Ethics in Practice for Registered Nurses

JANUARY 2010 ISSN NUMBER 1480-9990

ETHICS, RELATIONSHIPS AND QUALITY PRACTICE ENVIRONMENTS

Consider the following scenarios:

- Ushi, new to Canada and to her job in community health, does not feel accepted by some of the nurses in her practice environment – to the point where she dreads coming to work.
- Gladys' pride in the care she gives to a patient with breast cancer is quickly crushed after a colleague's comment leaves her feeling like she went from one of her better days in nursing to feeling that she may not have her priorities right.
- Donna, a new staff physician at a hospital, feels frustrated by the lack of support she is experiencing, and takes it out on the nurses.
- Ardelle and Mark, experienced home care nurses, once loved their jobs; however, both were beginning to think about leaving. Various pressures and problems were causing morale for the nurses to be at an all-time low.

An environment in which nurses support each other and celebrate nursing makes a healthier place to work.

INTRODUCTION

"I love being a nurse but I hate my job."

According to Canadian nurse scholars Boychuk Duchscher and Myrick (2008, p. 195), the above words capture the "experience of acute care nurses in most health-care institutions across North America." While many nurses have much more positive experiences, this comment certainly reflects the feelings of at least a proportion of nurses working in the Canadian health-care system (Rodney et al., 2002; Rodney, Hartrick Doane, Storch & Varcoe, 2006).

Why do nurses feel this way? For many, the practice environment plays a role and influences how nurses feel about their work.

CANADIAN NURSES ASSOCIATION

"Practice environments that have the organizational and human support allocations necessary for safe, competent and ethical nursing care" are **quality practice environments**[1] (CNA, 2008, p. 27). Factors such as staff shortages, cutbacks and lack of support for nursing can negatively impact a practice environment and significantly decrease a nurse's job satisfaction (Aiken, Clarke, Sloane, Lake & Cheney, 2008; Storch et al., 2009). The quality of the practice environment is an ethical issue because of its important effect on the quality of patient care (Aiken et al., 2008; CNA, 2008; Kramer & Schmalenberg, 2008). It also affects nurses' sense of health and well-being in the workplace (Peter, Macfarlane & O'Brien-Pallas, 2004). Research has shown that when staff and other resources are scarce, nurses experience frustration and **ethical (or moral) distress**, which can interfere with the ability to provide safe and ethical nursing care (Rodney, Hartrick Doane, Storch & Varcoe, 2006).

An environment in which nurses support each other and celebrate nursing makes a healthier place to work.

CONTENTS

It is vital, therefore, that nurses have and use strategies to make their experience in the workplace more positive. One way is through their relationships with others. The Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses* ("the Code") suggests there is "a pressing need for nurses to work with others (i.e., other nurses, other health-care professionals and the public) to create the moral communities that enable the provision of safe, compassionate, competent and ethical care" (CNA, 2008, p. 5). A **moral community** is "a workplace where **values** are made clear and are shared, where these values direct ethical action and where individuals feel safe to be heard" (p. 27). When individuals feel that their views are considered, they are less likely to experience moral distress, even when faced with difficult decisions and limited resources. Understanding relationships as part of ethical practice is therefore important to creating moral community (Austin, 2007) and positive practice environments.

It is essential that employers, regulators, professional associations, unions, governments and society at large work together with nurses to build quality work environments that support nurses in their practice and improve health care and health outcomes. While a healthy work environment is complex, multidimensional and comprises numerous components that require effort by many stakeholders to maintain (Registered Nurses' Association of Ontario, 2009), this *Ethics in Practice* paper will focus specifically on positive nursing relationships as one way nurses can improve their experience within their practice environments. Using the Code as a tool to help foster positive nursing relationships and practice environments will be explored under the following themes: nursing leadership, supporting each other, supporting the team, and supporting the patient and family. The concepts of **relational practice** and **relational connection** (Hartick Doane & Varcoe, 2005) will also be discussed.

[1] Bolded terms are defined in Box 1: Glossary of Terms, on page 3.

BOX 1: GLOSSARY OF TERMS

Ethics – The "moral practices, beliefs and standards of individuals and/or groups" (Fry & Johnstone, 2002, as cited in CNA, 2008, p. 24).

Ethical (or moral) courage – "Stand[ing] firm on a point of moral principle or a particular decision about something in the face of overwhelming fear or threat to himself or herself" (CNA, 2008, p. 7).

Ethical (or moral) disengagement – "Ethical or moral disengagement can occur if nurses begin to see the disregard of their ethical commitments as normal. A nurse may then become apathetic or disengage to the point of being unkind, non-compassionate or even cruel to other health-care workers and to persons receiving care" (CNA, 2008, p. 7).

Ethical (or moral) distress – A feeling of discomfort that "arises in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm" (CNA, 2008, p. 6).

Ethical (or moral) residue – Nurses experience ethical or moral residue "when they seriously compromise themselves or allow themselves to be compromised. The moral residue that nurses carry forward from these kinds of situations can help them reflect on what they would do differently in similar situations in the future" (CNA, 2008, p. 7).

Moral climate – "In health care, the implicit and explicit values that drive health-care delivery and shape the workplaces in which care is delivered" (Rodney, Hartrick Doane, Storch & Varcoe, 2006, as cited in CNA, 2008, p. 26).

Moral community – "A workplace where values are made clear and are shared, where these values direct ethical action and where individuals feel safe to be heard" (adapted from Rodney & Street, 2004, as cited in CNA, 2008, p. 27).

Quality practice environments – "Practice environments that have the organizational and human support allocations necessary for safe, competent and ethical nursing care" (CNA 2001, as cited in CNA, 2008, p. 27).

Relational connection – A way of connecting with others that "requires that nurses turn to people/families/experiences and open themselves up to their fullness and depth … it requires that nurses be willing to be surprised and to feel excitement, fear, uncertainty, or whatever is sparked through the inquiry process" (Hartrick Doane & Varcoe, 2005, p. 200).

Relational practice – "A humanely involved process of respectful, compassionate, and authentically interested inquiry into another (and one's own) experiences" (Hartrick Doane, 2002, p. 401).

Values – "Standards or qualities that are esteemed, desired, considered important or have worth or merit" (Fry & Johnstone, 2002, as cited in CNA, 2008, p. 28).

NURSING LEADERSHIP

Research in Canada and internationally has shown that nursing leadership is a key element of quality practice environments and quality nursing care (Konstantinos & Ouzouni, 2008; Rathert & Fleming, 2008; Siu, Spence Laschinger & Finegan, 2008; Spence Laschinger & Leiter, 2006; Wade et al., 2008). When researchers refer to nurse leaders, they generally mean those in formal leadership (management) positions. Having the support of a strong nurse manager is enabling for nurses in care delivery as it is related to better staffing ratios, better-functioning teams, greater nursing autonomy and in general, a more positive ethical climate. Research has shown that a positive ethical climate is one in which nurses experience recognition and cooperation, support for nursing values and abilities, and opportunities to act on their beliefs (Peter, Macfarlane & O'Brien-Pallas, 2004).

Much of the work of nurse managers involves developing a moral community through relationships where nurses feel that their views are, indeed, valued and respected. The Code states, "Nurses support a climate of trust that sponsors openness, encourages questioning the status quo and supports those who speak out to address concerns in good faith" (CNA, 2008, p.17). It also maintains that nurses "question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same" (CNA, 2008, p. 9). If nurses are to feel comfortable challenging unethical practice and dealing directly with conflict, they need to know that their nurse manager will stand with them and behind them. Managers need to foster an environment that demonstrates a belief in the importance of nursing values and ethical nursing practice. In other words, the nurse manager sets the tone for the moral community. Consider the following scenario as one example.

SCENARIO 1:

Ushi, new to Canada and to her job in community health, was experiencing some challenges in adjusting to her practice environment. She had been working in the health unit for a month and felt that some of the nurses were not accepting her very well. They seemed to question many of her care decisions, and she was getting the impression that they believed her nursing education to be inferior to theirs. She had always thought of herself as an excellent nurse, but in the face of these negative comments her confidence was beginning to slip. It was getting to the point where she was dreading coming to work.

One afternoon Magda, the nurse manager, heard raised voices outside her office door. Marlene, one of the staff nurses, was criticizing Ushi for something she had told a mother who had brought her infant for immunization. Listening to the conversation it was clear that Marlene was being disrespectful to Ushi. Approaching the two nurses, Magda asked what was going on. Ushi looked down and said nothing, but Marlene glared at Magda and said, "I'm tired of all these foreign nurses coming here and bringing down the standards in our unit." She then walked away in a huff.

Magda realized that she would have to address this situation immediately. She followed Marlene and asked her to step into her office. She expressed her disappointment in Marlene, indicating that she felt that a personal attack of this kind was unacceptable. Magda reminded Marlene that she had an obligation to try to make the team function well, and that abusive behaviour could not be tolerated. She pointed out that as a senior nurse, Marlene had a lot of influence, and by being rude and possibly racist, she was setting a negative example. Marlene apologized, but Magda was not certain that she was sincere.

Later that afternoon, Magda took Ushi to her office and asked if she was having problems. Ushi spilled out her frustrations and sense of being isolated and alienated from some of the other nurses. Magda realized that she had done little to ease Ushi's transition into the health unit, having taken for granted that the other nurses would accept her without question. She decided that something could be done at the Friday staff meeting. She asked Ushi to prepare a presentation about health care in her country, highlighting the school where she received her nursing education, some of her experiences as a nurse, and some of the kinds of problems she had overcome in trying to give quality care.

Ushi was nervous about the presentation but was proud of who she was as a nurse, so decided it was worth a try. After the presentation, which appeared to impress the nurses, Magda opened a discussion about some of the similarities and differences in nursing in the two countries. She pointed out that she felt they were very lucky to have Ushi, who would be able to bring a new perspective to the unit. She invited the nurses to welcome her over coffee and cake, and was gratified to see them all talking together. She was especially pleased to hear Marlene say, "I'm really sorry I treated you so badly. I had no idea you had such a lot of experience. Maybe I can learn something from you." She wondered if other nurses would value the opportunity to share their histories, and decided to pose it to them at the next staff meeting.

Nurse managers in particular need to be cognizant of effective conflict-resolution and communication skills, and the importance of relationships. In the scenario above, Magda was sensitive to the tensions, but recognized that strong positive relationships were vital to the workings of the unit. By reminding Marlene that relational connections with other nurses are an important part of ethical practice, and stating that disrespectful interactions would not be tolerated, she was providing leadership. Magda also recognized that it would not be effective to simply tell the nurses that they must respect Ushi. Instead, she helped them to see how Ushi's skills and knowledge were similar to their own and how some of her experiences might be helpful in bringing new ideas to the unit. She took time to evaluate her own role in developing a strong team and was able to see things that she could do differently and then take action. In this way she modeled ethical practice.

Although creating a moral community is essential for ethical practice, it takes time to build well-functioning teams – and that means time away from direct patient care. Too often when units become very busy, among the first things cut are staff meetings, workshops and educational sessions. However, these activities are vital to supporting ethical reflection. Nurse managers can use the Code to justify such activities as a budget item, pointing to how the Code emphasizes "advocating for the discussion of ethical issues among health-care team members…" and the importance of ethical reflection (CNA, 2008, p.21, item xii). They might also point to the fact that the purpose of the Code is to support the highest patient care standards and that failing to provide opportunities for ethical reflection can lead to a diminished quality of care.

Nurse managers need to be skilled in evaluating the need for other resources, such as nursing staff, and advocating for what is required to enable nurses to meet the first nursing value of "providing safe, compassionate, competent and ethical care" (CNA, 2008, p. 8). Essential characteristics of an effective nurse manager are a belief in the importance of the nursing values outlined in the Code and a willingness to stand up for these values. The Code can therefore be an effective tool in identifying key elements of practice and the need for adequate staffing.

Of course, not all nurse leaders are in formal management positions. Opportunities to demonstrate leadership are present in every nursing role. In fact, CNA notes that nursing leadership is "…about the competent and engaged practice of nurses, who provide exemplary care, think critically and independently, inform their practice with evidence, delegate and take charge appropriately, advocate for patients and communities, insist on practising to their full and legal scope and push the boundaries of practice to innovative new levels" (CNA, 2009a, p. 1).

Examination of these items reveals that most of these activities involve relational connections. Nurses who are strongly positive about nursing and who model excellence in their care are nurse leaders. The Code reinforces the notion of positive modeling by stating that "nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses and other health-care team members" (CNA, 2008, p.19). Nurses may need to be reminded of the fact that each individual is a potential leader and that others – particularly students and new graduates – may be watching and learning. They should understand that they might learn from students, too. By being open to new ideas, nurses learn to question their own practice, which is part of ethical reflection.

Nurses can also lead the way by challenging unacceptable practices and being vocal about the support they need to do their work. Although many nurses are reluctant to complain or "make waves," they should remember that "they have an obligation to make their expectations known" (Kramer & Schmalenberg, 2008, p. 69).

Ethical practice requires **ethical (or moral) courage**. It demands constant reflection and awareness of one's own practice and the effect it can have on others, and of the importance of advocating for what is needed to make the moral community strong.

SUPPORTING EACH OTHER

Leaders have a considerable impact on the quality of practice environments, but as suggested above, creating a moral community is not just the role of the nurse manager. All nurses have a part to play. Consider the following scenario, which is based on a nurse's report of her experience.

SCENARIO 2:

Elizabeth had been admitted for further investigation of possible metastases of her breast cancer as she was unable to care for herself at home. Pictures that family members brought in showed that she was usually well-groomed and stylish. However, Gladys, her primary care nurse, saw a very different person. Elizabeth appeared depressed and anxious, refused to bathe or groom herself and wanted only to stay in bed. Gladys felt she should spend some extra time with Elizabeth, despite her other work that also required attention.

Gladys asked Elizabeth if she would like to talk about her fears. The other woman began to cry and then started to talk. She shared her worries for her health, her appearance, her work and her future. Gladys was able to provide some assurances and some information that Elizabeth needed to reduce her uncertainty. After about 30 minutes, Elizabeth smiled faintly at Gladys and said, "Thank you so much. I really needed to talk. I feel so much better just having gotten things out in the open. I can't tell you how much I appreciate your taking this time with me." As Gladys left the room to resume her other duties, she noticed that Elizabeth was preparing to wash. When she checked in at the end of her shift, Elizabeth was sitting beside her bed reading. Her hair had been combed and she had put on a little lipstick. Gladys felt proud, knowing that she had really made a difference.

When giving a report to the oncoming team at change of shift, Gladys's pride in having made a difference to Elizabeth was crushed when Martha, one of the incoming nurses, countered, "It must be nice to have all that time to sit around gabbing with patients. We're too busy for that!" Gladys went from feeling she had one of her better days in nursing to feeling that maybe she did not have her priorities right.

This example is cited here because it reflects a situation that is not uncommon in nursing today. Sometimes nurses contribute to an unhealthy work environment by not supporting other nurses or even treating them in an abusive manner. In fact, the problem has become so prominent that it has been given a name – lateral, or horizontal, violence (Sheridan-Leos, 2008).

There are many theories about why such violence occurs, but the most popular suggests that nurses attack other nurses as a way of dealing with their own frustrations with hierarchy and powerlessness (Griffin, 2004). One of the factors limiting ethical practice was identified to be the dominance of "biomedicine and the corporate ethos" (Rodney et al., 2002, p. 86). In other words, the values that are seen as important are those of medicine and finance. If nurses feel that nursing values – and particularly, relational connections – are not seen as important, they may experience frustration. Constantly being prevented from enacting nursing values can result in feelings of oppression, which can lead nurses to strike out at others whom they perceive to have less power.

A practical suggestion as to how to approach this feeling of powerlessness in a more constructive way can be derived from the work of Maeve (1994), who makes an historical parallel between hunter/gatherer societies and modern medicine/nursing. According to Maeve, in primitive societies it was the female gatherers who provided most of the food and thus sustained the tribe over long periods. Their work was conducted quietly and without fanfare. By contrast, it was the success of male hunters in making a kill that was cause for celebration and feasting. The great hunter was honoured above all others, and his skills and techniques became the stuff of legend. The work done by females, in comparison, was less spectacular and therefore seen as less important. Their skills and

techniques were communicated only among themselves, through story and conversation, with quiet mentoring and support for good work.

Maeve draws an analogy with health care today, describing the relative importance given to the work of medicine (historically dominated by men) and nursing (historically women's work). Much of the media attention and celebration is about medical achievements and medical science, whereas nursing achievements remain relatively unnoticed and undervalued – yet it is the work of nurses that sustains the system on a daily basis. Maeve suggests that the important daily caring work of nurses should be celebrated. Indeed, a vital first step is that this work be recognized within nursing itself. Unfortunately, at present, too often nurses do not feel appreciated even by their co-workers or managers. Furthermore, while nursing is clearly important to those who receive care, seldom is it acknowledged or praised at the bedside or in the care encounter.

What can be taken from Maeve's ideas is a renewed belief in the importance of nursing and an awareness of the need to celebrate daily achievements. One way to grow and sustain a healthy work environment is to acknowledge excellence in nursing work. If nurses feel valued for their efforts and supported by their colleagues, it seems reasonable to assume that lateral violence might diminish. However, if Maeve's analogy holds, nurses themselves will have to be the ones to provide that recognition and reward.

In the scenario above, Gladys felt she had given exemplary care in talking to Elizabeth and helping her to move past her fear and grief. Instead of being rewarded with congratulations for her effort and achievement, Gladys was criticized by her colleague, who appeared to have lost sight of some of the key elements of nursing. The Code puts considerable emphasis on relationships in patient care. However, developing relationships may take time away from tasks and is not always appreciated by other staff. This was seen in the above scenario where Gladys understood Elizabeth's need to talk, but Martha was not supportive. It may be that Martha was reacting to the constant pressure in today's fast-paced system to reduce nursing to tasks, and was feeling that time she had once spent talking with patients had not been valued. Because of this, she could be distancing herself from the importance of relational connections. This could be seen as a form of ethical disengagement.

According to the Code, "**Ethical (or moral) disengagement** can occur if nurses begin to see the disregard of their ethical commitments as normal. A nurse may then become apathetic or disengage to the point of being unkind, non-compassionate or even cruel to other health-care workers and to persons receiving care" (CNA, 2008, p. 7). Some researchers believe that disengagement is a product of **ethical (or moral) residue**, that is, the buildup of unresolved moral distress that has led to compromises over time (Rodney, Brown & Liaschenko, 2004). The frequent expressions of moral distress among nurses who feel that the current Canadian health-care system fails to support ethical practice (Rodney et al., 2002; Rodney et al., 2006; Storch et al., 2009) suggest that the current **moral climate** does not foster nursing values. As a result, many nurses may be losing their belief in the fundamental importance of everyday nursing work.

The Code maintains that as part of a moral community, "all nurses acknowledge their responsibility to contribute to positive, healthy work environments" (CNA, 2008, p.21, item xiii).

What can individual nurses do? One suggestion is that they reflect actively on the values expressed in the Code, and use the Code to support their understanding of what is important in nursing. Then they can work to communicate that importance to others. In one Canadian study of nursing practice, most nurses defined their role primarily in terms of tasks (White et al., 2008), which suggests that nurses need to be more aware of and more articulate about the scope of nursing practice.

CNA envisions nurses exercising leadership in all areas of the health-care system, and nursing talent and competencies being put to full and efficient use in the next decade (CNA, 2009b). If nurses expand their vision of nursing and share their beliefs with other nurses, they can become part of a true reform in health care where they are able to practise according to the values put forward in the Code. Nurses' collective voice becomes stronger when they stand together and when they recognize and reward one another for excellence. When nurses share their stories in more public forums it helps to convey the importance and value of nursing work.

Some directed actions might include:

- making an effort to compliment other nurses when their work reflects ethical commitments of relationships, competence and compassion;
- supporting students in developing a positive understanding of the importance of nursing values;
- standing up for their right to "take the time it takes" to develop the relationships that are foundational to excellent care;
- actively engaging in mentorship and support of other nurses;
- organizing and participating in peer support groups that help nurses express their values and find strategies to enact them; and
- become actively involved in encouraging nurses to work to their full scope, including sharing their views with the public and with policy developers.

When nurses celebrate nursing accomplishments among themselves, they help to develop a healthier workplace, promote better patient care (Beal, Riley & Lancaster, 2008; Spence Laschinger & Leiter, 2006), and even reduce nurse turnover (Schluter, Winch, Holzhauser & Henderson, 2008). When they share their views with others, nurses enhance understanding of what nursing is really about and lessen the chance that nursing is seen by nurses and others only in terms of tasks. Even small efforts can go a long way in promoting nursing values. Thus, supporting each other through relational connections is a key part of ethical practice.

SUPPORTING THE TEAM

Teamwork has been shown to be a vital component of quality practice environments (Kramer & Schmalenberg, 2008; Manojlovich & Spence Laschinger, 2008; Siu, Spence Laschinger & Finegan, 2008) and ethical care. The Code states that, "Nurses treat each other, colleagues, students and other health-care workers in a respectful manner, recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way" (CNA, 2008, p. 14). The following scenario may serve to illustrate the point.

SCENARIO 3:

Donna, a new staff physician, arrived on the unit around 18:45, when nursing staff available on the floor was reduced. Some were at dinner, having been delayed for their breaks, while others were charting before the end of their shift. Donna was feeling rushed and impatient to get on to her next patients. Approaching the desk and seeing several nurses sitting there charting, she exclaimed "It sure would be nice if one of you could get off your butt and give me a hand."

Shawna, the nurse educator on the unit, had come into the nursing station just as Donna was snapping at the nurses. She said, "Donna, may I have a word with you in my office?" In her office, Shawna stated: "Donna, I'm surprised at your rudeness. You understand that nurses have professional responsibilities, one of which is to chart their activities in detail. It is an important part of their job. I think you'll find that you get a lot more teamwork if you speak to nurses in a more professional manner."

Donna looked startled, and responded, "I don't need a lecture right now." Shawna replied calmly, "It wouldn't be

necessary if you chose to speak more politely. I think we need to work together for patient care, not fight among ourselves. I mean no disrespect to you, but I won't allow you to be disrespectful to me and my colleagues, either."

Donna started to leave Shawna's office, then paused and reconsidered, "You know, you're right. I get frustrated when I come to the unit and can't find anyone who knows my patients, or can't find the charts, or can't find what I need. It slows me down and I feel that I'm not able to get to all the things I need to do to take care of my patients. It seems to be getting worse as the hospital gets busier and there are fewer staff around. I guess it's easy to take it out on nurses, but I know they're busy too, and I accept that it's no excuse for being rude."

Donna returned to the nursing station and apologized to the group for her rudeness. Shawna then said to Donna, "How about I help you with what you need now, and we'll see if we can work out a strategy to support you better when you come to the unit?"

Research has shown that nurses often feel disrespected and undervalued in the workplace (Peter, Macfarlane & O'Brien Pallas, 2004) – and interprofessional conflict is a major source of distress (Manojlovich & Spence Laschinger, 2008). Canadian nurse ethicist Wendy Austin points out: "The healthcare team can be an exceptional source of support for its individual members, but when that team support is unavailable, the consequences can be described by words like *lonely, betrayed, misunderstood, and ignored*" (Austin, 2007, p. 85).

What can nurses do to deal with conflict and foster better teamwork? How can nurses improve situations in which they experience lack of support – such as when physicians and other colleagues behave in ways that are demeaning or disrespectful? To start, they can participate in activities that help create a stronger moral community, such as holding regular staff meetings, attending workshops and taking continuing education courses. They can also develop conflict resolution skills to approach problems directly. All these activities can help nurses to develop strong beliefs about their own worth and the value of nursing practice. In the scenario above, Shawna recognized that the physician's behaviour was bullying in nature and that she needed to put a stop to it immediately. She spoke to Donna in a calm, firm and professional tone, making sure to avoid any personal references. Instead, she used their mutual goal of excellence in patient care as a focus. In this way she was able to establish a positive relational connection and maintain a professional stance. After accepting Donna's apology, Shawna offered to help find a solution to Donna's problem and in so doing, made it clear that she valued interdisciplinary collaboration.

Using relational nursing skills to foster a moral community is a necessary element of "advocat[ing] for practice settings that maximize the quality of health outcomes for persons receiving care [and] the health and well-being of nurses …" (CNA, 2008, p. 5). The Code states that, "Nurses in all facets of the profession need to reflect on their practice, [and] on the quality of their interactions with others …" (p. 5). Canadian scholars Gweneth Hartrick Doane and Colleen Varcoe suggest a number of questions that a nurse might ask of him or herself in trying to establish a relational connection: "What circumstances have brought us together? What circumstances hinder collaboration? What are the circumstances of the [other]? What circumstances shape their experience? How is my context shaping my perceptions? What is possible in these circumstances? What is knowable?" (Hartrick Doane & Varcoe, 2005, p. 266). Although focusing on relationships with family, these questions might be used to similar effect with members of the health-care team. A nurse who makes a habit of reflecting in this way may be better able to establish more positive relational connections. Such reflection is implicit in the scenario above, where Shawna was clearly taking into account the circumstances that shaped the experience.

Storch et al. (2009) proposed several strategies that could be useful in helping nurses develop a strong, team-based approach to optimizing the health-care environment. Strategies were based on participatory action research, which was intended to enhance the ethical climate in the workplace. The authors pointed

out that it was useful to view conflicts among team members through an **ethics** lens, as that offered some structure for resolution. They recommended:

- starting with a belief that the environment can be changed, then supporting one another in challenging those aspects that impact negatively on the moral community;
- organizing meetings to bring together interested nurses and other care providers to discuss issues and develop strategies;
- identifying a leader in the group who can move strategies forward;
- working consciously to equalize power dynamics;
- seeking support from others, particularly those higher in the organizational structure;
- organizing workshops to share concerns and develop and practice conflict-resolution skills; and
- building in regular evaluation periods to reflect on what has been done and what still needs doing.

One of the key points made by Storch and colleagues was that nurses must not give up hope, and must not underestimate the power of individual and collective action. It is clear that "to improve ethical practice, nurses must work proactively with other disciplines to identify problems in the moral climate in which they practise and to come up with solutions" (Rodney et al., 2006, p. 27). Taking the first step of acknowledging that good teamwork is integral to ethical practice in nursing, then taking the next steps of working to foster a strong moral climate, are necessary for the delivery of excellent patient care.

SUPPORTING THE PATIENT AND FAMILY

Providing safe, compassionate, competent and ethical care is the first value of the Code. Because of the close relationship between the quality of the practice environment and the quality of care, efforts directed toward creating a more positive environment help improve patient care (Dixon, 2008) and as such, are part of ethical practice. Celebrating nursing is not just about making nurses feel better; it is about helping nurses find the moral courage to stand up for what they need in order to do the job. It is also about giving nurses voice so they can articulate the value of their work, insist on certain practice standards and express their concerns in an effective way. Supporting nursing colleagues is an essential aspect of supporting the patient and family – because a healthy team works more effectively.

Supporting colleagues can help to reduce nurse turnover as well. Researchers have linked nurse burnout to the experience of moral distress (Juthberg, Eriksson, Norberg & Sundin, 2008; Rice, Mohamed, Hamrick, Verheijde & Pendergast, 2008), which, according to the Code, "arises in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm" (p. 6). Burned-out nurses exhibit depersonalization, emotional exhaustion and a sense of low personal accomplishment (CNA, 2007; Trufelli et al., 2008). Common sense tells us that a nurse with these characteristics is less likely to be able to support the patient and family by providing compassionate and ethical care.

Nurses should watch for signs of burnout in their colleagues and work to help them resolve their issues. When nurses are supported in expressing their distress, they are less likely to feel disempowered and voiceless. The Quality Worklife-Quality Healthcare Collaborative publication *Within Our Grasp: A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System* (2007) suggests that best practices in creating healthy workplaces involve built-in or formalized mechanisms for identifying signs of psychological and spiritual distress in nurses. Managers should consider having debriefing sessions for nurses who have been faced with difficult moral issues. Individual nurses can reflect on their own practice and try to be alert to signs of moral distress in others. In so

doing, they will find that the language of ethics can help them to express their concerns and be more vocal and effective in advocating for quality care.

When nurses have strong leadership, support each other, and support the team, they will be more effective in supporting the patient and family. When all members of the health-care community are working together for patient good, care is enhanced. Sometimes nurses have to take direct action to ensure that they have what they need to provide safe, compassionate, competent and ethical care, as illustrated in the following scenario.

SCENARIO 4:

Ardelle and Mark were experienced home care nurses who until recently had loved their jobs. However, both were beginning to think about changing jobs. Morale among the nurses was at an all-time low. Two nurses had resigned and had not been replaced due to budget cuts. As a result, the remaining nurses were taking heavier patient loads, and many felt that care was suffering. In addition, they were having repeated problems with one of the agencies that supplied caregivers for home support. From family complaints it appeared that some of the caregivers were not treating patients with respect. Also, two family physicians were making things difficult for the nurses by not answering telephone calls, by ordering treatments that were not supported by home care policy, and by challenging home care's established protocols for wound and palliative care. The nurses felt they were spending precious time chasing physicians to get different orders.

Ardelle and Mark knew they were not alone in feeling that better teamwork was needed and that they just didn't have enough support to give good care. They prepared an itemized list of their concerns and went to Sook-Yin, their nurse manager, stating that they wanted to do something positive about the problems. Sook-Yin realized that these were serious issues and called a staff meeting to discuss them. The nurses were pleased to have an opportunity to voice their concerns and strategize about solutions, so attendance at the meeting was excellent.

After a spirited discussion, several action strategies were agreed upon. First, Sook-Yin and several of the nurses would meet with the agency manager to work out an effective approach to nursing supervision of agency staff. If the agency was not amenable to that suggestion they were prepared to report to upper-level administration in the health region. A second action was to arrange a meeting with their chief medical officer and the family physicians to discuss issues that were arising. Finally, they agreed that part of the problem with scarce resources was that nurses were not working together effectively, with the result that workloads were difficult to manage. Sook-Yin agreed to advocate to the region to find some money to sponsor a day-long workshop during which nurses could examine their work practices and develop more efficient approaches. The nurses left the meeting excited that action was being taken and feeling like the patients would be getting the care they deserved.

In this scenario, nurses were compromised in their ability to deliver good care, which in turn impacted their patients. Taking action was an ethical responsibility. The Code states that, "When resources are not available to provide ideal care, nurses collaborate with others to adjust priorities and minimize harm. …They inform employers about potential threats to safety" (CNA, 2008, p. 9). It also states that, "Nurses make fair decisions about the allocation of resources under their control based on the needs of persons, groups or communities to whom they are providing care. They advocate for fair treatment and for fair distribution of resources for those in their care" (p. 17). In advocating for more supervision of agency staff, better working relationships with family physicians and more effective use of nursing time, the nurses were acting ethically to support the patient. Ardelle and Mark used their leadership, communication and relational skills in approaching Sook-Yin with a positive attitude. Sook-Yin demonstrated effective leadership in being open to their concerns and taking action to address them. The result was a stronger sense of moral community and, ultimately, greater support for patients.

CONCLUSION

Nursing ethics is about much more than making decisions in difficult moral dilemmas. While moral dilemmas certainly arise in health care, nursing ethics, to a large extent, is about everyday interactions with patients, families and colleagues. Relational connections with others are central to nurses' ability to give safe, competent, compassionate and ethical care because the strength of the moral community depends on such connections. Development of a positive work environment starts with effective leadership, as it takes a leader to make things happen. Managers are key, but individual staff nurses are also responsible for demonstrating leadership in ethical practice. An environment in which nurses support each other and celebrate nursing makes a healthier place to work. When the team is supported and everyone works together toward patient good, patients are better supported.

The Code maintains that the quality of the work environment in which nurses practise is fundamental (p. 1) and has a significant influence on practice (CNA, 2008, p. 4). The Code also "serves as an ethical basis from which nurses can advocate for quality work environments that support the delivery of safe, compassionate, competent and ethical care" (CNA, 2008, p. 2). Other CNA publications can also give nurses guidance and support (see Box 2). In addition, the provincial and territorial nursing associations and colleges have many helpful resources on their websites. Understanding the role of relationships in contributing to a positive workplace is important to nurses fulfilling their ethical mandate of providing safe, compassionate, competent and ethical care.

BOX 2: RESOURCES ON SUPPORTING QUALITY PRACTICE ENVIRONMENTS

Canadian Nurses Association publications:

- *Ethics in practice: Ethical distress in health care environments*. (2003)
  http://www.cna-aiic.ca/cna/documents/pdf/publications/Ethics_Pract_Ethical_Distress_Oct_2003_e.pdf
- *Improve your practice environment: CNA's action guide for nurses*. (2009)
  http://www.nurseone.ca
- Improving practice environments: Keeping up the momentum. *Nursing Now*. (2007)
  http://www.cna-nurses.ca/CNA/documents/pdf/publications/NN_Improving_Practice_Environments_2007_e.pdf
- *Joint CNA/CFNU Position Statement on Workplace Violence*. (2008)
  http://www.cna-aiic.ca/CNA/documents/pdf/publications/JPS95_Workplace_Violence_e.pdf
- Lowe, G., *Making a measurable difference: Evaluating quality of work life interventions*. (2006)
  http://www.grahamlowe.ca/documents/144/20060317%20Making%20a%20Measurable%20Difference%20-%20english.pdf
- *Nursing leadership* [Position statement]. (2009)
  http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS109_Leadership_2009_e.pdf
- *Overcapacity protocols and capacity in Canada's health system* [Position statement]. (2009)
  http://www.cna-nurses.ca/CNA/documents/pdf/publications/PS101_Overcapacity_e.pdf
- *Patient safety* [Position statement]. (2009)
  http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS102_Patient_Safety_e.pdf
- *Practice environments: Maximizing client, nurse and system outcomes*. [Joint CNA/CFNU position statement]. (2006)
  http://www.cna-nurses.ca/CNA/documents/pdf/publications/PS88-Practice-Environments-e.pdf

REFERENCES

Aiken, L. H., Clarke, S. P., Sloane, D. M., Lake, E. T., & Cheney, T. (2008). Effects of hospital care environment on patient mortality and nurse outcomes. *Journal of Nursing Administration, 38*, 223-229.

Austin, W. (2007).The ethics of everyday practice: Healthcare environments as moral communities. *Advances in Nursing Science, 30*, 81-88.

Beal, J. A., Riley, J. M., & Lancaster, D. R. (2008). Essential elements of an optimal clinical practice environment. *Journal of Nursing Administration, 38*(11), 488-493.

Boychuk Duchscher, J, & Myrick, F. (2008). The prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum, 43*(4), 191-206.

Canadian Nurses Association. (2007). Improving practice environments: Keeping up the momentum. *Nursing Now: Issues and Trends in Canadian Nursing.* Ottawa: Author.

Canadian Nurses Association (2008). *Code of ethics for registered nurses.* Ottawa: Author.

Canadian Nurses Association. (2009a). *Nursing leadership* [Position statement]. Ottawa: Author.

Canadian Nurses Association (2009b). *The next decade: CNA's vision for nursing and health*. Retrieved November 1, 2009, from http://www.cna-nurses.ca/CNA/resources/next-decade/pdf/default_e.aspx

Dixon, J. F. (2008). The American Association of Critical Care Nurses standards for establishing and sustaining healthy work environments: Off the printed page and into practice. *Critical Care Nursing Clinics of North America, 20*, 393-401.

Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *Journal of Continuing Education in Nursing, 35*, 257-263.

Hartrick Doane, G., & Varcoe, C. (2005). *Family nursing as relational inquiry: Developing health-promoting practice.* Philadelphia: Lippincott, Williams & Wilkins, 261-288.

Hartick Doane, G. (2002). Beyond behavioral skills to human-involved processes: Relational nursing practice and interpretive pedagogy. *Journal of Nursing Education, 41*, 400-404.

Juthberg, C., Eriksson, S., Norberg, A., & Sundin, K. (2008). Stress of conscience and perceptions of conscience in relation to burnout among care-providers in older people. *Journal of Clinical Nursing, 17*, 1897-1906.

Konstantinos, N., & Ouzouni, C. (2008). Factors influencing stress and job satisfaction of nurses working in psychiatric units: A research review. *Health Science Journal, 2*, 183-195.

Kramer, M., & Schmalenberg, C. (2008). Confirmation of a healthy work environment. *Critical Care Nurse, 28*(2), 56-63.

Maeve, K. M. (1994). The carrier bag theory of nursing practice. *Advances in Nursing Science, 16*(4), 9-22.

Manojlovich, M., & Laschinger, H. K. (2008). Application of the nursing worklife model to the ICU setting. *Critical Care Nursing Clinics of North America, 20*, 481-487.

Peter, E. H., Macfarlane, A. V., & O'Brien-Pallas, L. L. (2004). Analysis of the moral habitability of the nursing work environment. *Journal of Advanced Nursing, 47*(4), 356-367.

Quality Worklife-Quality Healthcare Collaborative. (2007). *Within our grasp: A healthy workplace action strategy for success and sustainability in Canada's healthcare system.* Ottawa: Canadian Council on Health Services Accreditation. Retrieved August 12, 2009, from http://www.cna-aiic.ca/CNA/documents/pdf/publications/2007_QWQHC_Within_Our_Grasp_e.pdf

Rathert, C., & Fleming, D. (2008). Hospital ethical climate and teamwork in acute care: The moderating role of leaders. *Health Care Management Review, 33*, 323-331.

Registered Nurses' Association of Ontario. (2009). *Healthy work environments best practice guidelines: Preventing and managing violence in the workplace.* Toronto: Author.

Rice, E. M., Mohamed, Y. R., Hamrick, A., Verheijde, J. L., & Pendergast, D. K. (2008). Determinants of moral distress in medical and surgical nurses at an adult acute tertiary care hospital. *Journal of Nursing Management, 16*, 360-373.

Rodney, P., Hartrick Doane, G., Storch, J., & Varcoe, C. (2006). Toward a safer moral climate. *Canadian Nurse, 102*(8), 24-27.

Rodney, P., Brown, H., & Liaschenko, J. (2004). Moral agency: Relational connections and trust. In J. Storch, P. Rodney, & R. Starzomski (Eds.). *Toward a moral horizon: Nursing ethics for leadership and practice.* Toronto: Pearson Prentice Hall, pp. 154-177.

Rodney, P., Varcoe, C., Storch, J. L., McPherson, G., Mahoney, K., Brown, H., Pauly, B., Hartrick, G., & Strarzomski, R. (2002). Navigating towards a moral horizon: A multisite qualitative study of ethical practice in nursing. *Canadian Journal of Nursing Research, 34*(3), 75-102.

Schluter, J., Winch, S., Holzhauser, K., & Henderson, A. (2008). Nurses' moral sensitivity and hospital ethical climate: A literature review. *Nursing Ethics, 15*, 304-321.

Sheridan-Leos, N. (2008). Understanding lateral violence in nursing. *Clinical Journal of Oncology Nursing,12*(3), 399-40.

Siu, H., Spence Laschinger, H. K., & Finegan, J. (2008). Nursing professional practice environments: Setting the stage for constructive conflict resolution and work effectiveness. *Journal of Nursing Administration, 38*(5), 250-257.

Spence Laschinger, H. K. S., & Leiter, M. P. (2006). The impact of nursing work environments on patient safety outcomes: The mediating role of burnout engagement. *Journal of Nursing Administration, 36*(5), 259-267.

Storch, J., Rodney, P., Pauly, B., Fulton, T. R., Stevenson, L., Newton, L., & Makaroff, K. S. (2009). Enhancing ethical climates in nursing work environments. *Canadian Nurse, 105*(3), 20-25.

Trufelli, D. C., Bensi, C. G., Garcia, J. B., Narahara, J. L., Abrao, M. N., Diniz, R. W., Da Costa Miranda, V., Soares, H. P., & Del Giglio, A. (2008). Burnout in cancer professionals: A systematic review and meta-analysis. *European Journal of Cancer Care, 17*, 524-531.

Wade, G. H., Osgood, B., Avino, K., Bucher, G., Bucher, L., Foraker, T., French, D., & Sirkowski, C. (2008). Influence of organizational characteristics and caring attributes of managers on nurses' job enjoyment. *Journal of Advanced Nursing, 64*, 344-353.

White, D., Oelke, N., Besner, J., Doran, D., McGillis Hall, L., & Giovannetti, P. (2008). Nursing scope of practice: Descriptions and challenges. *Nursing Leadership, 21*, 44-57.

Ethics in Practice *is published by the Regulatory Policy department of the Canadian Nurses Association (CNA).*

Copies are available on CNA's website.

For more information, mail, fax or e-mail:
Canadian Nurses Association
50 Driveway
Ottawa, ON Canada K2P 1E2
Telephone: 1-800-361-8404
or 613-237-2133
Fax: 613-237-3520
E-mail: info@cna-aiic.ca
Website: www.cna-aiic.ca

ISSN 1480-9990