the above stating "moral distress is the result of a perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action" (p. 331). After reviewing 20 definitions of moral distress, it is suggested that in order for moral distress to occur there must be a direct causal relationship between a moral event and psychological distress (Morley et al., 2019).

Moral Residue

After experiencing moral distress, nurses are left to work through the effects of the psychological distress and they must come to terms with feeling forced to act against their core values or ethical principles (Epstein & Delgado, 2010). What is left can be described as a wound or a scar that becomes part of the nurse and is then carried forward. This carrying forward of feelings is called moral residue. Webster and Bayliss best describe moral residue stating it "is that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised" (as cited in Epstein & Delgado, 2010, para 18).

Crescendo Effect

A situation that causes moral distress for a nurse can be very likely to repeat itself, especially if that incident is related to communication breakdowns or systems problems. When moral residue begins to build up (or is unresolved) Epstein and Hamric (2010) propose that a crescendo effect can happen. The crescendo effect occurs when a nurse experiences an event causing moral distress. The nurse works to resolve this, but is left with some moral residue. When another exposure happens, the level of moral distress increases again, higher than the first exposure. Resolution again leaves residue, and compounds creating a new baseline level of perpetual moral distress. As this cycle continues, the nurse begins to require less of a trigger in order to experience moral distress and the response felt by the nurse is often disproportional, or can be exaggerated, compared to earlier responses (Epstein & Hamric, 2010).

Moral Resilience

As nurses are gaining more understanding about moral distress they are looking for ways to help curb the negative effects it has both on them as people and on their careers. Moral resilience is suggested by some as something that a nurse can develop to help them cope with, or prevent, moral residue and the crescendo effect. Young and Rushton (2017) suggest that resiliency can be a tool for the nurse to use to fight the effects of moral distress and that it can help to promote personal growth. There is an argument against building resilience presented by Epstein and Hurst (2017), suggesting that moral distress is an alarm bell to a bigger problem. In order to become resilient to a distressing situation, we need to adapt or change how we view and deal with it. Epstein and Hurst (2017) argue that asking the nurse to be more resilient is equivocal to asking them to 'buck-up' and essentially points a finger back at the nurse indicating that not only do they feel terrible about the morally distressing event, but if they had better coping and resilience tools, they would not feel like this to begin with.

Summary

In this chapter the topic of overcrowding in EDs and the possibility of resulting moral distress in RNs is introduced. Background to the problem is provided and delimitations for the study described. The purpose of the study and the research question are presented. Key terms including moral distress, moral residue, crescendo effect, and moral resiliency are defined.

Chapter 2. Review of the Literature

Introduction

This literature review outlines the current available literature on moral distress in the ED. The focus of this review is an examination of the current qualitative and quantitative research. Geography was considered to be an important factor in determining inclusion criteria. While moral distress occurring across the globe is discussed in the literature, Morley et al., (2020) suggest that how we define and experience moral distress has a cultural and/or geographical component.

Searches

This literature review was conducted by searching simultaneously using the databases CINAHL Complete and Medline with full text. Inclusion criteria for this search were limited to peer reviewed, full text articles in the English language. The search was limited further to include dates from 2015-2020 and geographically to North America. Results that did not include RNs as part of the sample were excluded as well as any that did not include an ED perspective. Using these limitations and the terms *Moral Distress* AND *Emergency Department* AND *Crowding* resulted in only 1 article. This article was excluded from review for not including nurses in their sample. Using these same limitations and changing the terms to *Moral Distress* AND *Emergency Nursing* AND *Crowding* yielded no new results, with the terms *Moral Distress* AND *Emergency* AND *Hallway,* 1 further article was located but also was not included as it did not include any recent research.

To expand the search, the same inclusion and exclusion criteria as above were used with only the terms *Moral Distress* AND *Emergency Department*. This search

yielded 17 new items and on review of the abstracts, two qualitative studies and two quantitative studies met inclusion criteria. On further review, one of these quantitative studies was discarded due to its sample consisting of only nurse practitioners and not of registered nurses. Using the terms *Moral Distress* AND *Emergency Nursing* delivered no further results. When dates were expanded to include articles written between 2005 and 2020, one additional quantitative was located that met criteria for review. While the focus for this review remains on North American research, two qualitative studies were located and will be reviewed separately that are not focused on the North American context.

Google Scholar was also utilized using the search terms *Moral Distress* AND *Emergency Nursing* AND *Overcrowding* OR *Hallway* in a variety of combinations. A combination of doctoral dissertations and masters theses were found, including one by a Canadian author, although none were included in this review.

Quantitative Studies

Fernandez-Parsons and Goyal (2013) used a cross-sectional, descriptive design to assess moral distress experienced by ED nurses. This scale was originally developed by Corley in 2001, and revised by Hamric in 2010, and involves a 21 item Likert type questionnaire to gauge what may be causing moral distress, how frequently these events occur, and how disturbing these events are for the participant (Fernandez-Parsons & Goyal, 2013). Fifty-one participants from one community hospital in northern California contributed to the results showing that overall, ED nurses had a low level of moral distress. Nurses in this study reported feeling the most distressed about providing futile care and working with other health care providers who were believed to not be

competent. Fernandez-Parsons and Goyal (2013) state that ED nurses may have significantly lower levels of moral distress compared to ICU nurses due to the length of time spent with their patients (hours vs days). This study was limited by being the first to use the MDS-R in an ED setting and by its relatively small sample size (Fernandez-Parsons & Goyal, 2013). No demographic information was provided by the authors, citing anonymity, further limiting any generalizability for this study.

Zavotsky and Chan (2016) also took a quantitative approach to studying moral distress. 198 participants from across the United States took part in their study which set out to examine the relationship between moral distress in ED nurses and coping within that group. Using the MDS-R, Zavotsky and Chan (2016) were able to show that ED nurses experience moral distress with a similar frequency (mean 1.29) and intensity (mean 2.46) as nurses in Fernandez-Parsons and Goyal's 2013 study. Zavotsky and Chan (2016) also included a researcher developed survey using a similar 4-point Likert scale for participants to report on some ED specific clinical moral and ethical experiences. Unfortunately, this survey was not published for review as part of this publication, but Zavotsky and Chan (2016) report the highest frequency encounters were related to overcrowding of the ED (mean 3.7). Further to that, they report a strong and significant relationship between moral distress and overcrowding (Zavotsky & Chan, 2016). While some demographic data were collected and reported, this study did not collect data indicating race, ethnicity, or geographic location limiting generalizability.

Qualitative Studies

Both qualitative studies located for this review examined how the ED nurse experienced moral distress. Wolf et al. (2016) adopted an exploratory design and enrolled

17 participants from a variety of locations across the United States to participate in one of two focus groups. A moderator led a semi-structured interview to guide the participants through a series of questions while a second researcher audio-taped and made notes during the interview. An iterative process was used by the researchers to determine themes using a thematic analysis approach. This was followed by several rounds of discussion before the investigators landed on final themes and categories. A phenomenological design was used by Robinson and Stinson (2016) to examine 8 ED nurses' experience of moral distress. Participants in this study were all working in an ED in the south central United States. The researchers used a structured open-ended interview technique and analyzed the data using the 7-step method described by Colaizzi et al. (Robinson & Stinson, 2016).

Nurses reported feeling overwhelmed by patient volume and flow, concerning staffing levels, concerning quality and safety of patient care, feelings of guilt, feeling emotionless, and some reported that moral distress was causing negative changes to their personality (Robinson & Stinson, 2016; Wolf et al., 2016). ED nurses spoke directly to not being able to provide the care that they felt their patients deserved and they linked this to the 'dysfunctional' environment that exists within the ED (Wolf et al., 2016). This idea that the ED is dysfunctional should be highlighted as it is unclear whether the nurses are referencing the baseline chaos that exists (and is typical of many EDs) or if they are using the term dysfunctional more broadly referring to deeper issues that may include overcrowding, access block, and hallway nursing.

Both qualitative studies contained a small sample size and while this is typical within a qualitative methodology, it is potentially limiting in terms of generalizability.

The sample obtained by Wolf et al. (2016), was geographically diverse, however, the research done by Robinson and Stinson (2016), is further limited by its geography. The participants selected by Wolf et al. were recruited from a convenience sample of those registered for the Emergency Nurses Association annual conference. These participants present a bias towards higher education with the majority having achieved baccalaureate or masters level degrees and may already have a greater understanding of moral distress and its effects (Wolf et al., 2016).

Beyond North America

Kilcoyne and Dowling (2007) conducted an interpretive phenomenological study in Ireland with accident and emergency (A&E) nurses regarding their perspectives on overcrowding experiences. A purposeful sample of 11 A&E nurses were interviewed using unstructured interviews. Colaizzi's framework for data analysis revealed three themes which included restricted space, lack of care, and inability to influence. Kilcoyne and Dowling (2007) showed that an overcrowded emergency department contributes to the development of moral distress by limiting or preventing nurses from providing what the nurses believe to be quality care to their patients in a safe and dignified manner.

Transferability of the study findings outside of Ireland may be limited due to differences in the culture of healthcare in general and emergency medicine in Ireland compared to other countries. While this study did enrol registered nurses from Ireland, the working environment, scope of practice, and job descriptions may be significantly different in other countries and thus the perception of overcrowding may be different as well.

Eriksson et al., (2018) used semi structured interviews to explore nurses' perceptions of safe care in crowded EDs in Sweden. Fourteen nurses, 11 female and 3 male, were enrolled in this qualitative descriptive analysis study. Nurses described difficulty performing essential care, compromised patient safety and privacy, and denying a patient dignified care all as a result of prolonged stays in the ED (Eriksson et al., 2018). Further to this, participants reported that care was provided in inappropriate spaces stemming as a result of overcrowding (Eriksson et al., 2018). Limitations of this study include a small sample size, participants working in large 1000+ bed hospitals, and geographic location, results are in line with the study done 10 years earlier by Kilcoyne and Dowling (Eriksson et al., 2018).

Impact on the ED

Within the context of ED overcrowding, the constraint that causes moral distress becomes the access block that is created when patients begin to amass in the ED instead of moving to more appropriate in-patient units. This access block is described by Affleck et al. (2013) as stemming from changes in availability of timely primary care and delays in Altered Level of Care (ALC) patients moving out of acute care beds and into appropriate placement beds. The access block, and resulting increased workload, results in some of the negative outcomes previously discussed including delays in care and treatment and increased negative outcomes for patients (Affleck, et al., 2013). The nurse is left to choose which patients will be prioritized for timely treatments, or in some cases, which patients receive treatment at all, as some patients are left in waiting rooms, or placed on stretchers in hallways (and other inappropriate care areas) to await treatments.

Gaps in the Literature

Very little research has been done examining moral distress in ED nurses. The quantitative research that is done often uses the same MDS-R scale that is used by other investigators in other specialties such as ICU and NICU. The MDS-R was previously validated in the ICU and may not be transferable to the ED (Fernandez-Parsons & Goyal, 2013). While some of the Likert questions on the MDS-R are relevant in the ED, there is nothing on the scale to assess how, or if, some of the systems constraints specific to the ED are affecting nurses in this area (Robinson & Stinson, 2016). While other in-patient units typically are able to close their doors to an excessive volume of incoming patients, and may essentially avoid hallway nursing completely, the ED rarely, if ever has this luxury. It is important to examine how overcrowding impacts nurses in the ED in relation to moral distress in order to help point the spotlight of needed change. Affleck et al. (2013) claim that ED overcrowding is becoming a daily occurrence across many Canadian EDs and that "patient suffering, prolonged wait times, deteriorating levels of service, adverse patient outcomes, and the ability to retain experienced staff" (p. 359) are all symptoms of this problem. These symptoms can likely be categorized as some of the 'organization constraints' that lead to moral distress in nurses. Further research then needs to be done to explore the experience of moral distress in nurses within the context of overcrowding in the ED.

Summary

Since described over 30 years ago by Jameton, moral distress has become a popular term in the literature. As research has been done we have been able to expand our knowledge and understanding of what moral distress is, to include how it affects

nurses, and determine what the negative implications may be. We also have a greater understanding of the longer term effects and what can happen if moral distress is not dealt with effectively. Development of moral distress theory is ongoing and the MDS-R has been validated as an effective way to measure moral distress. Research has been focused in the past on specialty areas or situations outside of the ED, leaving gaps in knowledge about the occurrence of moral distress areas of emergency nursing, and in situations related to some of the bigger systems or organizational constraints that are known to cause moral distress. Further research needs to take place in the ED to examine the experience of moral distress on ED nurses within the context of overcrowding.

Chapter 3. Theoretical Framework

Underlying Philosophical Position

Creswell and Poth (2018) describe constructivism as knowledge resulting from interactions between people and their environments. Further, the researcher's beliefs and values influence the knowledge that is constructed. I acknowledge that as the tool of data collection and analysis for this qualitative study I bring influence the findings of the study. I also acknowledge that as unique individuals each participant brings their own reality to their answers to the research question. I acknowledge that each participant has their own viewpoint and truth and likewise I have my own biases (conscious and unconscious) because of being a RN who works in an ED.

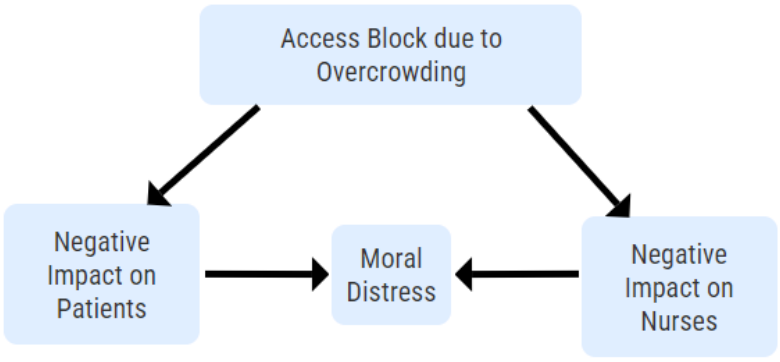
Because I was also an ED RN there was a relationship between me and the study participants. This relationship between the researcher and participants required me to conduct the study in a sensitive and respectful manner. By including verbatim quotes in the findings I am demonstrating respect for their voices in this study.

Linking Concepts from the Literature

The literature provides a foundation for this study. The following figure illustrates how key concepts that inform this study may be linked.

Figure 1

Conceptual Framework



Chapter 4. Methodology

Introduction

This chapter provides an introduction to the methodology used in this study. I detail the research question, describe participants, discuss my sampling process (including inclusion and exclusion criteria), review ethical considerations, detail approaches used to ensure trustworthiness of the study, and describe the data analysis process.

Qualitative Description

Qualitative description has been described as a research method that lacks sophistication, is unsexy and the lowest rung of methodology (Bradshaw et al., 2017; Doyle et al., 2020; Sandelowski, 2000). Others such as Sullivan-Bolyai et al. (2005) explain that the goal of qualitative description is "not thick description (ethnography), theory development (grounded theory), or interpretative meaning of an experience (phenomenology) but a rich description of the experience depicted in easily understood language" (p. 128). Bradshaw et al. (2017), also contrasts this method against others suggesting that it incorporates characteristics of qualitative research without a narrow focus as in ethnography, phenomenology, and grounded theory. Qualitative description is best used by those seeking to provide an in depth description of an experience (Bradshaw et al., 2017). The experience described is often one in which little is known or has not previously been reported on (Bradshaw et al., 2017; Doyle et al., 2020). Descriptive research uses a literal and simple or straightforward description of the experience and perceptions of the participants (Bradshaw et al., 2017; Doyle et al., 2020; Sandelowski,

2000). Researchers employing this methodology seek to answer the who, what, where, and why of events or experiences (Bradshaw et al., 2017; Sandelowski, 2000).

Qualitative description was used in this study to gain an understanding of the experience of moral distress in ED nurses. While moral distress has been studied now for over 30 years, very little of the literature has focused on the experiences in the ED as demonstrated in the literature review. Even less literature discusses or elaborates on any relationship between moral distress and overcrowding. Qualitative description lends itself well to health care and nursing focused research by describing the experience of participants to help in the development of policy, health interventions, health promotion and quality of life (Doyle et al., 2020). In a master's level thesis, qualitative descriptive research is suited to the novice researcher (Doyle et al., 2020).

I acknowledge that as an ED nurse myself that has experienced moral distress, I bring biases to data gathering and analysis. I realize that these biases can never fully be managed but to minimize influence I had on the study I engaged in ongoing self-reflection and reflexivity. I kept a journal throughout the research process to document my perceptions, thoughts, and feelings and to help me reflect on how the research affected me. I thought about my biases and continually shared my reflections with my supervisor. I also provided in the preface a story of my own moral distress related to overcrowding in the ED so that readers will be aware of my experiences and the potential that I could have introduced bias to the findings.

Research question

As stated earlier, the purpose of this study is to examine how ED nurses describe their experience of moral distress while taking care of patients in overcrowded working

conditions. The research question is: How do ED nurses describe their experience of moral distress when working in an overcrowded ED? Participants were asked to describe their experience with moral distress and how ED overcrowding in particular played a role in that experience.

Research Design

Participants

Participants in this study were all RNs who were currently working (or who had worked) in an ED department. A total of seven RNs who met the inclusion criteria participated in the study.

Sampling

Purposive sampling is often used in qualitative research and allows for selection of participants who have experience in (or with) the subject being studied (Bradshaw et al., 2017; Sandelowski, 2000). Purposive sampling helps to ensure that participants are able to provide a rich and in-depth account of their experiences (Sandelowski, 2000). The research question for this study does not inquire as to whether or not moral distress *is* experienced, but is looking to examine the experience of those who *do* experience it. This study employs a purposive sampling technique to ensure that participants have experienced moral distress and exclusion criteria was set to eliminate any potential participants who stated that they have not experienced moral distress.

Participants were recruited using a poster promoted through email and social media by collaboration with the National Emergency Nurses Association (NENA). The objectives of NENA are to promote the “highest standards and practices in emergency nursing and emergency departments across Canada [and to] promote the professional and

skill development of emergency nurses" (NENA, 2021). NENA's membership is over 1000 strong and consists of members across Canada (NENA, 2021). Potential participants emailed me and were screened for inclusion and exclusion criteria before being invited to participate in the study.

Inclusion and Exclusion Criteria

For this study, study participants had to be RNs currently working in the ED. RNs who had recently left the ED within the last year were also considered as participants if they met the other inclusion criteria because their experiences held significant value to the study. Participants were required to have worked in the ED for at least one year.

Potential study participants were excluded if they were not currently working in a Canadian ED. NENA welcomes members from all over the world, so it is possible that a non-Canadian nurse could have expressed interest in joining the study. Potential study participants were excluded if they are not RNs. Licensed Practical Nurses and Registered Psychiatric Nurses (LPNs and RPNs) were excluded. RNs working within the ED but not taking care of ED patients were excluded. This included but not limited to, youth mental health nurses, liaison nurses and med-surg float nurses. Potential participants were excluded if they had not been practicing in a clinical setting 'at the bedside' providing hands on care to patients within the last year. This category included, but was not limited to, educators, managers, and hospital leadership. Nurses working in the ED for less than one year were excluded. Finally, potential participants were excluded if they denied having experienced moral distress in the ED due to overcrowding issues. The purpose of this study was to examine the experience of nurses who *had* experienced moral distress

in an overcrowded ED, therefore, if they had not experienced this situation they were excluded.

Finally, any RNs who met the other inclusion criteria, but who were currently in a working relationship with me were excluded. I currently still work in an ED and have held a position there for the last 12 years. While I do not hold a position of management, and have no formal 'power over' relationship with staff, a pre-existing relationship may present a conflict of interest or expose an underlying bias.

Ethical considerations

Ethics approval was received from the Athabasca University Research Ethics Board prior to study commencement. Participants' confidentiality was maintained by removing all names and identifiers and by giving participants numbers. Data is stored electronically, including consent forms, emails, audio recordings, and transcriptions on a password protected flash drive. Data will be kept for a period of five years before being destroyed.

The experiences and the stories that the participants shared include details of patient care encounters or communication with coworkers that may also infringe on expectations of confidentiality. These accounts were referred to only in general terms so as to protect both the participant and the other person, be it patient or staff, involved.

The participants may have found that discussing their experience with moral distress distressing. Recounting some of the events that caused moral distress may have triggered an emotional response. Participants were reminded before the interview began, and again on completion, of the available Employee Family Assistance Program (EFAP) which offers a variety of free resources including counseling. All participants were also

aware that should they want to end the interview at any time, they were allowed to do so without penalty.

Trustworthiness

Establishing rigor in a qualitative research study is essential as it contributes to the validity and reliability of the study (Creswell & Poth, 2018; Doyle et al., 2020). A rigorous study is most often associated with quantitative research and requires reliability, replication, and validity (Maher et al., 2018). Trustworthiness, as described originally by Lincoln and Guba, lends itself more appropriately to qualitative work (Bradshaw et al., 2017; Doyle et al., 2020; Maher et al., 2018). Trustworthiness requires the establishment of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility. Credibility in this study was established by reviewing the transcription of the interview and preliminary analysis with each participant to ensure accuracy. This is referred to as member-checking and provides the opportunity to participants to correct any potential errors or misinterpretations (Lincoln & Guba, 1985).

Transferability. Transferability requires rich data and thick descriptions of findings to enable readers of the research to determine if the findings are transferable to their context (Lincoln & Guba, 1985). The use of the purposive sampling technique, detailed description of data, and providing transparency in methodology details contributes to transferability (Bradshaw et al, 2017; Lincoln & Guba, 1985). I also ensured that I was transparent with the participants (and readers) regarding my own experiences with moral distress and working in the ED.

Confirmability. To ensure confirmability findings must be "grounded in the data" (Lincoln & Guba, 1985, p. 323). A carefully documented research process also

helps with confirmability. Keeping a research journal notes about my perceptions, thoughts, and feelings throughout the research process and critically reflecting on how the research affected me are all elements of confirmability. I worked to make sure that the views included in the findings are those of the participants and not my own through reflection of what I was seeing emerge as themes.

Dependability. Dependability is met by making sure the research findings are coherent. I have aimed for dependability by communicating throughout the research process with my supervisor and by discussing with the committee key decision points related to my research process.

Data collection

Data collection in descriptive research can be done in a number of ways including observation, focus groups, document review, and most commonly semi-structured interviews (Bradshaw et al., 2017; Doyle et al., 2020; Sandelowski, 2000). Data collection took place during a scheduled 45-60 minute, one on one online interview. It was impractical to attempt in person interviews with participants located in various cities and provinces in Canada. Doyle et al. (2020) support the use of such forums suggesting that they allow for increased flexibility in scheduling and lower research costs.

Potential participants were screened for inclusion and exclusion criteria and when this was met they were sent an email from me containing a consent form (Appendix A) and an information letter explaining the purpose of the study, the research question, and an invitation to schedule an interview. Prior to the interview convening, the consent form and information letter were reviewed and the participant was given an opportunity to ask questions. During the consent process participants also consented to the meetings being

recorded using video, audio, or both. Recordings were used in the data analysis phase and will be discarded after 5 years. Participants were informed that they were able to withdraw from the study at any time without any negative effects.

Data analysis

Analysis of the data in qualitative descriptive research favours content or thematic analysis (Bradshaw et al., 2017; Doyle et al., 2020; Sandelowski, 2000). Thematic analysis uses a 6-step process to identify themes, topics, and ideas that repeatedly present in the data (Caulfield, 2020). Thematic analysis is favoured when using data collection strategies such as interviews and when the research question is centered on learning about the participants' experiences (Caulfield, 2020). The 6-step process, originally developed by Braun and Clarke (as cited in Caulfield, 2020), was utilized in this study. These steps include: familiarization, coding, generating themes, reviewing themes, defining and naming themes, and writing up (Caulfield, 2020). Thematic analysis is an appropriate method to explore the interview data for latent/implicit meaning and to answer the research question (Morgan, 2022). As part of the process initial codes were grouped, rearranged, and collapsed into broader themes.

After completing the data collection, I began my analysis by immersing myself in the data. I listened to the saved audio files multiple times while making a few early notes and comments in my journal. I transcribed the interviews and then re-read them several times again adding notes to my journal. With the aid of computerized software Delve, the data points were coded using an inductive process. During the coding process, 29 different codes were identified. After coding was completed I used the Delve software to begin grouping different codes together. During this process I tried several different

combinations of grouping codes and worked with my supervisor to determine three main themes with several sub themes associated with them. After determining the themes I both listened to and read the transcripts again to confirm that the themes identified were suitable and relevant to the initial research question.

While achieving data saturation could be an impossibility if every person has unique viewpoints and experiences, I felt confident that with the 7 participants I reached a place where I could see repetition in the things they were saying. I recognized that similar themes were emerging and that there were few (if any) new ideas coming forth from the participants.

Summary

This chapter provided an introduction to the methodology used in this study. The research question, participants, sampling process (including inclusion and exclusion criteria), ethical considerations, and approaches used to ensure trustworthiness of the study, and data analysis process was described.

Chapter 5. Results

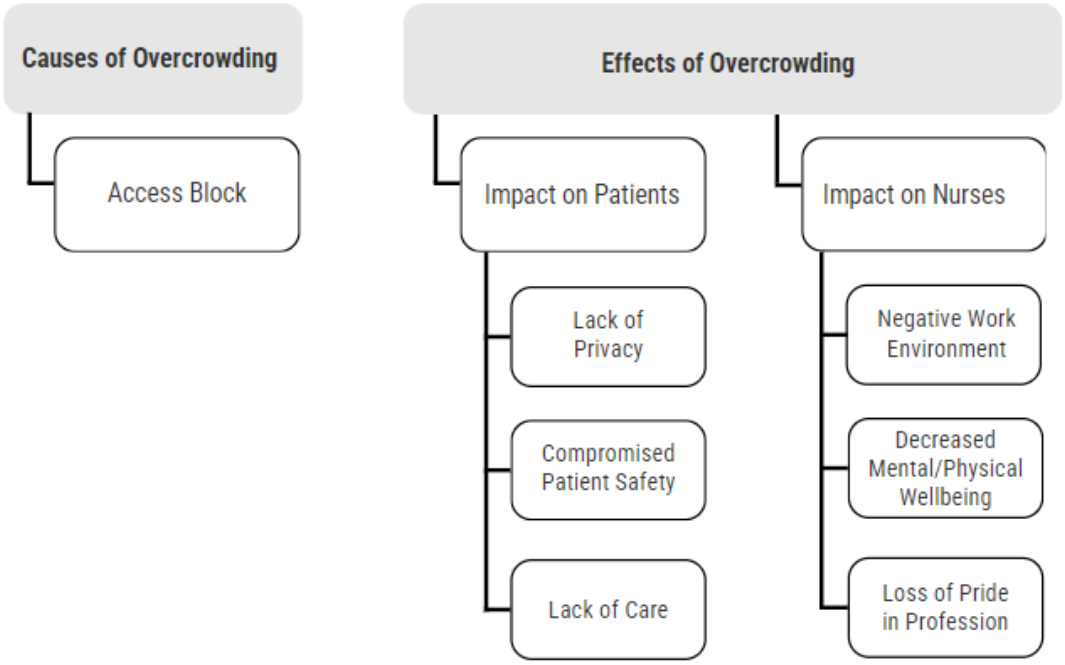
Introduction

In this section I identify the themes and subthemes that emerged during the analysis phase. Seven participants completed the online interviews. The interview questions are listed in Appendix B. All participants were female aged 25-45 years old. All participants were Emergency Department (ED) trained Registered Nurses (RNs) with 4-18 years of experience from a variety of nursing backgrounds. All were currently, or within the previous three months, actively working at the bedside in an ED. Participants were located across Canada spreading over four provinces. One participant had recently quit nursing and two were actively pursuing career paths away from bedside nursing. Interviews took place in July 2021 over Zoom and lasted between 42-58 minutes each.

In this study the research question was: How do ED nurses describe their experience of moral distress when working in an overcrowded ED? Throughout the analysis phase, two main themes emerged (Figure 1). The main themes identified were causes of overcrowding and effects of overcrowding. Two sub themes were also identified, particularly in relation to the effects of overcrowding. Subthemes include the impact of overcrowding on the patients and the impact of overcrowding on nurses.

Figure 2

Themes and Subthemes Identified



Causes of Overcrowding

Access block

All seven participants described access block, the boarding of in-patients, as a factor in overcrowding and a cause of feelings of moral distress. Access block, or boarding of inpatients, happens after the decision has been made to admit the patient into the hospital for treatment. The patient has to wait in the ED until a room or bed is available inside the main hospital. Most inpatient units have a maximum number of patients that can be admitted. When the maximum is reached, patients must wait in the ED for a discharge on an inpatient unit to occur. This wait, or boarding time, can be hours to days in length. During this waiting time the ED becomes overcrowded because

along with the "boarded" patients the ED is expected to stay open welcoming new patients.

The ED does not have a maximum capacity. Participants describe admitted (boarded) patients blocking access to appropriate care spaces for ED patients while waiting for transfers to inpatient units. Participant 6 stated that "the majority of our [ED] beds are taken up by admitted patients… then that means we have a bottleneck of people in the waiting room." Participant 5 stated their department would board up to 40 inpatients a day and shared "it's really the inpatients that are blocking us [from] being able to look after our [new] patients coming through the [ED] department."

Participants discussed how access block contributes to the utilization of hallway spaces as care areas. Prior to COVID-19 hallway nursing in the ED was common. During the early stages of the COVID-19 pandemic, when social distancing and infection control practices were at their peak and more was unknown than known about this new virus, hallway nursing became a distant memory. This only lasted for a few short months. As the pandemic lessened, hallway nursing re-emerged. All participants stated that hallway nursing was practiced regularly in their EDs pre and now post pandemic. Most commonly participants discussed hallway space being utilized by admitted, and often stable patients waiting inpatient bed placement. For example, Participant 3 shared, "there's not enough inpatient spaces so all the patients are stuck in emergency taking up the beds… but lately, we've had high numbers of admitted patients in the department. And so in order to see any of those patients in our emergency, they will pull some of those admitted patients to the hallways to get patients in [to the ED]."

At times participants described utilizing hallway space for less stable patients such as ambulance patients awaiting placement in a care area, mental health patients requiring close observation, or ED patients awaiting assessments. Participant 3 described a decision to pull a critical Cardiac Care Unit (CCU) patient into the hall stating "we had a walk-in stabbing come in and I had to put them in our resus room [but] we had a patient who was a CCU patient who was waiting to be admitted for an n-stemi. You know, I was like, unfortunately, we are pulling that [CCU] patient out into the hallway right now."

New patients arriving to the ED via ambulance transfer with paramedics are often high acuity or have physical needs requiring them to be placed in a bed rather than waiting on a stretcher or in a chair. As a result of access block, badly needed beds are often not available for patients arriving by ambulance. Participant 6 stated, "But there's times that we have to tell them we cannot offload this patient. Last week, at one point, we had five ambulances come at the same time… so we had them just lined up in the hallway and some of them were getting mad at us. But every single space was full." Similarly, Participant 7 shared, "Our ambulances are bringing us patients and we have nowhere to put them. Even the hallways… we're not supposed to use them, but we do. We don't even have that sometimes."

Five participants discussed how these patients often received delays in care and prolonged and excessive waits to be given an ED bed. Participant 5 even described one example of abandonment of a patient who arrived by ambulance when the paramedics were forced to leave the ED to attend to other calls in the community. Typically, paramedics would stay with the patient in the ED until handover of care could take place in a safe manner. This is done when there is both space and nursing capacity to accept

care. In Participant 5's situation the patient was left on a stretcher in the hallway without a nurse being assigned as their caregiver – essentially abandoned.

All seven participants also shared experiences related to how access block leads to patients waiting longer in waiting rooms or minor treatment areas rather than being placed in beds with treatment and monitoring capabilities. Participant 1 described a situation saying, "you end up with people who need a bed and need to be in the intermediate area and they end up being brought into your minor area, because at least they can be seen and have some tests started and have someone have better eyes on them than [if they were] in the waiting room." Three participants described nurse to patient ratios of up to 40 patients per nurse in waiting rooms and 10 to 20 plus patients per nurse in minor treatment areas. All participants reported that this overcrowding of the ED, most often caused by access block, and resulted in negative effects for both nurses and patients.

Effects of Overcrowding

The second theme that emerged from the interviews relates to the effects of overcrowding. From the nurses' perspective, overcrowding in the ED had negative impacts on both nurses and on patients.

Impact on Patients

Study participants consistently reported that overcrowding of the ED negatively impacted people seeking care. The three main effects on patients were lack of privacy, compromised patient safety, and lack of care. Each of these impacts is described with supporting quotes from the interview transcripts.

Lack of Privacy. Participants gave examples of times in their practice as ED nurses where overcrowding resulted in patients being cared for in locations that did not allow for appropriate protection of privacy. Due to the constraints of the overcrowded ED, nurses were often not able to protect the dignity of patients in their care by shielding them from the view of others when providing care. Nurses sensed this situation was hurtful to patients and their family members and equally challenging for the nurses. Nurses are sensitive to the dignity of patients and taught to protect their privacy especially during care that may involve exposure of the body or during conversations about sensitive topics. In overcrowded EDs where out of necessity, nursing care is provided in what are public spaces (i.e., hallways, kitchens, waiting rooms), it becomes impossible for nurses to meet their professional standards for protecting the dignity, privacy, and confidentiality of those in their care. This situation has negative ramifications for nurses and for patients.

For example, Participant 7 described some of the limitations related to assessing patients in the hallway commenting, “you're getting only bits and pieces of the story because everybody is really aware that everybody else around them can hear them. So, they may not be telling you the full truth. They might not be telling you everything.” Several participants shared how they believe their patients feel when they are moved into unconventional spaces, “You’re out in the open… it's like you're nothing. You're a nobody. You're stretcher number 4” (Participant 5). Additionally, Participant 3 shared their perspective of the patient experience stating, “all of a sudden they're being whisked into the hallway amongst supplies and equipment and they're like, oh, well, I've been shunned to the corner and I'm being neglected.” Regarding the lack of privacy that

patients experience in the hallway, Participant 7 described it as “dehumanizing” while Participant 3 described it as “demeaning.”

Lack of Care. ED overcrowding by its very nature pushes nurses into situations where they have more patients and less resources than the system is designed to handle. When this situation arises, ED nurses are forced to constantly reprioritize their work and to balance the risk. The participants in this study all discussed how overcrowding forced them to reprioritize care and other tasks. Some participants described how the reprioritization impacted their patients' care. For instance, Participant 3 stated, “you're doing the bare minimum… [thinking] what needs to get done now and what can wait? I'm going to do the stat meds and maybe I.V. fluids or whatever might be ordered.” Participant 2 shared, “If I can't do it in less than 10 seconds, I probably don't have time to do it… I've stabilized you, I can't care about you anymore. It's not that I don't, it's that I can't.” Participant 5 stated, “there's this huge lack of care because the nurses [are] also looking after 10 or 20 [other patients] that are still sitting in the main waiting room.”

While some participants described being unable to provide complex care, others described how overcrowding limits even basic care. For example, Participant 7 stated “Nobody's really looking after you. You don't get to shower. You don't get to eat proper food.” In relation to overcrowding Participant 4 stated, “I don’t know how the patients are getting appropriate care… people are getting the bare minimum.”

Compromised Patient Safety. Every shift nurses are constantly prioritizing nursing care and interventions for their patients. In an overcrowded ED nurses are often prioritizing by eliminating what they consider to be nonessential tasks and this choice contributes to the lack of care previously described. Patient safety can be compromised

when nurses are over tasked, over saturated, and unable to manage their workload. All study participants described situations where overcrowding led to situations where they believed that patient safety had been compromised. Participants described situations when during their 12 hour shift they were not able to document patient care, vital signs were not done, and patients in the waiting room were never addressed or even looked at to check for acuity changes. When asked about who was the Most Responsible Nurse (MRN), the nurse responsible for taking care of the hallway patients, the participants shared a variety of care models but no model provided for a consistent MRN. The MRN for the hallway patients varied from the charge nurse, a bedside nurse, or an occasional hallway assigned nurse, but all of these assignments were in addition to work and patients already assigned. This situation left participants believing that patient care was compromised due to lack of ownership (assigned accountability for specific patients) and lack of continuity of care. Participants believed that tasks and reassessments would be missed and if a patient was deteriorating, this serious change in condition may not be caught in time. Participant 6 shared, “we try to monitor their vital signs, but we're also a very small department and we're very understaffed. So there's nights where I literally can't reassess people.” Participant 1 added, “you're missing that constant visualization of your hallway patients, which definitely can be a problem if things aren’t going well.”

Placing patients in hallway spaces typically comes with additional inherent risks. Hallway spaces were not designed for patient care and lack standard equipment. Participant 5 shared what the hallway space is like commenting “there's no safety equipment, there's no suction, there's no oxygen, there's no [nurses] that work down that hall.” When talking about one hallway care situation Participant 7 stated, “there was no

room in the hallway to get the crash cart inside and it was a poor outcome." Several participants described having patients in the hall that were not stable. Participant 3 described a patient with a history of seizures presenting to the ED reporting "there's no suction, there's no oxygen at this hallway space… that would be such a terrible situation if they ended up seizing again." Confused patients are often identified as hallway patients so that staff can in theory, keep a closer watch on them. Participants identified however that when confused patients are pulled to the hall, behaviours escalate, and they are a higher risk for delirium. Participant 5 specifically spoke about a patient who was confused and pulled into the hall saying, [the patient was] "right next to the nurse's station so that we could keep an eye on [her]. But then it's just so chaotic that [she] ended up being on [restraints]."

Impact on Nurses

Study participants repeatedly shared how overcrowding and hallway nursing impacted them in a variety of ways. Nurses described how overcrowding contributes to a negative work environment, decreased mental and physical well-being and loss of pride in profession.

Negative Work Environment. During the interviews all participants described the state of the ED they were currently working in. Participant 5 described their current workplace as "hostile", while Participant 4 stated "it's a horrible place to work." Participants described some of the stressors that they believed contributed to what was described either directly or indirectly as a negative work environment. Participant 1 described the constant pressure of working in an overcrowded ED as "enduring stress…

because we are always full, we are in gridlock on a near daily basis, and this becomes the baseline."

Within the negative work environment there was a shared sense by some participants that nurse safety was often compromised. Violence was discussed by multiple participants, most often directed to the nurses by patients or their family members because of long wait times or lack of care. Participant 6 shared, "you'll have families yelling at you. And I know for good reason… I feel like I'm giving them these answers that just aren't sufficient." Participant 7 described leaving the hospital after a shift and interacting with a patient's family member outside "somebody started yelling at me because I was still in my scrubs [saying] 'What the hell are you guys doing in there? Why haven't you seen my wife yet? Why haven't you done anything yet?'"

When nursing staff are in crisis and needing support they reach out to management and hospital leadership for assistance. Most participants described an underwhelming or lackluster response from management when support was requested. The participants described feeling unheard, muffled, and dismissed. Participant 5 stated "And we're just tired, we're exhausted, and we just want something, a little something from our department or our hospital just to say, hey, we hear you guys." Participant 6 shared, "we've been screaming from the rooftops right now to management that need help, we need to fix these issues. And nobody's listening to us."

Decreased Mental and Physical Well-being. Most EDs are open 24 hours a day, 7 days a week, and nursing staff is required on site during all of those hours. Nurses often work 12 hour shifts in the ED with a mix of day shifts and night shifts resulting in a 4 shifts on, 4 off schedule. As a baseline, physically and mentally, shift work is exhausting.

There is often little reserve when added stressors begin to compound onto this already exhausting work. The study participants each described some of the ways their bodies and minds had taken a toll working in the ED. Several descriptions overlapped and included expressions of guilt, helpless, fear, anger, stress, frustration, exhaustion, and anxiety.

The most common feeling expressed by participants was anger. Five out of seven participants described feeling angry about some aspect of their current working conditions. Participant 4 discussed patients receiving the bare minimum care, she stated, "it equates to like built up anger and resentment towards my employer." Participant 7 described the feeling after being forced to move an unstable patient into the hallway commenting, "I've never been more pissed off about being right, because being right about your patient being unstable usually means poor outcomes for the patient."

The feeling of helplessness was another commonly expressed concern. Participant 7 repeatedly stated they felt helpless when discussing workload issues, staffing issues, and a lack of resources like physical space, cardiac monitors and leadership support. They shared "That helplessness, more than anything, is what made me consider leaving emergency [nursing]." Participant 3 discussed the overwhelming workload and questioned "Sometimes [I think], why am I even here? What am I doing? I feel like helpless is probably the word to describe how I feel… I just feel defeated all the time."

Some participants described physical symptoms that were concerning such as depression and anxiety. Participant 6 described their anxiety as "chest tightening [and] tunnel vision… I just feel so on edge." Participant 7 described the lasting effect of the fear and helplessness at the possibility of making a mistake or missing something stating

"it's absolutely terrifying. [I] still have nightmares… I hope this patient that I was really, really worried about didn't deteriorate and die."

Loss of Pride in Profession. The nursing profession is generally accepted by the public as a respected and often noble profession. There is rich history and traditions within the profession that lead new nurses to feel a large amount of pride in holding the title of "Nurse". It was evident in several interviews that some of the participants had become disenfranchised with the profession. Some participants had started to look at leaving not just emergency nursing, but nursing in general. What they described was a loss of pride in the profession of nursing. Participant 4 stated, "I wish I could go back and tell myself never to be a nurse. It's a horrible profession. [People think] nursing is so noble…. No, it isn't. It's a horrible profession… if I had options, I would do something else." Participant 3 discussed not being able to provide the level of care she wants and expects to be able to do. She stated, "I definitely come home and I feel like I was a terrible nurse today. I didn't do a lot of things for patients that I used to be able to do, like, you know, to comfort someone." Participant 5 spoke about her decision to leave emergency nursing due to the overwhelming distress and lack of support in her department. She stated that "we've really lost our voices and the respect of being a nurse… when I first started nursing, I was so proud of my career and I took pride in it. And I've lost that."

Summary

In this chapter the findings were reported including verbatim quotes from the participants. The themes and subthemes were described including two major themes of

causes of overcrowding and effects of overcrowding. Subthemes of impact on nurses and impact on patients associated with the of effects of overcrowding were detailed.

Chapter 6. Discussion

The ED is an inherently high stress environment by the very nature of the types of patients that arrive needing treatment. ED nurses acclimate to this stress and become accustomed to needing to be constantly “on" and ready for anything to walk in the door. Overcrowding is an outside factor that imposes increased stress over and above what ED nurses come to work expecting to experience. A nurse experiences moral distress when they believe that their core values and duties were violated while being prevented from taking appropriate ethical action. This chapter explores the relationship between the findings described in chapter 5 and moral distress experienced by ED nurses.

Returning to Defining Moral Distress

Nurses are especially prone to experiencing moral distress in clinical practice, in part because the scenarios they face daily often necessitate making decisions with moral and ethical ramifications (Ulrich et al., 2010). This possibility may be magnified in the ED environment when overcrowding is experienced requiring nurses to provide care in spaces such as hallways. Jameton (1984) was among the first to define moral distress saying it occurs when a nurse knows what to do in a situation but for some reason is prevented from taking that action. The Canadian Nurses Association (2017) framed moral distress emphasizing that a nurse’s values, commitments, and moral identity are impacted when they experience moral distress.

The negative impacts of moral distress on nurses and patients have been documented in the literature. For example, Cavaliere et al. (2010) reported that moral distress can have negative effects on quality of care, nurse burnout, and can result in nurses leaving the profession. When a nurse experiences ongoing or repeated morally

distressing incidents moral residue can result. Webster and Bayliss (2000) define moral residue as nurses feeling they are responsible for compromising their values or for allowing themselves to be compromised.

Linking Study Findings to Moral Distress Theory

A commonality of the published literature on moral distress in nursing is that it is complex and that the causes are often connected and entwined. There is also agreement that the experience of moral distress has negative consequences for nurses and because of this patient care is negatively impacted. When examining findings from this study in relation to moral distress theory it is helpful to differentiate causes that are external to the nurse (e.g., lack of support, lack of resources) and those that are internal (e.g., values, conflicts).

External Constraints and Structural Empowerment Theory

Structural Empowerment Theory (SET) puts forward the idea that organizational structures and processes influence employee's empowerment and autonomy (Kanter, 1993). It is clear in the findings that the participants experienced overcrowding and the organizational response to this reality (i.e., hallway nursing and lack of support from management) as dis-empowering. Further, lack of staff (i.e., nurses reporting high nurse to patient ratios) could also be considered in the SET model as an organizational process that would negatively affect nurses and their ability to provide the care they wanted to provide, moral distress could result.

Internal Constraints and Rest's Four-Component Model of Morality

The four components of Rest's (1992) model of morality includes:

1. moral sensitivity – being sensitive to situations that have moral implications and knowing there are possible consequences to one's actions,
2. moral judgment – deciding on the most ethically appropriate way to proceed;
3. moral motivation – prioritizing moral values over other personal values if they conflict; and
4. moral character – the ability to act what one believes is morally even if there are challenges.

Moral distress arises then these components conflict (Rest, 1992). In the findings of the study there is evidence that the participants experienced conflict in these internal elements. For example, participants described situations that they knew had moral implications and they also reported being aware that their actions (or lack of actions) would have negative consequences for patient care demonstrating moral sensitivity. Further, in relation to moral judgment, participants expressed experiencing moral distress when they were forced to make decisions believing both options available to them were wrong. An example of moral judgement was when nurses were choosing between putting unstable patients in the hall or leaving an unstable patient in the waiting room without medical or nursing care. Similarly, nurses in this study also reported several instances where they questioned whether or not they were able to meet the Standards of Care set out by their regulatory colleges. This demonstrates a conflict of moral motivation when they were unable to provide privacy and dignity when placing patients in the hallway or when they were unable to document adequately on their patients. Finally, a conflict of moral character was evident as the participants discussed feelings of helplessness. Many had begun to feel so defeated they had become incapable of speaking up and the inability

to do so, or to do so effectively was another source of moral distress. The result was often choosing to leave the profession.

Implications in Healthcare

This study has implications for healthcare policy makers and healthcare leaders. The following recommendations for these stakeholders arise from the findings of this study. Healthcare policy makers could benefit from the findings that indicate that the structural elements of healthcare impact nurses and patients. Policies that prioritize nurse safety and wellbeing and reduce overcrowding in EDs could ultimately enhance nurse satisfaction, improve nurse retention thus reducing nurse attrition, and improve quality of patient care.

Healthcare leaders who read this study might consider adding more supports for RNs working in EDs that nurses find valuable. It is recommended that health care leaders ask nurses for recommendations in terms of what supports they would find helpful especially in times of overcrowding. One recommendations might be for administrators to consider new workload arrangements where non-nursing tasks are completed by other than RNs leaving RNs with time to provide patient care.

Limitations

All studies have limitations. In this study one limitation is that I am a novice researcher. This is my first experience with conducting qualitative interviews and analyzing data. A further limitation is that only seven nurses were interviewed for this study. A larger sample may have netted additional insights since each participant has unique experiences and perspectives. Another limitation of this study is that all

participants were female. The ED typically has a disproportionately higher ratio of male nurses than found in other specialties, none of whom are represented in this study. The focus of this study was entirely set in the ED and as such other nursing specialties were unrepresented. Finally, the findings of this study were not meant to be generalizable given the study design. However, some readers of the study might find the findings transferable to their experience.

Recommendations for Future Research

This study highlights the experience of moral distress in ED nurses which has previously been under researched and potentially undervalued. The ED is a very different environment with very different challenges, many of which are not experienced by nurses working in other areas. Further research should be done looking specifically at the challenges unique to ED nurses and how those challenges impact moral distress.

Summary

This chapter explored the relationship between the findings described in chapter 5 and moral distress experienced by ED nurses. Advanced understandings of moral distress in ED nurses were presented furthering the description of moral distress discussed at the outset of the study. Additionally, the findings were considered in related to moral distress theory.

Chapter 7. Conclusion

Overcrowding in the ED is a complex systems issue that has been building and worsening for years. Overcrowding is often a result of a multitude of system failures often caused from outside the ED itself. Overcrowding cannot and will not be solved in the ED, it is a larger, systems level problem. More space, more nurses, and/or, faster processes will stop or prevent overcrowding. One of the most noticeable and disruptive causes of overcrowding is access block. The study participants repeatedly referenced access block, the backlog of patients waiting in the ED for admission to room inside, as a contributing factor in the overcrowding they were experiencing in their EDs. Access block often leads to placing patients in hallways, closets, break rooms or offices. Access block also contributes to blocked ED beds forcing ED patients to wait longer in waiting rooms and causes a delay in care. When patients are placed in inappropriate care spaces the nurses believe they are often delivering below standard care and that the patient is no longer afforded the basic standards of privacy and dignity. The findings relate to the experience of moral distress in nurses working in overcrowded EDs. Specifically, I found that overcrowding in ED (caused largely by access block) had negative impact on the nurses and on the patients (from the nurses' perspective). Many of the negative impacts on nurses are evident in the definition of moral distress used in this study.

When ED capacity has stretched to the point of overcrowding, nurses are often faced with increased workload and higher patient ratios. This is compounded by short staffing and increasing patient acuity. Nurses are doing more with less every day. Most EDs do not have the capacity to close their doors or redirect patients away. They cannot hold admissions until more staff come in or until a few patients get discharged. The ED

must face the community and be ready at all times for anything that is headed their way. They must do this regardless of the number of staff and despite having no capacity, because if they do not, people will die. Saying no, asking someone to wait, and asking for a minute to breathe can be the difference between life and death for the sickest and most vulnerable patients in our community. Saying yes, allowing for no limits, and pushing through exhaustion can be the difference between life and death for the patients already in our care. Every single ED nurse knows and breathes this every single day. Being unable to say no, and forced by a failing system to say yes, puts ED nurses in a position where they feel they are compromising patient care and safety while being unable to achieve the standard of care they want and expect to be able to provide. This leads to a devastating amount of moral distress on the nurses.

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Appendix A: Consent Form

Moral Distress and Overcrowding in the Emergency Department

PARTICIPANT CONSENT FORM

Principal Researcher:
Laura MacKinnon
MASTER OF NURSING STUDENT
ATHABASCA UNIVERSITY laurabmackinnon@gmail.com

THESIS Supervisor:
Dr Beth Perry
PROFESSOR, ATHABASCA UNIVERSITY
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You are invited to participate in a research study about Moral Distress in the Emergency Department. MORAL DISTRESS IS DEFINED AS "the result of a perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action" (EPSTEIN & HAMERIC, 2009, p. 331). This study will look specifically at the impacts of overcrowding on the registered nurses experience of Moral Distress. I am conducting this study as a requirement to complete my Master of Nursing Degree.

As a participant, you are asked to take part in a scheduled one on one interview via Zoom about your experience of moral distress in an overcrowded emergency department. Participation will take approximately 45-60 minutes of your time. THE INTERVIEW WILL BE RECORDED IN ORDER TO BE TRANSCRIBED BY THE RESEARCHER.

By participating in this study, YOU ARE helping to bring awareness to nurses' experiences of moral distress. Recounting these experiences may trigger an emotional response and unpleasant memories for YOU. YOU will receive a $10 E-gift card of their choice from Starbucks or Tim Hortons as a thank you for participating in the interview process. SHOULD YOU CHOOSE TO WITHDRAW FROM THE STUDY, THIS CARD DOES NOT NEED TO BE RETURNED. Involvement in this study is entirely voluntary and you may refuse to answer any questions or to share information that you are not comfortable sharing. You may withdraw from the study at any time during the data collection period by informing the principal researcher. Any personal information or data collected to that point will be deleted from electronic records.

After the interview has been transcribed it will be provided to YOU for review electronically via email. YOU will be offered the opportunity to discuss or review the transcript with the principal researcher via phone or zoom meeting. YOU will have 14 days to request the meeting to provide comments, clarifications or request withdrawals.

Results of this study may be published in literary journals and will be available electronically to participants upon completion of this project.

If you have any questions about this study or require further information, please contact Laura MacKinnon or Dr Beth Perry using the contact information above.

This study has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns regarding your treatment as a participant in this study, please contact the Research Ethics Officer at 780.213.2033 or by e-mail to rebsec@athabascau.ca.

Thank you for your assistance in this project.

Athabasca University

CONSENT:
I have read the Letter of Information regarding this research study, and all of my questions have been answered to my satisfaction. I will keep a copy of this letter for my records.

My signature below confirms that:

- I understand the expectations and requirements of my participation in the research;
- I understand the provisions around confidentiality and anonymity;
- I UNDERSTAND THAT MY INTERVIEW WILL BE RECORDED AND TRANSCRIBED BY THE RESEARCHER AND WILL BE DELETED AFTER 5 YEARS
- I understand that my participation is voluntary, and that I am free to withdraw at any time with no negative consequences;
- I am aware that I may contact the researcher, research supervisor, or the Office of Research Ethics if I have any questions, concerns or complaints about the research procedures.

Name: _____

Date: _____

Signature: _____

By initialing the statement(s) below,

_____ I am granting permission for the researcher to use a video and/or audio recorder

_____ I acknowledge that the researcher may use specific quotations of mine, without identifying me

_____ I would like to receive a copy of the results of this research study by email

e-mail address:
_____

If you are willing to have the researcher contact you at a later time by e-mail or telephone for a brief conversation to confirm that I have accurately understood your comments in the interview, please indicate so below. You will not be contacted more than six months after your interview.

_____ Yes, I would be willing to be contacted.

Athabasca University

Appendix B: Interview Questions

Prior to commencing the interview, a review of the consent document will take place.

A reminder to the participant that the interview will be recorded using the zoom platform, stored on the researcher's laptop and deleted 5 years from now.

Share with participants:

Epstein and Hamric (2009), provide a definition encompassing all of the above stating "moral distress is the result of a perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action" (p. 331).

Question 1: Describe your experience with moral distress in the ed, can you share any examples of times when you experienced moral distress as a result of overcrowding.

Question 2: Describe how overcrowding impacted your experience of moral distress.

Question 3: How does your experience with moral distress impact you while you are working as a nurse in the ED?

Appendix C: Ethics Approval

Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: 24325

Principal Investigator:
Ms. Laura MacKinnon, Graduate Student
Faculty of Health Disciplines\Master of Nursing

Supervisor:
Dr. Beth Perry (Supervisor)

Project Title:
Moral Distress and Overcrowding in the Emergency Department

Effective Date: June 08, 2021 **Expiry Date**: June 07, 2022

Restrictions:

Any modification or amendment to the approved research must be submitted to the AUREB for approval.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

A Project Completion (Final) Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: June 08, 2021**

Barbara Wilson-Keates, Chair
Faculty of Health Disciplines, Departmental Ethics Review Committee

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